

Much Ado About COVID -19 Vaccine[s]: Understanding Perceptions and Experiences of vaccines among Healthcare Workers in Three Hospitals in Eswatini

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COLLEGE OF HUMANITIES DECLARATION

I, Nqobile Thobile Ndzinisa (216073982) declare that:

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For the completion of this work, all glory and honour goes to my Lord and Saviour, Jesus Christ…: "*My mouth is filled with Your praise and with Your glory all day long*..."**Psalm 71:8** This work is a product of His unfailing grace.

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DEDICATION

To my mother, who placed a book in my hands before I could even read, nurturing the curiosity that has guided me ever since.

To my father, whose quiet pride has been a steady reminder of the value of this journey, even when its meaning was not always clear.

And to my sister Nokuphila, my constant cheerleader, who called me “Dr” long before the results of this work were visible – your belief in me has always been unwavering and I love you for that.

ABSTRACT

The COVID-19 pandemic has been widely narrated through biomedical framings and global statistics, yet such accounts often obscure the lived realities and perceptions of healthcare workers in fragile health systems. In Eswatini, nurses occupied a dual role as frontline caregivers and trusted community communicators, navigating systemic shortages, cultural expectations, and contested narratives around vaccination. This study interrogates how nurses perceived, experienced, and communicated about COVID-19 vaccines, situating their voices within broader debates on health communication, cultural identity, and systemic fragility.

Methodologically, the research makes a distinctive contribution by employing Interpretative Phenomenological Analysis (IPA) in combination with in-depth interviews and focus group discussions. This design captured both individual narratives and collective negotiations of meaning, enabling a nuanced understanding of how nurses interpreted vaccination within contexts of trauma, stigma, and resilience. By explicitly foregrounding perception alongside experience, the study demonstrates how IPA can be extended to interrogate communicative practices in under-resourced, culturally complex health systems. Nurses at Raleigh Fitkin Memorial, Mbabane Government, and Hlatikulu Government Hospitals were purposefully selected because they were the first recipients of vaccines and simultaneously key intermediaries between state messaging and community realities, making their perspectives critical for understanding how trust and authority were negotiated in practice.

Findings reveal that nurses' perceptions of vaccination were shaped by trauma, stigma, and resilience. Trauma extended beyond clinical encounters to encompass psychological strain and uncertainty; stigma manifested in how nurses were perceived as potential carriers of infection; resilience was expressed through improvisation, peer support, and faith commitments, yet often masked systemic vulnerabilities. Importantly, nurses contested reductive framings of "hesitancy," articulating concerns rooted in cultural identity, professional responsibility, and inequitable resource distribution. Their accounts demonstrate that vaccine communication cannot be reduced to compliance or behavioural deficit but must be understood as a negotiation of trust across biomedical and cultural domains, particularly in a context where the government of Eswatini did not impose vaccine mandates yet expected citizen; including nurses, to be vaccinated.

This study contributes to scholarship by addressing three critical gaps: the limited attention to healthcare workers' communicative roles in under-resourced contexts; the dominance of

biomedical framings that marginalise cultural identity and systemic fragility; and the lack of methodological approaches that capture perception as well as experience. Its methodological innovation; using IPA to foreground nurses' meaning-making through interviews and focus groups, marks its most significant contribution, offering a model for future research that seeks to capture the complexity of frontline health communication. These insights are vital for strengthening pandemic preparedness and designing strategies that resonate with communities in Eswatini and comparable settings.

KEY WORDS: COVID-19 vaccination; nurses; health communication; fragile health systems; Eswatini; cultural identity; Interpretative Phenomenological Analysis (IPA)

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LIST OF ACRONYMS

AFDB – African Development Bank

AIDS – Acquired Immunodeficiency Syndrome

CDC – Centres for Disease Control and Prevention

COVID-19 – Coronavirus Disease 2019

ENHI – Eswatini Nazarene Health Institutions

FDGs - Focus Group Discussions

HBM – Health Belief Model

HIV – Human Immunodeficiency Virus

IPA – Interpretative Phenomenological Analysis

MoH – Ministry of Health (Eswatini)

NGO – Non-Governmental Organization

RFM – Raleigh Fitkin Memorial Hospital

MGH – Mbabane Government Hospital

HGH – Hlatikulu Government Hospital

TB – Tuberculosis

TPB – Theory of Planned Behaviour

TTM – Transtheoretical Model

UNAIDS – Joint United Nations Programme on HIV/AIDS

UNDP – United Nations Development Programme

UNICEF – United Nations Children's Fund

WHO – World Health Organisation

CHAPTER ONE

OVERVIEW OF THE STUDY

Introduction

The COVID-19 pandemic has often been narrated through global statistics, biomedical framings, and state-led interventions. Yet such accounts risk presenting the crisis as a uniform event, obscuring the uneven realities of how communities and healthcare workers experienced it. In Eswatini, the pandemic was not simply a biomedical emergency but a social, political, and communicative phenomenon. Government measures, international aid, and scientific advancements contributed to managing the crisis, but questions remain about whether these interventions translated into equitable outcomes. Persistent challenges in resource distribution, infrastructural readiness, and community engagement continued to define the country's capacity to respond effectively (Mabundza, 2020).

Eswatini's healthcare system illustrates this tension between progress and vulnerability. Targeted investments have led to measurable improvements, including rising life expectancy and declining AIDS-related deaths (Statista, 2025; UNAIDS, 2025). The country continues to carry one of the highest HIV prevalence rates globally, with approximately 25.6% of adults living with HIV (UNAIDS, 2023). Despite substantial international support, the country's health sector remains underfunded and unevenly resourced, with persistent gaps in service delivery and institutional capacity (World Health Organization, 2022a). These systemic weaknesses were not abstract policy concerns but daily realities for nurses, who navigated shortages of supplies, uneven access to medicines, and communities whose trust in biomedical authority was often fragile (Bell et al., 2025; Truppa et al., 2024).

Framing the pandemic in terms of "waves" or "hesitancy" further illustrates how dominant narratives can obscure lived experience. Official briefings described successive phases of infection, yet frontline workers reported a continuous burden that did not neatly align with epidemiological curves. Similarly, doubts about vaccines were frequently labelled as "hesitancy," a term that risks dismissing legitimate concerns about safety, fairness, and global inequities (de Figueiredo et al. 2020; Paul, et al, 2020; Gumede, 2021). To problematise these

categories is to recognise that communities were not passive recipients of biomedical directives but active participants negotiating trust, authority, and survival.

This study situates Eswatini's pandemic response within these contested narratives. By foregrounding the perspectives of nurses, it highlights how systemic vulnerabilities, cultural expectations, and communicative practices intersected to shape the country's public health positioning and trajectory. In doing so, it challenges reductive framings of the pandemic and underscores the importance of context-specific analysis that acknowledges both structural inequities and the everyday labour of healthcare workers.

This chapter therefore situates Eswatini's pandemic response within contested narratives of crisis, authority, and communication. By foregrounding the perspectives of nurses, it highlights how systemic vulnerabilities and cultural expectations intersected with biomedical directives to produce uneven outcomes. Nurses' roles as intermediaries between state messaging and community realities make them central to understanding how the pandemic was experienced, narrated, and negotiated in Eswatini.

Having outlined the purpose and focus of this research, it is important to situate the study within the wider global and national contexts of the COVID-19 pandemic. The background provides the foundation for understanding how international developments, regional dynamics, and local realities shaped Eswatini's response and why nurses' perspectives are central to this inquiry.

Background to the study

The emergence of COVID-19 in late 2019 prompted an urgent global response, culminating in the rapid development of vaccines by December 2020. International health bodies such as the World Health Organisation (WHO) framed vaccination as the most effective strategy to curb transmission and restore social and economic stability (World Health Organization, 2021a; World Health Organization, 2022). Initial campaigns were concentrated in high-income countries, while African nations began their programmes later, often under conditions of resource scarcity and structural vulnerability (UNICEF, 2021; Adebisi et al., 2021).

Health communication became central to these efforts, with campaigns designed to promote vaccine uptake and counter misinformation. However, dominant approaches were largely biomedical and top-down, privileging institutional authority while neglecting the lived realities of healthcare workers and communities (Dutta, 2021; Govender, 2021). These framing risks

presenting vaccine hesitancy as a behavioural deficit rather than a contextually grounded response shaped by inequities, cultural dynamics, and historical mistrust. Parker (1994; 1998) emphasises that effective health communication must move beyond awareness campaigns to participatory approaches, a principle that resonates with the need for culturally grounded vaccine communication in Eswatini. Similarly, as Govender, Lewis and Holland (2021) argue, interdisciplinary perspectives are essential to move beyond biomedical framings and to recognise the social and cultural dimensions of pandemic communication.

Eswatini's experience illustrates these tensions. The country launched its vaccination programme in March 2021, prioritising healthcare workers, the elderly, and those with comorbidities (WHO, 2021a). These campaigns largely reproduced dominant biomedical framings, emphasising compliance, efficacy, and risk reduction. While such approaches aligned with international directives, they reflected the same narratives that often reduce hesitancy to a behavioural deficit (de Figueiredo et al., 2020; Paul et al., 2020). Nurses' accounts reveal the limits of these framings, as they had to negotiate cultural remedies, stigma, and systemic fragility in their daily practice. Therefore, nurses, positioned simultaneously as recipients of vaccine information and trusted disseminators within their communities, navigated these complexities in ways that reveal the limitations of purely biomedical messaging (Ndzinisa and Govender, 2024).

By situating Eswatini's response within this global and regional landscape, the background underscores why nurses' perspectives matter. Their dual role as clinical professionals and community members makes them central to understanding how vaccine communication was received, contested, and re-interpreted in practice (Oomen and Gašpert, 2025; CDC, 2024; Kaufman et al., 2024). This study therefore addresses a critical gap in scholarship: the limited attention to healthcare workers' communicative roles in under-resourced, culturally complex settings.

The global and national contexts highlight both the urgency of vaccination campaigns and the limitations of dominant communication strategies. These realities underscore the need to examine why healthcare workers, particularly nurses, must be placed at the centre of pandemic communication. The rationale therefore explains why their perspectives are critical and how this study contributes to addressing gaps in scholarship.

Rationale

Healthcare workers play a pivotal role during public health emergencies, serving not only as frontline responders but also as trusted sources of information (Oomen and Gašpert, 2025). While all healthcare workers were affected by the pandemic, this study focused specifically on nurses because they occupy a dual position as frontline biomedical practitioners and community members. Nurses were the most visible point of contact between hospitals and the public, bearing both the professional trauma of clinical exposure and the social trauma of community stigma. Their communicative labour in negotiating trust around vaccination was therefore uniquely situated, making them central to understanding how vaccine messages were interpreted and contested in Eswatini. Their proximity to patients and communities positions them as key actors in shaping perceptions and influencing health behaviours, particularly in relation to vaccination (Barry et al., 2021; Wróblewski et al., 2024).

Yet global assumptions that healthcare workers would uniformly accept and advocate for vaccination during COVID-19 overlooked the complexity of their concerns, experiences, and cultural positioning. Studies have shown that vaccine hesitancy among healthcare workers was influenced by uncertainty about safety, limited access to reliable information, and mistrust in health authorities (Goje and Kapoor, 2024; Peterson et al., 2022; Biswas et al., 2021; de Figueiredo et al., 2020; Momplaisir et al., 2021; Elbaranzi et al., 2021). Dominant narratives often framed hesitancy as a behavioural deficit, relying on definitions shaped by institutions in the Global North, rather than recognising it as a contextually grounded response (Dutta, 2021; Airhihenbuwa et al., 2020).

