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Health Communication Inequalities in the Digital Age: A Study of Marginalized Communities

Priyanka Maheshwari

Research Scholar, Department of Media Communication and Fine Arts, Manipal University Jaipur, India

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ABSTRACT

The high rate of digitalization of healthcare communication has fundamentally changed the nature in which health information is generated, shared, and utilized in society. Though online platforms could offer more opportunities, effectiveness, and active interactive communication, they also lead to the possibility of reproducing traditional social and communication disparities. The digital era of health communication disparities critically analyzes this paper by giving special focus to the marginalized communities in the Global South, especially India. The study applies the theory of communication inequality, digital divide models, and health humanities viewpoints to have a qualitative-dominant mixed-methods approach, which utilizes systematic literature reviews, secondary data analysis of global and national health reports, and a critical approach to the digital health communication practices. The results indicate that digital health communication tends to replicate structural injustices based on socioeconomic status, education, language, gender, geography, and digital literacy. The article posits that digital health initiatives will increase health disparities instead of decreasing them unless designed with intentional equity and mediated through the community. The paper ends on the importance of redefining digital health communication into a human rights and social justice problem, which should be supported with an inclusive, culturally sensitive, and participatory model of communication.

Introduction

Health communication holds a key role in the public health systems, and it determines how people perceive illness, as well as assess risk and seek preventive and curative health services. Over the past few decades, the rise of digital technologies has transformed health communication practices, and the flow of information is no longer directed to the traditional mass media and interpersonal communication, but rather to digital resources, which include websites, mobile applications, telemedicine services, and social media. Digital communication infrastructures are becoming important in governments, health institutions and global organizations to distribute health news, health emergency management and behavior change. But the idea that digitalization is a process of health communication democratization has been thoroughly debunked in recent scholarship. The digital health communication exists in highly unequal social settings. The availability of digital technologies including access to appropriate digital platforms, the ability to navigate the digital environment and the ability to critically assess health information is not distributed equally. Poverty, low levels of education, caste and ethnic disadvantage, gender inequality, isolation in rural areas, marginality in languages, and disability have been identified as marginalized communities that can be restricted in terms of meaningful engagement in digital health ecosystems due to structural factors. Due to this fact, a digital health project can lead to inadvertent discrimination of more privileged groups and leave out the most vulnerable who need the correct and accessible health information the most. The purpose of the paper is to assess the critical analysis of health communication inequalities in the

***Corresponding Author:** Priyanka Maheshwari
Address: Research Scholar, Department of Media Communication and Fine Arts, Manipal University Jaipur, India
Email ✉: priyanka.23fa30smc00002@muj.manipal.edu

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digital era that will be achieved by considering how digital health communication systems interplay with other social hierarchies that are already present. The main thesis pursued in this paper is that digital health communication cannot be perceived as a technological innovation but should be viewed as a socio-cultural and political process, which is inherent to power relationships. This study will help to add to the interdisciplinary discussions on health communication, media studies, and development communication by placing digital health communication in a humanistic and equity-oriented context.

Review of Literature

The presence of scholarly interest in health communication inequality is based on the wider literature on communication differences and social determinants of health. According to the communication inequality theory, the disparities in accessibility to communication resources, information exposure, and message processing ability are the reflection and replication of the existing social inequalities (Viswanath and Finnegan, 1996). The available empirical data has always shown that the better one is socioeconomic, educated and media literate, the more he/she is likely to actively seek health information, understand the complex medical messages, and translate knowledge into health promoting behavior (Nutbeam, 2008). The digital divide is a concept whose definition has evolved over a long time since it was first defined as a dichotomy between internet-enabled and internet-disabled people. Modern researchers single out several layers of digital inequality, such as inequalities in digital abilities, patterns of usage, and the actual benefits of digital interaction. These stratified divides take the form of imbalanced access to telemedicine, mobile health applications and online public health campaigns in health settings (World Health Organization [WHO], 2022). The experience of low- and middle-income countries indicates that digital health programs frequently do not reach marginalized populations because of the infrastructural constraints, poor digital literacy, and insufficient confidence in institutional channels of communication (Rana, 2024). Health literacy has a mediating role that is vital in the exposure of communication and health outcomes. Digital health literacy goes further than just the level of basic reading, to encompass the capacity to navigate digital interfaces, evaluate the legitimacy of online information, and decode the role of algorithms in determining the visibility of content. Studies show that a low level of digital health literacy correlates with a high susceptibility to health misinformation, especially in the time of a pandemic (Kbaier et al., 2024; Tsao et al., 2021). This weakness is compounded in the situations when the institution is distrusted and health communication is seen to be top-down or alien to the culture. Digital health communication is also complicated by cultural and linguistic reasons. Health messages tend to be created using the most common languages and through the prism of biomedical thinking that can not necessarily be adapted to local belief systems or experience. These cultural differences can decrease the relevance and uptake of the message, supporting exclusion, as opposed to empowerment (Rana, 2024). Health humanities theorists state that beneficial and ethical communication of health, especially among the marginalized groups, depends on narrative inclusion, empathy, and lived experience recognition.