In Eswatini, these issues were particularly pronounced. Nurses operated within overlapping roles as clinical professionals and members of indigenous communities, navigating systemic shortages, socio-economic inequalities, and cultural expectations. Their perceptions were influenced not only by biomedical training, but also by lived realities and community trust. Despite this, public health communication during the pandemic largely followed a top-down biomedical model, leaving little room for participatory engagement or culturally sensitive messaging (Ndzinisa and Govender, 2024).

This study is therefore justified by the need to foreground nurses' perspectives in Eswatini. By examining how they perceived, experienced, and communicated about COVID-19 vaccines, the research contributes to more inclusive and context-sensitive health communication

strategies. It also addresses a critical gap in scholarship by situating healthcare workers' communicative roles within the realities of under-resourced, culturally complex settings, where their voices are essential to building trust and strengthening pandemic preparedness. Govender (2024) emphasises that communication for social and behavioural change requires sensitivity to cultural identity and systemic fragility, a principle that underpins the rationale for foregrounding nurses' perspectives in this study. Situating the study within the critique of dominant narratives underscores its contribution. By foregrounding nurses' perspectives, the research challenges the reduction of vaccine hesitancy to individual cognition and highlights how systemic fragility and cultural identity complicate communication. This moves beyond biomedical framings to show how trust is mediated in practice, making nurses' voices essential for re-thinking pandemic communication in Eswatini.

Problem Statement

This study investigates healthcare workers' perceptions and experiences of COVID-19 vaccines in three hospitals in Eswatini during the second wave of the pandemic, specifically within the national vaccination rollout period of 2021–2022. Understanding these perspectives is critical for informing vaccine communication, uptake, and policy in the country, and the research employs a qualitative methodology using in-depth interviews and focus group discussions to capture nuanced insights.

Despite being central to the pandemic response, nurses have received limited scholarly attention in research exploring their communicative role, cultural positioning, and vaccine-related concerns. In Eswatini, nurses were the first group to receive the vaccine, yet their uptake and engagement with vaccine promotion varied, shaped by personal experiences, professional responsibilities, and broader socio-cultural factors.

Global discourses on vaccine hesitancy have often relied on narrow definitions framed by institutions in the Global North, overlooking the nuanced realities of healthcare workers in under-resourced settings (Salam, 2021; WHO, 2021; Paterson et al., 2016). Such framings risk reducing hesitancy to a behavioural deficit rather than recognising it as a contextually grounded response shaped by inequities, cultural dynamics, and historical mistrust. In Eswatini, where public health messaging followed a predominantly biomedical and top-down approach, little

space was provided for nurses to express concerns or contribute to culturally grounded communication strategies.

This gap is significant. Nurses are not only frontline caregivers but also trusted sources of health information within their communities (Brauer et al., 2021; Parisi et al., 2025). Their perceptions and communicative practices can directly influence vaccine uptake, patient trust, and broader public health outcomes (West et al., 2023West et al., 2023; Lin et al., 2020; Shirazi et al., 2020). Understanding how nurses perceive, experience, and communicate about COVID-19 vaccines is therefore essential for developing inclusive health communication strategies that resonate with local realities and strengthen pandemic preparedness in Eswatini and similar contexts.

The problem outlined above leads directly to the research questions guiding this study. These questions translate the identified gap into a focused inquiry, while the objectives clarify how the study will address them in practice.

Research Questions

1. How do nurses at Raleigh Fitkin Memorial, Hlatikulu, and Mbabane Government Hospitals experience and interpret COVID-19 vaccination within the context of trauma, stigma, and resilience?
2. How have nurses' concerns and scepticisms regarding COVID-19 vaccines, been shaped by cultural identity, professional responsibility, and systemic fragility?
3. How do nurses perceive and enact their role as mediators of trust in promoting COVID-19 prevention across clinical and community settings?
4. In what ways do cultural context and health beliefs influence vaccine communication?

Research Objectives

The objectives of the study are:

1. To explore nurses' perceptions and experiences of COVID-19 vaccination, with attention to trauma, stigma, resilience, and systemic fragility in Eswatini's health system.
2. To identify and analyse the concerns and scepticisms nurses hold about COVID-19 vaccines, situating these within cultural practices, professional identity, and institutional dynamics.

3. To examine how nurses perceive and perform their role in enabling and promoting effective COVID-19 prevention, both within clinical environments and in wider community contexts.
4. To examine how cultural context and health beliefs shaped vaccine communication in Eswatini, with particular attention to how nurses interpreted and negotiated tensions between biomedical prescriptions and community narratives.

Trauma, stigma, and resilience are central to understanding how nurses in Eswatini experienced COVID-19 vaccination. Trauma in this context extends beyond clinical encounters to encompass the psychological strain of working under conditions of uncertainty, loss, and heightened risk, which has been documented among healthcare workers in sub-Saharan Africa during the pandemic (Semo and Frissa, 2020). Stigma refers not only to the social labelling of patients but also to the ways nurses themselves were perceived as potential carriers of infection, a dynamic that has been shown to affect professional identity and wellbeing in frontline staff (Bagcchi, 2020). Resilience, while often celebrated as a positive attribute, requires critical examination because it can mask systemic vulnerabilities by placing the burden of adaptation on individuals rather than institutions. Studies of faith-based health institutions in Eswatini and the wider region highlight how resilience was expressed through improvisation, peer support, and faith commitments, yet these strategies also reveal the structural gaps in resources and communication that shaped practice (Nanji and Olivier, 2020; Olivier et al., 2015). Framing the research question through these three concepts therefore underscores the need to interrogate not only individual experiences but also the broader social and institutional conditions that defined the pandemic response. These concepts were not only theoretical anchors but also analytic lenses that guided the interpretative phenomenological approach adopted in this study. Trauma, stigma, and resilience were anticipated in the research design, yet they also emerged directly from participants' narratives, confirming their salience in the lived experiences of nurses. This dual presence, both in the framing of the inquiry and in the data itself, underscores the coherence of the study's design and strengthens its contribution to understanding how healthcare workers in Eswatini negotiated the complexities of COVID-19 vaccination

Having established the guiding questions and objectives, it is necessary to define the boundaries of the research. The scope outlines the hospitals selected, the timeframe considered, and the focus on nurses, ensuring that the study remains coherent and context-specific.

Scope of the study

This study focuses on the perceptions, experiences, and communicative roles of nurses regarding COVID-19 vaccines at three selected hospitals in Eswatini: Raleigh Fitkin Memorial Hospital, Mbabane Government Hospital, and Hlatikulu Government Hospital. These sites were purposefully chosen to reflect both urban and rural healthcare settings, ensuring that the research captures diverse perspectives across different regions of the country.

The scope is limited to the period following the initial vaccine rollout in March 2021, with particular attention to the first phase of the vaccination promotion campaign. By concentrating on this critical moment, the study examines how nurses engaged with vaccine information and how their perceptions of risk, benefits, barriers, and cues to action shaped their responses. This dual focus highlights not only the communicative practices of nurses during a period of uncertainty, misinformation, and structural constraints, but also the beliefs and assessments that informed their decisions and interactions with patients and communities.

The scope further acknowledges that nurses' engagement with vaccine communication was influenced by their cultural positioning. Their ability to interpret and convey information was shaped by awareness of community values, sensitivity to cultural practices, and the skills required to adapt biomedical directives into forms that resonated locally. As both clinical professionals and community members, nurses navigated the intersection of institutional authority and cultural expectations, making their perspectives essential for understanding how vaccine communication was received and adapted in practice.

By narrowing the inquiry to nurses in these institutions, the study generates context-specific insights into health communication, vaccine engagement, and the cultural dynamics that informed public health responses in Eswatini. This scope strengthens the study's contribution by situating nurses' perceptions within both systemic vulnerabilities and culturally embedded realities, offering lessons relevant to other under-resourced, complex settings.

The scope introduces the parameters of the research, and the following section provides detail on the specific hospitals chosen. By highlighting both urban and rural settings, this section demonstrates how the study captures diverse perspectives across Eswatini's healthcare landscape.

Hospitals selected for this study

To capture diverse perspectives on vaccine communication, the study was conducted at three hospitals in Eswatini: Raleigh Fitkin Memorial Hospital (RFM), Mbabane Government Hospital, and Hlatikulu Government Hospital. These sites were purposefully chosen to reflect both urban and rural healthcare contexts, ensuring that the research accounts for differences in resource availability, patient demographics, and community engagement.

The Raleigh Fitkin Memorial Hospital (RFM), located in Manzini, is a mission hospital with 350 beds and serves as a regional referral and teaching institution (Manzini Municipal Council, 2025). Situated in the country's commercial hub, which reported the highest number of COVID-19 cases nationally, RFM provides insight into how nurses managed high patient volumes and intensive public health campaigns during the pandemic. The fact that RFM is a mission hospital may also influence the perspectives of nurses. Mission institutions in Eswatini operate within a faith-based framework while simultaneously fulfilling public health functions, which can shape how staff interpret their responsibilities and challenges (Amankwah et al., 2025; Eswatini Nazarene Health Institutions, 2024; World Bank, 2022). Nurses working in such settings often balance clinical duties with the ethos of service and community trust that mission hospitals cultivate, potentially affecting how they engage with patients and respond to public health campaigns (Eswatini Nazarene Health Institutions, 2024; Mndzebele, 2021; Olivier and Wodon, 2012). Moreover, the reliance of mission hospitals on mixed funding sources, including government support and donor contributions, can heighten awareness of resource constraints and the need for adaptability in practice. These institutional characteristics mean that nurses' experiences at RFM cannot be understood solely in terms of patient volumes or epidemiological trends, but must also be situated within the broader dynamics of faith-based healthcare provision in Eswatini.

The Mbabane Government Hospital, in the capital city, represents the urban public healthcare sector. Mbabane Government Hospital, with approximately 500 beds, is the country's largest public referral facility and serves as the central hub for specialised care and national health directives (Eswatini Ministry of Health, 2021). As the largest national hospital, it played a central role in implementing government directives. Nurses here were at the forefront of responding to misinformation circulating in urban settings, while balancing institutional protocols with community concerns.

The Hlatikulu Government Hospital offers a contrasting perspective. The hospital, a regional facility with about 210 beds, provides essential general medicine, surgical and paediatric services to rural communities in the Shiselweni region (WHO Country Cooperation Strategy, 2020). Although the region recorded fewer cumulative cases, it had the highest case fatality rate nationally (Ministry of Health Eswatini, 2021; World Health Organization, 2022). Nurses in this hospital faced distinct challenges, including limited infrastructure, long travel distances for patients, and the need to adapt vaccine communication to communities with restricted access to formal health information.

By including hospitals from both urban and rural regions, the study captures the breadth of nurses' experiences across Eswatini's healthcare landscape. This diversity strengthens the analysis by situating vaccine communication within contrasting epidemiological profiles, resource capacities, and cultural contexts. However, the hospitals cannot be understood in isolation from the broader national context. Locating Eswatini geographically, politically, and socio-economically provides the necessary background for interpreting the experiences of nurses within these institutions.

Figure 1:1 a map of Eswatini showing the four regions of the country where the hospitals selected for this study are located.



Locating the Kingdom of Eswatini

Geographically, the Kingdom of Eswatini is a landlocked country in Southern Africa, bordered by South Africa to the west and Mozambique to the east. Administratively, it is divided into four regions: Hhohho, Lubombo, Manzini, and Shiselweni. With a total area of 17,364 km², Eswatini is one of the smallest countries in the region, yet its strategic location has historically shaped its political economy and health system development. Formerly known as the Kingdom of Swaziland, the country officially adopted the name Eswatini in 2018, following a declaration by King Mswati III to reflect the name most commonly used by its citizens (The World Factbook, 2024).

Eswatini is classified as a lower-middle-income country, a designation that has had an impact on its economic trajectory and policy priorities. Although the national growth rate improved from 0.5% in 2022 to 4.8% in 2024 (AFDB, 2024; World Bank, 2024), the country was identified by the United Nations Development Programme (UNDP) as one of 33 African countries least prepared to respond to the COVID-19 pandemic in 2020 (UNDP, 2020). Persistent socio-economic challenges, including high levels of poverty, unemployment, and inequality, continue to constrain development (World Bank, 2022).

Eswatini's vulnerabilities are further compounded by a generalised HIV epidemic, with women disproportionately affected due to a convergence of biological, behavioural, and structural factors (Becker et al., 2022; Jolly et al., 2017; Baral et al., 2014). This epidemic has influenced the country's healthcare priorities for decades, influencing both resource allocation and public health communication strategies. The intersection of HIV and COVID-19 created a dual burden, intensifying the need for effective health communication and vaccine uptake. Parker (2002) highlights how communication strategies must be tailored to vulnerable populations, a lesson that remains critical in addressing vaccine hesitancy among marginalised groups in Eswatini.

Figure 1:2 a map of Africa showing the location of the Kingdom of Eswatini



Regional Comparison

Earlier work by Govender and Abdool Karim (2018) on HIV prevention technologies in KwaZulu-Natal illustrates how cultural positioning and trust shape health behaviours, offering a useful parallel for understanding vaccine communication in Eswatini. When viewed in regional perspective, Eswatini's small size and limited resources are often presented as vulnerabilities. Yet this framing risks obscuring the broader structural dynamics that defined Southern Africa's pandemic experience. South Africa, with its larger economy and more extensive healthcare infrastructure, was able to mobilise resources more rapidly, but this did not translate into equitable outcomes.

Persistent inequalities and contested narratives around vaccines revealed that capacity alone could not guarantee trust or compliance (Africa CDC, 2021; Runciman et al., 2025). Mozambique, meanwhile, faced fragile health systems and political instability, which complicated its response, but these challenges were also influenced by long-standing histories of underinvestment and external dependency (WHO, 2021b). Eswatini's position between these two countries meant that its pandemic trajectory was not simply a product of its own limitations, but was defined by regional interconnections, cross-border movement, shared epidemiological trends, and the circulation of information and mistrust. To reduce Eswatini's experience to questions of "size" or "capacity" is therefore inadequate; its response must be understood within the wider Southern African context of inequality, mobility, and contested health governance.

Cultural and Political Context

Eswatini is one of the few remaining absolute monarchies in the world, with King Mswati III wielding significant influence over governance and public life (Ngwenya, 2022). Traditional structures, including chiefs and community councils, play a central role in local administration and social organisation (Dlamini, 2020). These cultural and political dynamics influence how health messages are received and trusted, with government directives often mediated through traditional leadership structures, influencing both compliance and resistance (Ndzinisa and Govender, 2024). This dual reliance created tensions during the COVID-19 pandemic: while the government depended on traditional authority structures to maintain legitimacy, it was also the source of biomedical health directives that often conflicted with local practices such as communal rituals, herbal remedies and funeral traditions (Ndzinisa and Govender, 2024). The coexistence of cultural authority and biomedical governance meant that nurses and communities were frequently caught between respecting traditional norms and adhering to state-issued health protocols. This tension influenced both the reception of vaccine messages and the credibility of those tasked with delivering them. Comparative studies by Parker, Rau and Peppa (2007) show that dominant communication approaches across African countries often sidelined participatory engagement, reinforcing similar dynamics observed in Eswatini. Therefore, understanding these dynamics is critical for situating nurses' communicative roles, as they operate within both biomedical institutions and culturally embedded systems of authority.

Linkage to Healthcare System

The geographic and socio-economic profile of Eswatini directly impacts healthcare delivery. Rural regions such as Shiselweni face significant barriers to access, including long travel distances, limited infrastructure, and shortages of healthcare personnel (World Bank, 2022). Urban centres like Mbabane and Manzini, while better resourced, experienced higher caseloads during the pandemic due to population density and mobility (UNDP, 2020). These disparities highlight the importance of context-specific communication strategies. Nurses in rural hospitals often had to adapt messages to communities with limited access to formal health information, while those in urban centres navigated misinformation circulating through social media and informal networks (Becker et al., 2022).

By situating Eswatini within its geographic, economic, cultural, and healthcare contexts, this section underscores the complexity of the country's pandemic response. It also highlights why

nurses' perspectives are essential: they operate at the intersection of systemic vulnerabilities, cultural expectations, and frontline healthcare delivery.

Having situated Eswatini within its wider context, attention turns to the structure and functioning of its healthcare system. This section outlines both improvements and persistent challenges, setting the stage for understanding the pressures nurses faced during the pandemic.

Eswatini's healthcare system

Eswatini's healthcare system is a dual structure comprising public and private sectors, with the majority of the population relying on government facilities. The system has made notable progress in expanding access to primary healthcare and addressing communicable diseases such as HIV/AIDS and tuberculosis (World Health Organization, 2024; UNAIDS, 2022). However, persistent challenges remain, including shortages of healthcare workers, limited infrastructure, and uneven distribution of resources between urban and rural regions (WHO, 2021).

In this study, the sample consists of two public hospitals and one mission hospital. The inclusion of a mission hospital is significant because faith-based institutions, such as the Eswatini Nazarene Health Institutions, provide a substantial proportion of healthcare services and often serve as referral centres for large segments of the population (ENHI, 2024). Private hospitals were not included in the sample because they cater primarily to urban, higher-income groups and expatriates, representing a small fraction of national healthcare utilisation. Their exclusion ensures that the analysis reflects the systemic challenges faced by the majority of the population who depend on public and mission facilities, thereby aligning the study with the broader equity and access concerns that define Eswatini's health sector (Ministry of Health Eswatini, 2019; World Bank, 2022).

These systemic realities shaped the country's pandemic response. While urban hospitals benefited from relatively better staffing and equipment, rural facilities struggled with limited capacity, long travel distances for patients, and restricted access to reliable health information. Nurses across both contexts faced high workloads, inadequate protective equipment, and the pressure of implementing government directives under resource constraints. Studies confirm that nurses comprised the majority of frontline healthcare workers and experienced compliance difficulties due to systemic resource gaps (Nsenga et al., 2022). These pressures were compounded by socio-economic vulnerabilities that strained the health system (UNDP, 2020).

The pandemic exposed the fragility of the system: capacity alone could not guarantee trust or compliance. Inequalities in access, coupled with contested narratives around vaccines, revealed that effective communication was as critical as clinical capacity. Nurses, positioned at the intersection of institutional authority and community trust, became central to bridging these gaps. Their ability to interpret biomedical directives and adapt them to local realities highlights the importance of examining their perspectives within the broader healthcare system.

The systemic strengths and weaknesses of Eswatini's healthcare system affected not only the delivery of services but also the communication strategies employed during the pandemic. Limited resources, uneven access, and structural inequalities meant that biomedical directives alone could not secure trust or compliance. As a result, the government's crisis communication had to operate within these constraints, often relying on traditional leadership structures and community networks to mediate official messages (Ndzinisa and Govender, 2024). The next section therefore examines how communication and containment strategies unfolded, highlighting the interplay between institutional authority, cultural dynamics, and frontline mediation by nurses.

Systemic healthcare challenges and frontline realities

Despite targeted investments in Eswatini's healthcare system, the pandemic exposed persistent systematic failure that shaped frontline realities. Systemic failure refers to the breakdown of institutional structures, processes, and resources that are essential for the effective functioning of a health system," (World Health Organisation, 2007). Eswatini's COVID-19 response manifested in inadequate Personal Protective Equipment (PPE) supply, limited Intensive Care Unit (ICU) capacity and fragmented communication between the Ministry of Health and frontline hospitals (Diluxe et al., 2021; WHO, 2021)." Systematic vulnerabilities, defined as the inherent weaknesses in health system structures, resources and governance that predispose institutions to collapse under stress, compounded the situation (Kruk et al., 2015). Chronic shortages of personnel, uneven distribution of resources, and reliance on international aid left hospitals vulnerable to surges in demand. Urban centres such as Mbabane and Manzini struggled with overcrowding and high caseloads, while rural regions like Shiselweni faced barriers of distance, limited infrastructure, and higher fatality rates despite lower case numbers (COVID-19 Situational Report, 2021; World Bank, 2022).

For nurses, these systemic challenges translated into daily improvisation: managing patients without adequate supplies, negotiating trust in contexts of scarcity, and balancing biomedical directives with community expectations (Ndwandwe et al., 2025, UNDP, 202). Their dual role as clinical professionals and community members meant they were simultaneously constrained by institutional limitations and relied upon as trusted sources of guidance (Nsenga et al., 2022). These realities underscore that Eswatini's pandemic response cannot be understood solely in terms of policy or epidemiological data; it must be situated in the lived experiences of frontline actors navigating systemic vulnerabilities under conditions of uncertainty.

These systemic constraints and frontline realities highlight the gap between policy intent and lived experience, underscoring why top-down biomedical messaging often failed to resonate with nurses and their communities.

Crisis communication and containment: Eswatini's COVID-19 policy framework

Eswatini's pandemic response was influenced by a combination of legal authority, containment measures, and communication strategies that reflected both biomedical imperatives and traditional governance structures. The government drew on existing public health legislation and emergency powers to enforce restrictions, including lockdowns, curfews, and limits on gatherings. These measures were reinforced through pandemic preparedness laws that gave the state broad powers to manage health emergencies (Coronavirus (COVID-19) Regulations, 2020; Disaster Management Act, 2006). Non-pharmaceutical interventions such as mask-wearing, hand hygiene campaigns, and social distancing were promoted nationally, while border closures were periodically imposed to limit transmission from neighbouring South Africa and Mozambique (WHO, 2021).

Communication was central to containment, but its delivery was largely top-down. Directives issued by the Ministry of Health and endorsed by King Mswati III defined the pandemic in biomedical terms, emphasising state authority while often overlooking the cultural and social contexts in which messages were received (Ndzinisa and Govender, 2024). Traditional leadership structures, including chiefs and community councils, mediated these directives at the local level. In some communities, this dual channel of communication guided compliance, as messages carried the weight of both state and traditional authority. In others, however, directives generated resistance when they conflicted with cultural practices or community priorities (Ngwenya, 2022).