Objectives of the Study

- To critically examine nature and the level of inequalities in health communication in the digital era.
- To address the connections between digital health communication systems.
- To find out current social and structural inequalities.
- To determine the socio-cultural and technological dimensions.
- To identify human-centered digital health communication practices.

Research Methodology

The research design in this study is a qualitative-dominant mixed-method study focusing on depth of interpretation and critical synthesis as opposed to statistical generalization. The methodology of the research relies on three interconnected methodological elements, including the systematic literature research, the secondary analysis of the policy and institutional reports, and the critical analysis of digital health communication practices. The systematic literature review implied the recognition and discussion of peer-reviewed journal articles that were published in 2018-2024 in the spheres of health communication, public health, media studies, and information science. A combination of key words was used in academic databases, including Scopus, Web of Science, PubMed, and Google Scholar, and included the keywords digital health, communication inequality, marginalized communities, and health literacy. The research studies were chosen through relevancy, methodological quality, and value addition to the knowledge of digital health disparities. The sources of secondary data were reports issued by international organizations (mostly the World Health Organization) and national policy documents and surveys regarding the problem of digital health and internet access in India. This set of sources has given contextual and institutional insights into the process and effects of digital health initiatives. Moreover, the critical qualitative analysis of the chosen digital health communications campaigns was performed to investigate the way health information is framed, disseminated, and presented on the digital platform. The selection of campaigns was done purposely to show the variation in the language use, type of platform, and target audience. The study was analytically oriented on narrative framing,

linguistic accessibility, interactivity, and implicit beliefs regarding the digital competence of the users.

Data Analysis and Interpretation

Thematic synthesis was used in data analysis and incorporated the knowledge gained in literature, policy documents, and media. The coding of the textual data was inductively and deductively coded with the aim of identifying the patterns of recurrence of access, literacy, language, trust, and algorithmic visibility. Interpretive analysis pointed at the intersection of these dimensions as a means of yielding differentiated health communication experiences among the marginalized populations. It was found that infrastructural issues like poor internet connectivity and access to smartphones remain limitations to digital health use by rural and low-income communities. Limited digital and health literacy limits the capacity of users to understand medical information accurately even in the case of availability. Language proved to be a major exclusion criterion, industrialization of most digital health contents favoring dominant languages and technical terms. The prioritization of social media feeds through algorithms continues to marginalize information about the health of the population, with the highest-ranking content being the most sensational content, or the content with the highest engagement at the cost of the accuracy and inclusivity criteria.

Findings and Discussion

The evidence shows that digital health communication often replicates the present social inequalities instead of alleviating them. Digital health platforms have not been accessible, confusing, or even relevant to marginalized communities because of both infrastructural, linguistic, and cultural barriers. The absence of participatory design in digital health projects is one of the factors of mistrust and disengagement, especially in the population that has endured the exclusion condition in the formal healthcare systems. The research also establishes that misinformation is an aspect that prospers in such situations where authoritative health communication does not make any impression either culturally or linguistically, making individuals vulnerable during health emergencies. The results highlight the shortcomings of technologically determined methods of health communication. Digital health projects tend to emphasize scale and efficiency at the expense of equity and cultural relevancy, which is indicative of even more generalized neoliberal tendencies in the governance of public health. Critically, the concept of digital health communication should be viewed as a place of power in which knowledge matters and whose voices are listened to are determined by decisions regarding language, platform design and visibility of content. Humanities' approach on matters of health draws on the ethical value of focusing on lived experience, empathy, and narrative inclusion in health communication. Intermediary acts including health workers and community organizations are vital in overcoming such digital divides by putting health information in context and humanizing them.

Conclusion

This paper has concluded that health communication disparity during digital age is not only a matter of technology but also a social and ethical issue. Digital health communication can positively influence the health outcomes of the population, though only under the conditions of being based on the principles of equity, participation, and cultural sensitivity. Reducing the digital health disparity can be achieved through combined efforts of both infrastructural investment and media and health literacy programs, participatory content design, and policies that clearly reinforce the prioritization of the marginalized groups. To make sure that technological innovation helps to promote health equity instead of worsening the existing disparities, it is necessary to reconceptualize the field of digital health communication as a human right challenge.

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