Frontline healthcare workers, particularly nurses, became vital intermediaries in this communication chain. Their role extended beyond implementing biomedical protocols to translating official messages into culturally resonant forms for patients and communities. In rural regions, where access to formal health information was limited, nurses were often trusted as the most reliable source of guidance (Becker et al., 2022). In urban centres, by contrast, they confronted the challenge of misinformation circulating through social media and informal networks, which frequently shaped public perceptions in ways that undermined official campaigns (World Bank, 2022; UNDP, 2020).

Doubts about vaccines persisted, but framing these doubts simply as "hesitancy" risks oversimplifying complex realities. Communities in Eswatini, as across Africa, raised legitimate concerns about safety, efficacy, and fairness in distribution. Many questioned why vaccines arrived later in Africa compared to wealthier regions, and how global inequities influenced access (Africa CDC, 2021). To reduce these concerns to "hesitancy" is to ignore the structural and historical factors underpinning them. What is often described as reluctance can instead be understood as critical engagement with biomedical authority, shaped by socio-economic inequalities, cultural dynamics, and uneven access to reliable information.

By interrogating the language of "hesitancy," this study foregrounds the importance of context-specific communication strategies that acknowledge local realities and build trust. Nurses' perspectives are central because they operated at the intersection of systemic vulnerabilities, cultural expectations, and frontline healthcare delivery, navigating both the biomedical imperatives of the state and the legitimate concerns of their communities.

Communication strategies reveal the tensions between biomedical authority and community realities, but the trajectory of the pandemic shows how these dynamics unfolded over time. Official narratives of waves structured public discourse, yet nurses' accounts highlight the continuous burdens that cut across phases.

From rollout to reception: Eswatini's vaccination campaigns

The Kingdom of Eswatini commenced its COVID-19 vaccination programme on March 19, 2021, adopting a phased approach intended to ensure equitable distribution. Priority was given first to healthcare workers, followed by the elderly and individuals with comorbidities, then those at high risk of exposure, and finally all other individuals above 18 years of age (WHO,

2021). Alongside the rollout, public health campaigns promoted vaccine uptake and reinforced preventive behaviours such as mask-wearing, social distancing, and remote working.

Yet the effectiveness of these campaigns was influenced by the broader socio-cultural and economic context. Structural inequalities, contested narratives, and varying levels of trust in government institutions complicated both the delivery and reception of health messages. Healthcare workers occupied a particularly complex position: they were recipients of vaccine information, subject to the same uncertainties and fears as the wider population, while simultaneously tasked with disseminating and legitimising these messages to patients and communities (Parisi et al., 2025). This dual role exposed them to the tensions between biomedical directives and community perceptions, highlighting how hesitancy and resistance were embedded in social realities rather than reducible to individual ignorance (Toth-Manikowski et al., 2022; Reddy et al., 2021; Chersich et al., 2020).

Eswatini experienced four major waves of COVID-19 between 2020 and 2022, each shaped not only by new variants but also by uneven vaccine uptake and systemic inequalities. Nurses were central to managing these surges, both clinically and communicatively, as they navigated what official discourse labelled "vaccine hesitancy." In practice, this hesitancy reflected deeper structural inequities, mistrust in government institutions, and contested narratives circulating within communities. These dynamics complicated containment efforts, positioning nurses at the frontline of negotiating trust and translating biomedical directives into culturally resonant forms.

Limitations of biomedical messaging in pandemic settings

Building on the systemic disparities outlined in Eswatini's healthcare system, the pandemic revealed how communication strategies often failed to account for frontline realities. Messaging was largely biomedical and top-down, emphasising compliance with protocols such as mask-wearing, distancing, and vaccination. While these directives carried institutional authority, they rarely engaged with the cultural and social contexts in which they were received (Ndzinisa and Govender, 2024; Dutta, 2021).

For nurses, this disconnect was particularly acute. They were tasked with enforcing state directives while simultaneously addressing community concerns shaped by inequality, mistrust, and cultural expectations. What official discourse labelled "hesitancy" was instead a form of critical engagement, reflecting legitimate questions about vaccine safety, fairness in

distribution, and global inequities in access (Africa CDC, 2021; Runciman et al., 2025). These limitations demonstrate that biomedical messaging alone could not sustain public trust or motivate vaccine uptake in under-resourced, culturally complex settings. They underscore the need for participatory communication strategies that recognise healthcare workers not only as implementers of policy but as cultural agents whose voices are central to building legitimacy and resilience in public health responses.

This critique of messaging provides the necessary backdrop for examining Eswatini's pandemic trajectory, where successive waves of infection and evolving government interventions further exposed the tensions between policy intent and lived realities.

The trajectory of the COVID-19 pandemic in Eswatini

This section discusses the trajectory of the COVID-19 pandemic in Eswatini. However, problematising the notion of "trajectory" is crucial. To speak of a linear path or predictable waves implies a uniform experience, yet the pandemic unfolded unevenly across Eswatini's social and geographic landscape (United Nations Development Programme, 2020); WHO, 2022a). What official reports described as successive waves were, for frontline nurses, lived realities of adapting communication, negotiating trust, and responding to communities whose concerns were often legitimate but too easily dismissed under the label of "hesitancy" (Ministry of Health Eswatini, 2021; WHO, 2022b). Their perspectives reveal that Eswatini's pandemic story is less about epidemiological curves and more about the intersection of systemic vulnerabilities, cultural expectations, and everyday practices of care.

Initial outbreak and First Wave (March –August 2020)

The initial outbreak in March 2020 revealed the fragility of Eswatini's health system. Border closures and curfews were framed as containment, but for nurses the reality was improvisation under severe shortages of Personal Protective Equipment (PPE) and Intensive Care Unit (ICU) capacity. What official discourse described as "public scepticism" was, in practice, communities questioning the credibility of biomedical authority in the absence of visible preparedness (WHO, 2020; Ndzinisa and Govender, 2024). Nurses had to negotiate these doubts, showing that hesitancy was rooted in uncertainty and legitimate concern rather than ignorance.

Second wave and escalation (December 2020- March 2021)

The Beta variant surge highlighted inequalities in access to care. Urban hospitals were overwhelmed, while rural facilities faced delayed referrals and resource scarcity. Preparations for vaccine rollout collided with mistrust in government messaging, revealing how communication gaps reinforced perceptions of exclusion (WHO, 2021; Reddy et al., 2021). Nurses became mediators of contested narratives, navigating between biomedical directives and community scepticism. Hesitancy here reflected structural inequities and political mistrust, not simply refusal.

Vaccination rollout and Third Wave (Mid-2021 – Early 2022)

The Delta wave was the most severe, exposing the limits of capacity-driven approaches. Vaccination began in March 2021, but campaigns assumed that information alone would secure uptake. In reality, inequalities in access and mistrust in institutions undermined compliance, particularly in a context where the government of Eswatini did not impose vaccine mandates yet expected citizens — including nurses — to be vaccinated (Toth-Manikowski et al., 2022). Nurses were positioned as both recipients of vaccine information and frontline communicators, tasked with legitimising biomedical authority while acknowledging community concerns. What was labelled "hesitancy" was, in practice, a negotiation of trust shaped by lived realities (Ndzinisa and Govender, 2024).

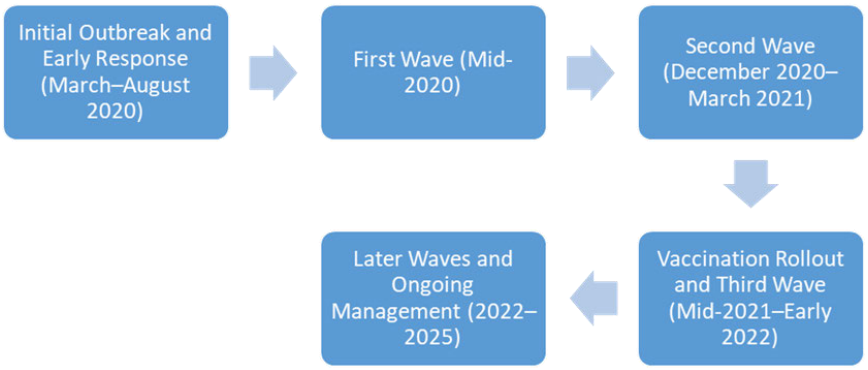
Later Waves and On-going Management (2022 -2025)

By the fourth wave (late 2021–early 2022), the language of "waves" itself had become contested. While official statistics charted peaks and declines, nurses who participated in this study described the pandemic as a continuous burden, with shortages, misinformation, and community concerns persisting across phases. The framing of waves served a communicative function for government briefings, but it obscured the uneven realities of care. For frontline workers, the pandemic was not neatly segmented but experienced as an ongoing negotiation between systemic vulnerabilities, cultural expectations, and everyday practices of care.

Evidently, the pandemic's "trajectory" in Eswatini was uneven, shaped less by epidemiological curves than by systemic vulnerabilities, contested narratives, and the communicative labour of nurses. Communicative labour refers to the effort required to produce, sustain, and negotiate communication within social and institutional contexts. It encompasses the work of being understood, understanding others, and acting on the basis of such understanding, often under conditions of scarcity, power imbalance, or systemic vulnerability (McKinney, 2015).

Therefore, what official discourse labelled as vaccine hesitancy was, in reality, a reflection of inequality and mistrust. Nurses' perspectives reveal that containment was not simply a matter of biomedical capacity but of negotiating trust across fractured social landscapes.

Figure 1:3 shows a summary of the trajectory of the COVID-19 pandemic in Eswatini.



Eswatini's uneven pandemic trajectory mirrors wider Southern African patterns, where successive waves were shaped not only by viral variants but by structural inequalities, political mistrust, and contested narratives around vaccination. Studies across South Africa, Zimbabwe, and Lesotho similarly highlight that what was labelled "hesitancy" often reflected lived experiences of marginalisation and distrust in state institutions rather than simple refusal (Runciman et al., 2025; Gumede and Govender, 2024; Chersich et al., 2020). In this regional context, Eswatini's nurses exemplify a broader phenomenon: frontline health workers positioned as communicators who must negotiate between biomedical authority and community realities. By foregrounding their perspectives, this thesis contributes to a regional understanding of pandemic communication, showing that containment strategies across Southern Africa were less about epidemiological curves than about the everyday negotiation of trust, inequality, and care.

To build on these insights, the study turns to conceptual frameworks that explain how individual perceptions of risk intersect with the cultural positioning of healthcare workers. This approach allows the analysis to move beyond epidemiological data, situating nurses' communicative labour within broader social and cultural processes that shaped Eswatini's pandemic response.

Conceptual framework

This study is guided by two complementary models: the Health Belief Model (HBM) and Campinha-Bacote's Model of Cultural Competence in Healthcare Delivery. The HBM, developed in the 1950s by social psychologists Godfrey Hochbaum, Irwin Rosenstock and Stephen Kegeles within the United States Public Health Service, sought to explain why individuals failed to adopt preventive health measures such as tuberculosis screening (Hochbaum, 1958; Rosenstock, 1960; Kegeles, 1963). Their work established the foundational constructs of perceived susceptibility, severity, benefits and barriers, later expanded by Rosenstock, Strecher and Becker (1988) alongside cues to action and self-efficacy (Champion and Skinner, 2008; Janz and Becker, 1984; Bandura, 2004). In this study, it helps analyse how nurses judged their risk of COVID-19, their beliefs about vaccine efficacy, and the factors shaping their communication practices. Yet the HBM has been criticised for neglecting cultural and structural contexts, limiting its applicability in under-resourced settings (Dutta, 2008).

To address this gap, Campinha-Bacote's model highlights cultural awareness, knowledge, skills, encounters, and desire as central to healthcare delivery (Campinha-Bacote, 2002; Betancourt et al., 2002). It recognises nurses as both clinical professionals and cultural agents whose engagement with vaccine communication is shaped by social identities and community relationships (Kreps and Sparks, 2008). While valuable, cultural competence must be understood as a dynamic negotiation of trust and power rather than a checklist.

Having established the theoretical lenses through which nurses' perceptions and communicative roles are examined, the next section highlights the methodological approach to the study.

Methodology

This study adopted a qualitative phenomenological design to explore nurses' perceptions and experiences of COVID-19 vaccine communication across three hospitals in Eswatini. Phenomenology, as the study of lived experience, seeks to understand how individuals interpret events within their social world (Tuffour, 2017; Smith, Flowers and Larkin, 2009; Sokolowski, 2000). The research was situated within an interpretivist-constructivist paradigm, which views reality as socially constructed, multiple, and contextually located (Creswell, 2013; Lincoln and Guba, 1985). This orientation was complemented by a critical paradigm, which interrogates

how power, institutional structures, and historical legacies shape vaccine-related perceptions and communicative practices (Kincheloe and McLaren, 2002; Carspecken, 1996).

Data were collected through semi-structured interviews and focus groups between 2022 and 2023. Fieldwork began at Hlatikulu Government Hospital due to protest-related disruptions at the other sites. Once access was secured, additional rounds of interviews and focus groups were conducted at Mbabane Government Hospital, the country's largest referral hospital, and at Raleigh Fitkin Memorial (RFM) in Manzini, a mission hospital serving as a regional referral and teaching centre. Each focus group comprised eight nurses purposively sampled to reflect diverse departmental experiences, with matrons acting as gatekeepers and assisting with participant selection based on inclusion criteria.

Analysis followed a multi-layered hermeneutic approach, moving from participant meaning to researcher interpretation and critical reflection (Love et al., 2020). Thematic analysis identified patterns across narratives, supported by reflexive journaling to enhance rigour (Gurr et al., 2024; Shai, 2020; Tomaselli, Dyll-Myklebust and van Grootheest, 2016). By including both urban hospitals (Mbabane and RFM) and a rural site (Hlatikulu), the study captured diverse frontline realities, strengthening the validity of its findings and ensuring a contextually grounded, critically engaged account of how nurses navigated vaccine communication within clinical and community roles.

Having outlined the methodological foundations and analytical approach, the thesis now turns to its overall structure, showing how each chapter builds toward addressing the research questions and objectives.

Structure of the thesis

Chapter One establishes the foundation of the study by situating it within the global and national contexts of the COVID-19 pandemic and its impact on Eswatini's healthcare system. It outlines the background and rationale, presents the research problem, objectives, and questions, and explains the theoretical and methodological foundations guiding the inquiry.

Chapter Two reviews existing literature on vaccine perceptions, health communication, and cultural competence in healthcare. It situates the study within broader theoretical and empirical

debates, drawing on models such as the Health Belief Model and Campinha-Bacote's Cultural Competence framework to contextualise nurses' experiences during the COVID-19 pandemic.

Chapter Three presents the conceptual framework guiding this study, integrating the Health Belief Model (HBM) and Campinha-Bacote's Model of Cultural Competence in the Delivery of Healthcare Services. It also examines the concept of culture and its relevance to health communication, highlighting how cultural beliefs influence health-seeking behaviour and the interpretation of disease.

Chapter Four outlines the qualitative phenomenological design adopted to explore nurses' perceptions and experiences of COVID-19 vaccine communication in Eswatini. It details the interpretivist–constructivist and critical paradigms guiding the study, the use of semi-structured interviews and focus groups for data collection, and the purposive sampling strategy facilitated by hospital matrons. A multi-layered hermeneutic approach was used for data analysis, supported by reflexive journaling to ensure ethical and contextual depth.

Chapter Five presents the IPA-guided analysis of interviews and focus groups with nurses from three hospitals in Eswatini. Through iterative coding and theme development, the chapter explores how participants made sense of COVID-19 vaccination within their cultural and social contexts, offering a nuanced interpretation of their lived experiences.

Chapter Six outlines the key themes that emerged from the data, offering a structured interpretation of nurses' experiences and perceptions of COVID-19 vaccination. Guided by IPA, the chapter highlights how cultural context, professional identity, and personal beliefs influenced participants' narratives during the pandemic.

Chapter Seven presents the study's findings, illustrating how nurses' experiences and perspectives shaped the reception, contestation, and reinterpretation of vaccine communication within fragile health systems.

Chapter Eight highlights the study's contributions to theory, practice, and policy. It underscores the implications of nurses' perspectives for culturally responsive health communication, acknowledges research limitations, and outlines directions for future studies.

Chapter Nine concludes the thesis by synthesising the central arguments, reflecting on the broader significance of nurses' perspectives for health communication in fragile systems, and reaffirming the study's contributions to theory, practice, and policy.

Conclusion

This chapter has situated this study within the global and national contexts of the COVID-19 pandemic, highlighting how Eswatini's healthcare system confronted overlapping burdens of HIV, inequality, and limited infrastructure. It traced the trajectory of the pandemic and the state's containment and vaccination strategies, showing how biomedical, top-down communication often failed to resonate with the lived realities of healthcare workers. Nurses emerged as pivotal actors, positioned at the intersection of biomedical authority and community trust, yet their communicative roles and concerns were largely overlooked in dominant narratives.

By interrogating the limitations of biomedical messaging and reframing vaccine "hesitancy" as critical engagement shaped by cultural and structural factors, the chapter established the rationale for focusing on nurses' perspectives. It underscored the significance of examining how frontline healthcare workers navigated both professional responsibilities and cultural expectations in a context marked by systemic vulnerability. This emphasis on nurses' voices responds to a gap in global scholarship, which has tended to privilege institutional perspectives while neglecting the communicative labour of those most directly involved in patient care and community engagement.

The chapter also clarified the problem statement, research questions, and objectives, situating the study within Eswatini's healthcare landscape and identifying the selected hospitals as sites of inquiry. By foregrounding the dual roles of nurses as both clinical professionals and cultural agents, it established the need for a context-sensitive approach that moves beyond biomedical framings to incorporate cultural competence and participatory communication.

CHAPTER TWO

LITERATURE REVIEW

Introduction

Much of the scholarship on COVID-19 vaccination has centered on the notion of "hesitancy," often treated as an individual-level problem of compliance. While this framing has generated extensive debate, it tends to universalise behaviour and obscure the wider social and historical conditions that shape vaccine engagement in specific contexts. Scholars such as Dutta (2021), Govender (2021), and Airhihenbuwa (1995) argue that reducing complex realities to "hesitancy" depoliticises legitimate concerns about safety, equity, and trust, while reinforcing a deficit model that blames individuals rather than interrogating systemic failures. In the Eswatini context, this critique is particularly relevant given the interplay of systemic vulnerabilities, cultural expectations, and the everyday practices of care that shaped nurses' experiences during the pandemic.

In African contexts, the notion of hesitancy is particularly problematic. It overlooks the legacies of colonial medicine, persistent inequalities in healthcare access, and the role of frontline healthcare workers who are simultaneously recipients and disseminators of vaccine information. Nurses, for example, are often positioned as passive implementers of biomedical directives, yet literature on health communication demonstrates that they actively interpret, negotiate, and translate messages within their cultural and professional environments (Matthews and Van Wyk, 2018; Topp et al., 2022). This dual role challenges simplistic assumptions about compliance and highlights the need for more nuanced frameworks.

A critical review of existing scholarship therefore requires moving beyond descriptive accounts of vaccine uptake to interrogate how communication, culture, and power intersect in shaping perceptions. This chapter examines global, regional, and local debates on vaccine communication, highlighting the limitations of biomedical messaging and the inadequacy of "hesitancy" as an explanatory category. It foregrounds nurses' communicative roles as a neglected dimension in the literature, situating the study within broader theoretical debates on health communication and cultural competence.

By problematising vaccine hesitancy and engaging critically with existing scholarship, the chapter establishes the intellectual gap that this thesis addresses: the need to understand how nurses in Eswatini navigated vaccine communication within contexts of systemic vulnerability, cultural complexity, and contested trust.

Global approaches to vaccine communication

The COVID-19 pandemic prompted an unprecedented global mobilisation of health communication resources. Governments, international organisations, and media outlets disseminated vaccine-related information at scale, often relying on biomedical narratives that emphasised efficacy, safety, and collective responsibility (Lazarus et al., 2021; WHO, 2021). Global campaigns emphasised vaccine efficacy, but this term requires clarification. At the biomedical level, efficacy referred to clinical trial results demonstrating high levels of protection against COVID-19 (Polack et al., 2020; Baden et al., 2021). In Eswatini, however, perceptions of efficacy were shaped by nurses' lived experiences and community narratives, where doubts arose not from trial data but from systemic fragility, cultural remedies, and inconsistent communication (Ndzinisa and Govender, 2024; Runciman et al., 2020). Distinguishing between clinical efficacy and perceived efficacy is therefore essential to understanding vaccine communication in fragile health systems.

These strategies were grounded in the assumption that scientifically accurate information would lead to behavioural compliance, a logic consistent with traditional behaviour change models such as the Health Belief Model and Theory of Planned Behaviour (Rosenstock, 1974; Ajzen, 1991). Yet this assumption reflects a narrow, technocratic view of communication, privileging information transmission over dialogue and ignoring the socio-political conditions in which vaccine decisions are made (Pedroni and Rubin, 2024; Steenberg et al., 2023).

Dominant communication approaches during the pandemic were largely top-down and expert-driven, privileging biomedical authority over participatory engagement (Airhihenbuwa, 2020). Messaging often lacked cultural nuance and failed to address historical mistrust in health systems or structural barriers to access (Airhihenbuwa et al., 2020; Gumede and Govender, 2024; Dutta, 2021; Assefa et al., 2021). Campaigns that foregrounded global efficacy data and herd immunity, for example, did not resonate with communities whose lived realities were shaped by inequality, marginalisation, or prior experiences of exclusion from health systems (Dutta, 2021; Assefa et al., 2021). In this sense, the discourse of "hesitancy" functioned less as

an analytical category than as a label that pathologised communities, obscuring the structural determinants of vaccine engagement. Scholars such as Dubé et al. (2013) have argued that hesitancy is best understood as a continuum shaped by trust, access, and socio-cultural context, rather than as irrational resistance.

Participatory approaches to health communication, such as Social and Behaviour Change Communication (SBCC), offer a counterpoint by advocating for community involvement, cultural relevance, and structural sensitivity (Green et al., 2015; McKee et al., 2014). These models recognise that health behaviours are shaped not only by information but also by social norms, institutional trust, and lived experience (Kavuwa, 2024; McKee et al., 2014). Evidence from HIV communication in Africa demonstrates that participatory strategies, including peer education and community dialogue, were more effective in building trust and resilience than purely biomedical messaging (Campbell and Cornish, 2010; Parker, 2014; Govender 2024). In pandemic contexts, participatory strategies are essential to building vaccine confidence and promoting equitable health outcomes. Yet, despite decades of evidence supporting SBCC, global COVID-19 communication largely defaulted to biomedical framings, revealing a persistent gap between theory and practice.

Healthcare workers played a central role in global vaccine promotion. As trusted sources of information, they were expected to model vaccine uptake, counsel patients, and counter misinformation. Studies from high-income countries demonstrate that healthcare workers' attitudes toward vaccination significantly influenced public perceptions and uptake (Paterson et al., 2016; Zhang et al., 2011). However, these roles were complicated by the rapid pace of vaccine development, evolving scientific guidance, and the emotional toll of frontline work (Pavlovic et al., 2022; Alasmari et al., 2022). Research in Italy and the United States shows that healthcare workers themselves expressed uncertainty and fatigue, which shaped how they communicated with patients (Verger et al., 2021; Shekhar et al., 2021). Therefore, nurses and other healthcare workers were not simply neutral transmitters of biomedical information; they were embedded in cultural and institutional contexts that shaped how messages were interpreted and conveyed. The global literature, however, has tended to treat healthcare workers as instruments of compliance rather than as communicative agents, thereby neglecting their interpretive and relational roles. Some literature has framed nurses less as autonomous communicators and more as instruments of compliance within hierarchical health systems. For example, Foucault's notion of biopower has been applied to nursing, showing how frontline

workers are positioned to enforce biomedical directives (Foucault, 1978; Allen, 2007). In African contexts, Airhihenbuwa (1999; 2020) critiques such top-down approaches, arguing that they reduce nurses to enforcers of compliance rather than negotiators of trust and meaning.

In this study, 'active negotiators of meaning' are understood as practitioners who mediate between technical biomedical knowledge and patients' lived experience. Mishler's distinction between the 'voice of medicine' and the 'voice of the lifeworld' shows how clinical encounters require negotiation between professional expertise and everyday concerns (Mishler, 1984). Wenger's work on communities of practice further clarifies this mediating role by describing frontline actors as 'boundary brokers' who translate institutional directives into locally meaningful practice (Wenger, 1998). Nursing scholarship on negotiated care demonstrates how nurses routinely interpret, adapt and reframe clinical directives so they resonate with patients' social contexts and needs (Allen, 2007; Svensson, 1996). Framing nurses in this way emphasises their interpretive and relational labour: they do not merely transmit messages but actively influence vaccine communication through dialogue and contextualisation.

All considered, global perspectives reveal a tension between the dominance of biomedical, deficit-based framings of vaccine hesitancy and the evidence for participatory, culturally grounded approaches. While behavioural models and expert-driven messaging provided insights into individual decision making, they reinforced a narrative of reluctance as irrational resistance, obscuring systemic inequities and the communicative labour of healthcare workers (Fakih and Copas, 2023; Solak-Grassie et al., 2023). This gap underscores the need for research that situates vaccine perceptions within broader contexts of inequality, trust, and cultural identity, an imperative that becomes particularly urgent in African settings where fragile health systems, historical legacies, and cultural pluralism shape vaccine communication in distinctive ways (West et al., 2023; West et al., 2023; Ekezie et al., 2023).

Southern Africa and Eswatini in focus

Southern Africa presents a distinctive set of challenges for vaccine communication, shaped by high burdens of infectious disease, entrenched inequalities, and complex political economies of health. Countries such as South Africa, Mozambique, Namibia, and Zimbabwe share epidemiological trends, including elevated HIV prevalence and tuberculosis incidence, which conditioned public perceptions of COVID-19 vaccination. Abdool Karim and Baxter (2022) highlight that South Africa's dual HIV/TB burden was influenced both health system capacity

and public trust during the pandemic. Similar dynamics were observed in Mozambique, where Dula et al. (2021) and De Schacht et al. (2025) found that overlapping HIV/TB burdens and socio-economic disparities affected vaccine acceptability. In Namibia, Niikondo and Awofolu (2024) argue that structural inequalities in healthcare, compounded by HIV/TB prevalence, undermined communication outcomes. Zimbabwean scholarship echoes these findings: Murewanhema et al. (2022) and Midzi et al. (2024) highlight that HIV/TB burdens intersected with socio-economic disparities to shape vaccine uptake. Regional meta-analyses confirm this pattern, with Wondmeneh and Mekonnen (2023) documenting the high incidence of TB among HIV-positive populations across Southern Africa, reinforcing the need to situate vaccine communication within broader epidemiological contexts.

Regional scholarship also highlights the role of inequality in conditioning vaccine communication. In South Africa, Govender (2021) critiques the dominance of biomedical narratives and argues for participatory approaches that directly address socio-economic disparities. Gumede (2021) demonstrates how communities in rural and township settings interpreted COVID-19 communication through the lens of inequality, with limited access to credible information undermining trust. Kollamparambil, Oyenubi and Nwosu (2021) further show that vaccine intentions were stratified by income and education, reinforcing the link between inequality and communication outcomes. In Namibia, Mushaandja and Ithindi (2023) reveal that newspaper coverage of COVID-19 vaccines lacked cultural and socio-economic sensitivity, while Niikondo and Awofolu (2024) argue that public health regulations were undermined by structural inequalities in healthcare access. Mozambique faced similar challenges: De Schacht et al. (2025) found that targeted communication strategies were necessary in Zambézia Province, where socio-economic disparities influenced vaccine acceptability, and Dula et al. (2021) identified trust and inequality as key determinants of uptake. In Zimbabwe, Murewanhema et al. (2022) and Midzi et al. (2024) highlight that poor booster uptake and barriers to vaccination were strongly linked to socio-economic disparities, while Larsson et al. (2023) show that youth vaccine uptake was stratified by inequality. Collectively, these studies demonstrate that vaccine communication in Southern Africa cannot be understood without reference to structural inequities. Moreover, cross-border mobility further complicated communication strategies. Southern Africa's porous borders facilitated the circulation of both people and information, including misinformation. Rapa et al. (2023) note that regional interconnectedness meant that vaccine narratives were not confined to national boundaries but were influenced by broader discourses across the sub-region. This dynamic

underscores the inadequacy of communication strategies that relied solely on national biomedical messaging without accounting for transnational flows of trust and mistrust.

Eswatini's specific context illustrates these tensions vividly. With one of the highest HIV prevalence rates globally: UNAIDS (2024) reports that 23.4% of adults aged 15–49 live with HIV, the country's health system was already under strain before the pandemic. Additionally, Afrobarometer (2024) found widespread dissatisfaction with public healthcare, including medicine shortages and long wait times, while Diluxe et al. (2021) note that the system's fragility, driven by HIV and TB burdens, limited its capacity to absorb new shocks.

To this end, Eswatini's high HIV and TB burdens complicated the COVID-19 vaccine roll-out in two distinct ways. First, they placed immense strain on the health system, diverting resources and staff toward ongoing treatment programmes and thereby limiting capacity for new vaccination campaigns (Eswatini Ministry of Health, 2021). Second, they shaped perceptions of the vaccine itself: communities and nurses interpreted COVID-19 vaccination through the lens of their long experience with HIV and TB interventions, which sometimes generated mistrust, fatigue or comparisons with antiretroviral treatment (UNAIDS, 2021; Airhihenbuwa, 2020). These dynamics reveal that the challenge was not only logistical but also communicative, requiring nurses to negotiate trust in a context where biomedical authority was already contested.

Vaccine communication therefore unfolded within a landscape of systemic vulnerability, where communities were accustomed to donor-driven interventions and contested governance. The Africa CDC (2021) and WHO (2021) promoted biomedical narratives of efficacy and collective responsibility, but these messages often failed to resonate with local realities (Ndzinisa and Govender, 2024). Nurses and other frontline healthcare workers, as shown in regional studies across Southern Africa, were often tasked with translating biomedical directives into culturally meaningful forms, negotiating community concerns, and countering misinformation circulating through informal networks (Becker et al., 2022). While this communicative labour has been documented in neighbouring contexts, there remains a notable scarcity of scholarship that examines these dynamics within Eswatini. This absence represents a critical gap in the literature, one that the present study seeks to address by foregrounding the communicative roles of nurses in the country's vaccine response.

Altogether, Southern African perspectives reveal that vaccine communication cannot be understood through deficit models of hesitancy. Instead, it must be situated within systemic vulnerabilities, regional interconnectedness, and historical legacies of exclusion. Eswatini exemplifies these dynamics, highlighting the need for research that foregrounds the communicative roles of nurses as both professionals and community members. By interrogating how vaccine messaging was interpreted, negotiated, and contested in this context, the literature points to the inadequacy of biomedical framings and the urgency of culturally grounded approaches.

Comparative Case Studies Beyond Southern Africa

While the preceding discussion has focused on Southern Africa, comparative evidence from other African contexts further illuminates the dynamics of vaccine communication. Studies in Nigeria highlight how misinformation and distrust in government institutions shaped vaccine uptake, particularly in urban centres where social media amplified scepticism (Afolabi et al., 2021). In Ghana, research shows that community engagement strategies were more effective when they drew on local leadership structures, underscoring the importance of participatory approaches (Agyekum et al., 2021). In Kenya, Nyika et al. (2022) document how gender and socio-economic status influenced vaccine perceptions, pointing to the need for intersectional analyses. Tanzania presents yet another variation, where political contestation over the pandemic itself complicated communication strategies and undermined public trust (Mbogori et al., 2022).

These cases are not directly comparable to Eswatini in terms of population size, governance, or cultural context. However, they illustrate broader continental patterns: the entanglement of vaccine communication with inequality, trust, and political legitimacy. Situating Eswatini alongside these examples highlights both commonalities and distinctions. Unlike larger states such as Nigeria or Kenya, Eswatini's small population and concentrated HIV burden create a uniquely fragile health system. Yet the absence of scholarship on how nurses navigated vaccine communication in Eswatini is striking, given that similar dynamics have been studied elsewhere. This comparative lens therefore strengthens the rationale for focusing on Eswatini, by showing that while continental patterns exist, the country's specific vulnerabilities demand closer analysis.

Nurses as frontline communicators

The preceding discussion underscored how systemic vulnerabilities and inequalities conditioned vaccine communication in Southern Africa, with Eswatini exemplifying these dynamics. Within this landscape, nurses and other frontline healthcare workers were central to vaccine engagement, yet their communicative labour has received limited scholarly attention. This absence reflects a broader tendency in global health research to privilege biomedical efficacy and policy directives over the everyday communicative practices that determine whether such directives resonate with communities (Chimberengwa and Naidoo, 2019; Lalla-Edward et al., 2022).

Evidence from Zimbabwe suggests that frontline healthcare workers were often the first point of contact for communities navigating vaccine uncertainty, but their role in influencing communication was obscured in national reporting (Murewanhema et al., 2022). In South Africa, Lalla-Edward et al. (2022) highlight how healthcare workers faced significant challenges in countering misinformation and adapting official messaging to local realities. These studies demonstrate that vaccine communication is not simply a matter of transmission but of translation, where nurses mediate between institutional authority and community trust.

In Eswatini, however, there is a notable scarcity of scholarship that examines nurses' communicative practices. While UNAIDS (2024) and Afrobarometer (2024) document systemic strain and public dissatisfaction with healthcare services, they do not interrogate how nurses managed the communicative burden of vaccine rollout within these fragile conditions. This silence risks reproducing deficit framings of "hesitancy" by ignoring the relational work through which nurses sought to counter misinformation, negotiate scepticism, and embed biomedical narratives in culturally meaningful practices.

Foregrounding nurses as communicators also challenges dominant hierarchies in health communication research. Much of the literature privileges top-down strategies designed by ministries of health, international agencies, or donor organisations (WHO, 2021; Africa CDC, 2021). Yet as Govender (2021) and Gumede, Durden and Govender (2022) demonstrate, these strategies often falter when they fail to account for the socio-economic and cultural realities of communities. Additionally, Dutta (2008) advances the Culture-Centered Approach, emphasising how communicative practices emerge from local contexts and resist biomedical dominance. Obregón and Waisbord (2010) highlight the importance of participatory

communication in health campaigns, showing how frontline workers mediate between institutional directives and community realities. Airhihenbuwa (1999; 2020) critiques top-down biomedical communication that reduces frontline workers to implementers rather than negotiators of meaning. These perspectives frame the communicative labour of nurses as situated within wider dynamics of authority and culture, a point elaborated further in the following section. Nurses, positioned at the intersection of institutional authority and everyday life, embody the tensions between policy and practice. Their communicative labour is not ancillary but constitutive of vaccine engagement.

This study therefore addresses a critical gap by examining how nurses in Eswatini navigated the communicative demands of COVID-19 vaccination. By situating their practices within systemic vulnerability and inequality, the analysis moves beyond descriptive accounts of vaccine rollout to interrogate the relational and cultural dimensions of communication. In doing so, it contributes to a more nuanced understanding of vaccine engagement that resists deficit framings and foregrounds the agency of frontline healthcare workers.

Nurses as Mediators of Trust in Health Communication

Trust is a central dimension of the nurse–patient relationship and has been shown to influence disclosure, adherence, and cooperation in care. Wang et al. (2024) argue that nurses' expectations of patients in high-risk environments are moderated by institutional trust and communication, underscoring how trust shapes clinical interactions and outcomes. Shin et al. (2025) similarly demonstrate that patient-centred communication mediates nurses' safety-care activities, linking professional competence with patient trust and perceptions of safety. These findings highlight that trust is not only interpersonal but also embedded in broader institutional dynamics, which is particularly relevant in fragile health systems.

In Sub-Saharan Africa, therapeutic communication has been identified as a critical factor in patient engagement and outcomes. Abraham et al. (2024), in a scoping review of nurse–patient communication across African contexts, found that effective communication improved emotional wellbeing and compliance, while barriers such as resource constraints and cultural misalignment undermined trust. Kwamea and Petrucka (2020) also emphasise that in Sub-Saharan healthcare settings, patients' participation in care and compliance with medical advice are strongly influenced by the quality of nurse–patient interaction. These studies

confirm that nurses' communicative practices are integral to building trust in environments where systemic fragility and cultural diversity complicate biomedical messaging.

Nurses' role as mediators of trust is particularly significant in vaccination campaigns. Ekezie et al. (2024) note that communication strategies in African vaccination programmes often rely on institutional authority, yet uptake improves when nurses and frontline workers act as trusted intermediaries. UNICEF South Africa (2023) similarly highlights that parents and caregivers place high levels of trust in nurses to provide accurate information about immunisation, especially during outbreaks. These findings resonate with Eswatini's context, where historical mistrust of health authorities intersects with systemic fragility. Nurses, positioned simultaneously as professionals and community members, bridge institutional messaging and local realities, negotiating concerns about vaccine safety, fairness, and cultural identity in ways that institutional communication alone cannot achieve.

Situating nurses as mediators of trust therefore highlights their importance not only as caregivers but also as communicative actors whose voices are essential for understanding how vaccination was experienced, contested, and reinterpreted in practice. This perspective addresses a gap in scholarship, which has often focused on hesitancy as a behavioural deficit rather than recognising the relational and communicative labour through which trust is built in fragile health systems.

While trust is central to understanding how nurses communicate during public health crises, it does not operate in isolation. Nurses' experiences and communicative practices are shaped by overlapping social identities and systemic conditions that influence both how they are perceived and how they interpret their roles. These intersections highlight the need to consider how health communication is mediated through multiple, converging factors. This leads to a discussion of intersectionality in health communication, which provides insight into how identities and structures interact to shape vaccine communication in Eswatini.

Intersectionality in Health Communication

The limited attention to nurses' communicative labour is compounded by the absence of intersectional analysis. Feminist public health scholarship has long argued that health communication cannot be disentangled from the social identities of those who deliver it (Crenshaw, 1989; Squires, 2017). Nurses' roles are shaped not only by professional hierarchies

but also by gendered expectations, socio-economic positioning, and cultural norms. In many African contexts, nursing is feminised labour, often undervalued within health systems despite its centrality to patient care and community engagement (Mackintosh and Tibandebage, 2004).

Intersectional perspectives reveal how these identities intersect to shape communicative practices. For example, community health worker programmes in Zimbabwe and Tanzania show that women's authority in health communication is simultaneously enabled by their proximity to communities and constrained by patriarchal structures that limit professional recognition (Chimberengwa and Naidoo, 2019; Mackintosh and Tibandebage, 2004). In South Africa, Govender (2021) notes that frontline communicators often had to navigate class and linguistic divides when translating biomedical messages into locally resonant forms.

Applying intersectionality to Eswatini highlights a critical gap. While the country's health system relies heavily on nurses, there is little scholarship examining how gender, class, and professional identity shaped their communicative labour during the vaccine rollout. This omission matters because it risks flattening nurses' roles into technical functions, rather than recognising the complex social negotiations through which they mediated trust and authority. By foregrounding intersectionality, this study seeks to interrogate how nurses' communicative practices were conditioned by overlapping identities and systemic inequalities, thereby contributing to a more nuanced understanding of vaccine communication in fragile health systems.

Perceptions Of Healthcare Workers

The effectiveness of vaccine communication is shaped not only by the content of messages but also by how healthcare workers themselves are perceived. Trust in nurses and frontline staff is often higher than trust in political leaders or state institutions, yet it is uneven and conditioned by social identity, professional hierarchies, and historical legacies. Gilson (2003) argues that trust in health systems is mediated through interpersonal encounters, with nurses frequently serving as the visible embodiment of institutional authority. This interpersonal dimension of trust is critical in fragile health systems, where institutional credibility is often contested. Larson et al. (2014) similarly highlight that perceptions of healthcare workers are central to vaccine acceptance, since credibility and relational proximity often outweigh official messaging. Their systematic review demonstrates that communities frequently rely on the

relational authority of frontline staff rather than abstract institutional communications, underscoring the importance of healthcare workers as mediators of trust.

Yet perceptions cannot be treated as neutral or static. They are socially constructed, fluid, and often contested. Ozawa and Sripad (2013) emphasise that trust is fragile and contingent on institutional credibility, easily undermined by systemic failures. African case studies reinforce this point. In Zimbabwe, Murewanhema et al. (2022) note that healthcare workers were simultaneously trusted as sources of biomedical knowledge and questioned when rumours suggested they were complicit in externally driven agendas. In Mozambique, De Schacht et al. (2025) show that community health workers were perceived as credible precisely because of their embeddedness in local networks, though their authority was constrained by systemic shortages and weak institutional support. In South Africa, Cooper et al. (2018) demonstrate that vaccine acceptance was strongly influenced by perceptions of healthcare workers' relational proximity and cultural sensitivity, with trust in nurses and community health workers often outweighing trust in government campaigns. In Nigeria, Oduwole et al. (2019) found that mistrust in health authorities filtered down to frontline staff, shaping how communities interpreted vaccine messages and sometimes undermining their credibility. These examples illustrate that perceptions are not simply reflections of healthcare workers' behaviour but are shaped by discourse, rumours, and institutional messaging.

Problematising perceptions therefore requires recognising their dual character: healthcare workers can embody both credibility and scepticism, authority and vulnerability. As Airhihenbuwa et al. (2020) argue, health communication must be understood through culture-centred approaches that situate trust within local contexts of meaning. Nurses and community health workers, by virtue of their dual role as professionals and community members, are uniquely positioned to embody this cultural mediation. Yet their authority is fragile, contingent on both institutional support and community recognition. Dutta (2021) critiques deficit-based framings of vaccine hesitancy, noting that such narratives often ignore the relational dynamics through which healthcare workers negotiate trust and scepticism.

In Eswatini, scholarship has not examined how nurses were perceived during the vaccine rollout. While Afrobarometer (2024) documents widespread dissatisfaction with healthcare services, including medicine shortages and poor service quality, there is no empirical research on how these conditions shaped trust in frontline staff. This absence leaves a critical gap: whether nurses were viewed as trusted communicators, constrained professionals, or contested

figures remains unknown. Addressing this gap is central to understanding how vaccine communication was socially constructed within fragile health systems. By examining perceptions of nurses in Eswatini, this study seeks to illuminate how trust, credibility, and relational dynamics conditioned vaccine communication in practice.

Experiences of Healthcare Workers

The global literature demonstrates that healthcare workers' experiences during the COVID-19 pandemic were marked by both professional responsibility and personal vulnerability. Studies from high-income countries highlight the dual burden of modelling vaccine uptake while coping with uncertainty, fatigue, and rapidly evolving scientific guidance (Verger et al., 2021; Shekhar et al., 2021). Pavlovic et al. (2022) and Alasmari et al. (2022) note that frontline staff faced intense emotional strain, which shaped how they communicated with patients and influenced their willingness to advocate for vaccination. These findings underscore that healthcare workers were not neutral transmitters of biomedical information but actors negotiating their own anxieties, workloads, and institutional pressures.

African case studies reveal similar dynamics, though often intensified by fragile health systems. In South Africa, George et al. (2023) found that healthcare workers' willingness to promote vaccines was conditioned by the availability of clear evidence and institutional support. In Nigeria, Adebisi et al. (2021) reported that healthcare workers expressed hesitancy rooted in safety concerns and mistrust of government messaging, reflecting broader systemic challenges. In Zimbabwe, Murewanhema et al. (2022) observed that healthcare workers' experiences of resource shortages and political contestations shaped their communication with communities, sometimes reinforcing scepticism rather than alleviating it. These examples illustrate that experiences are not uniform but mediated by structural inequities, historical legacies, and the everyday realities of frontline work.

Problematising experiences requires recognising that they are not simply accounts of individual hardship but reflections of systemic conditions. As Ozawa and Sripad (2013) argue, institutional credibility is fragile, and healthcare workers' experiences of shortages, unclear guidance, and political contestations directly affect how they embody authority. Airhihenbuwa et al. (2020) emphasise that health communication must be understood through culture-centred approaches, which situate healthcare workers' experiences within broader contexts of meaning. Dutta (2021) critiques deficit-based framings of hesitancy, noting that they often ignore the

relational labour through which healthcare workers negotiate trust while managing their own vulnerabilities.

In Eswatini, scholarship has not examined how nurses experienced the vaccine rollout. Afrobarometer (2024) documents widespread dissatisfaction with healthcare services, including medicine shortages and poor service quality, but there is no empirical research on how these systemic conditions shaped nurses' lived experiences of vaccine promotion. This absence leaves a critical gap: whether nurses experienced themselves as trusted communicators, constrained professionals, or contested figures remains unknown. Addressing this gap is central to understanding how vaccine communication was socially constructed within fragile health systems. By examining the experiences of nurses in Eswatini, this study seeks to illuminate how frontline realities conditioned vaccine communication in practice.

Distinguishing Perceptions and Experiences of Healthcare Workers

Although closely related, perceptions and experiences represent distinct dimensions of vaccine communication. Perceptions refer to how healthcare workers are viewed by communities, patients, and institutions (Gilson, 2003; Ozawa and Sripad, 2013). These perceptions are central to the credibility of vaccine communication, particularly in contexts where relational trust outweighs official messaging (Larson et al., 2014; Murewanhema et al., 2022; Oduwole et al., 2019). Perceptions are relational and contingent, reflecting how communities interpret healthcare workers' roles within broader social and political contexts (Holford et al., 2024; Watermeyer et al., 2022; Larson et al., 2014).)

Experiences, in contrast, capture healthcare workers' own lived realities of vaccine promotion. They include anxieties, fatigue, institutional pressures, and the relational labour of communication. Experiences are internally felt and narrated, shaped by systemic shortages, evolving scientific guidance, and the emotional toll of frontline work (Verger et al., 2021; Shekhar et al., 2021; George et al., 2023). They highlight how healthcare workers negotiate professional responsibilities while managing personal vulnerability and structural constraints (Pavlovic et al., 2022; Alasmari et al., 2022).

Distinguishing between perceptions and experiences is analytically important. Perceptions show how healthcare workers are positioned within systems of trust and authority, while experiences reveal how they themselves navigate those systems. The two dimensions intersect

in practice. Negative experiences, such as shortages or unclear guidance, can erode perceptions of credibility (Holford et al., 2024; Ozawa and Sripad, 2013). Negative experiences among nurses influenced not only their own attitudes but also how they communicated with patients. These experiences; including exhaustion, frustration with systemic fragility, and mistrust of top-down directives, influenced the tone and content of their interactions (Dutta, 2008; Airhihenbuwa et al, 2020). Patients, in turn, may have formed perceptions of nurses based on these communicative encounters. Thus, while the experiences belonged to healthcare workers, the perceptions were those of patients and communities, who interpreted nurses' communicative labour as either reinforcing or undermining trust in vaccination (Obregón and Waisbord, 2010). Contested perceptions, such as rumours of complicity, can intensify the strain of frontline work, as studies show that misinformation and mistrust often undermine healthcare workers' credibility and increase the burden of their communicative labour (Murewanhema et al., 2022) Oduwole et al., 2019**;** Larson et al., 2014)). Yet they are not reducible to one another. Treating them separately allows for a more nuanced understanding of vaccine communication as both externally constructed and internally lived.

In Eswatini, this distinction is particularly salient. Afrobarometer (2024) documents public dissatisfaction with healthcare services, which likely shaped perceptions of nurses. At the same time, no empirical research has examined nurses' own experiences of vaccine promotion under conditions of systemic fragility. Addressing both dimensions, namely how nurses were perceived and how they experienced their roles, is central to understanding vaccine communication in fragile health systems.

Taken together, the literature shows that healthcare workers' experiences of vaccine promotion were shaped by systemic shortages, unclear guidance, and the emotional toll of frontline work. These experiences were not isolated but closely linked to how communities perceived their credibility, illustrating the intersection between lived realities and external trust. In fragile health systems, the strain of frontline work often intensified when contested perceptions and institutional weaknesses converged. In Eswatini, however, there is no empirical research on how nurses experienced the vaccine rollout. This absence leaves a critical gap in understanding how frontline realities conditioned vaccine communication. By examining the experiences of nurses in Eswatini, this study contributes to a deeper account of how systemic fragility and everyday practice intersect in shaping vaccine communication.

The experiences of healthcare workers reveal systemic fragility and emotional strain. These realities are further illuminated by concepts such as trauma, stigma, and resilience, which shape how health communication is negotiated in fragile contexts. The following subsection unpacks these concepts to show how they condition both frontline experiences and the reception of vaccine messages.

Trauma, Stigma, and Resilience in Health Communication

Health communication is influenced not only by institutional credibility but also by the social histories and lived realities of communities and healthcare workers. Concepts such as trauma, stigma, and resilience provide important lenses for understanding how vaccine messages are interpreted and negotiated in fragile health systems. These concepts highlight that communication is not simply a matter of transmitting information but of navigating collective memory, social barriers, and adaptive strategies.

Trauma influences receptivity to health messages by embedding mistrust within collective memory (Hirschberger, 2018). Kirmayer et al. (2014) argue that historical trauma is transmitted across generations, producing enduring scepticism toward institutions and shaping responses to health interventions. Historical trauma refers to the cumulative emotional and psychological wounding across generations, resulting from massive group trauma experiences such as colonisation, epidemics, or systemic oppression (Brave Heart, 2003; Brave Heart et al., 2011). It differs from individual trauma in that it is collective in impact, cumulative across adverse events, and transmitted intergenerationally (Hartmann and Gone, 2014).

In the context of health communication, historical trauma embeds mistrust within collective memory, shaping how communities interpret vaccine messages and institutional authority (Kirmayer et al., 2014). For example, Enria et al. (2016) demonstrate how trauma from the Ebola epidemic and militarised health responses in Sierra Leone left communities sceptical of vaccine trial communication. Similarly, Campbell et al. (2010) show that trauma from the HIV/AIDS epidemic in Sub-Saharan Africa conditioned community engagement with subsequent health campaigns, reinforcing suspicion of official health messages. These insights highlight that trauma is not simply an individual psychological state but a communicative context that frames collective narratives and conditions the reception of vaccine promotion (Mutuyimana and Maercker, 2023).

In this study, trauma is understood as both biomedical and social. Biomedical trauma refers to the physical and psychological strain of frontline exposure — fear of infection, witnessing death, and burnout within hospital settings (Herman, 1992; WHO, 2020). Social trauma, by contrast, reflects the collective grief, stigma, and disruption experienced by communities, which nurses also shared as community members (Alexander, 2004; Airhihenbuwa, 2020). In Eswatini, nurses embody this duality: as healthcare workers they carry professional trauma from biomedical risks, and as community members they share in collective trauma, making their communicative labour central to negotiating trust in vaccination."

Stigma functions as a communicative barrier that constrains dialogue and undermines trust. Goffman (1963) conceptualised stigma as a social process of exclusion, while Nyblade et al. (2019) demonstrate how stigma within health facilities discourages patients from seeking care and silences open communication. In Nigeria, Ilesanmi et al. (2021) reported that healthcare workers faced stigma during the COVID-19 pandemic, with frontline staff being avoided in public spaces due to fears of contagion. This weakened their authority as communicators and reduced the effectiveness of vaccine promotion. Stigma also operates at the community level, where association with illness or vaccination can mark individuals as outsiders, discouraging participation in health initiatives. In fragile health systems, stigma is not only a social attitude but a communicative process that shapes who is heard, who is silenced, and how credibility is constructed (Falade and Murire, 2021; Smith, 2016). Addressing stigma therefore requires more than factual correction; it demands strategies that reframe narratives, legitimise marginalised voices, and rebuild relational trust.

Resilience in fragile health systems demonstrates that communication is not only vulnerable to breakdown but also capable of renewal, as frontline workers and communities adapt messages to local realities. Ungar (2011) conceptualises resilience as a social ecology, enacted through cultural narratives and collective practices that allow communities to sustain engagement even under strain. This perspective highlights that resilience is not simply endurance but an active communicative practice, where actors mobilise relational authority and improvisation to maintain credibility. Southwick et al. (2014) reinforce this view by showing that resilience is relational and adaptive, with healthcare workers improvising strategies to rebuild trust during crises. Kok et al. (2015) provide empirical evidence from Uganda, where community health workers drew on local trust networks and cultural narratives to sustain vaccine promotion despite systemic shortages. Similarly, Abramowitz et al. (2015) document how communities

in West Africa during the Ebola epidemic adapted communication strategies to local realities, renewing trust in the midst of fear and uncertainty. Taken together, these studies show that resilience is enacted through communication practices that reframe narratives, mobilise authority, and adapt messages to fragile contexts, enabling health systems to sustain vaccine promotion even when institutional support is weak.

Together, trauma, stigma, and resilience illuminate the communicative conditions under which vaccine promotion unfolds. Trauma underscores the historical legacies that embed mistrust, stigma highlights the barriers that silence dialogue, and resilience points to the adaptive strategies that sustain trust. In Eswatini, where systemic fragility and public dissatisfaction with healthcare services are documented (Afrobarometer, 2024), these concepts provide a critical framework for analysing how nurses navigated vaccine communication during the COVID-19 rollout. They show that communication is not only about message design but about negotiating histories of harm, social exclusion, and collective adaptation.

The dynamics of trauma, stigma, and resilience reveal that vaccine communication is deeply conditioned by collective histories, social processes of exclusion, and adaptive strategies of trust-building. These insights highlight that communication is not simply about the transmission of biomedical facts but about negotiating meaning within fragile health systems. Building on this foundation, the next section turns to vaccine hesitancy and communication models, examining how theoretical frameworks and empirical studies conceptualise the drivers of hesitancy and the strategies through which health communicators attempt to foster confidence and uptake.

Vaccine hesitancy and communication models

The notion of "vaccine hesitancy" has become a dominant frame in global health discourse, often deployed to explain uneven uptake of COVID-19 vaccines. Yet critical scholarship increasingly challenges this framing, arguing that it risks stigmatizing communities while obscuring structural determinants of health behaviour (Dubé et al., 2013; Cooper et al., 2018). In Southern Africa, where systemic inequalities and overlapping burdens of HIV and tuberculosis shape public health engagement, the language of hesitancy often functions as a deficit model that blames individuals rather than interrogating the communicative and structural conditions under which vaccine decisions are made (Larson et al., 2014; Lalla-Edward et al., 2022).

Communication models underpinning vaccine campaigns have tended to rely on linear, top-down approaches that assume information deficits can be corrected through biomedical messaging (WHO, 2021; Africa CDC, 2021). These models privilege institutional authority and biomedical efficacy, but they often fail to account for the relational work required to embed messages in local contexts. Govender (2021) critiques such approaches in South Africa, showing that communication strategies that ignore socio-economic realities and cultural frames struggle to build trust. Similarly, Gumede, Durden and Govender (2022) demonstrate how presidential communication styles shaped public reception of health messages, underscoring the importance of political and cultural context in vaccine engagement.

The reliance on deficit models also obscures the agency of frontline healthcare workers. As discussed in other sections of this review, nurses and community health workers are often tasked with translating biomedical directives into culturally meaningful forms. Yet communication models rarely acknowledge this mediating role, treating frontline staff as passive transmitters rather than active negotiators of meaning (Chimberengwa and Naidoo, 2019; Murewanhema et al., 2022). This silence reinforces the inadequacy of "hesitancy" as an explanatory category, since it fails to capture the relational and communicative labour through which vaccine engagement is negotiated.

In Eswatini, the paucity of scholarship on vaccine communication compounds these limitations. While UNAIDS (2024) and Afrobarometer (2024) document systemic strain and public dissatisfaction with healthcare services, they do not interrogate how communication models framed vaccine uptake or how nurses navigated these framings in practice. This absence is significant. It suggests that the dominant discourse of hesitancy has been imported into Eswatini without sufficient attention to local communicative dynamics, thereby reproducing deficit framings that obscure structural vulnerability.

This study therefore engages critically with the concept of vaccine hesitancy and the communication models that sustain it. By foregrounding nurses' communicative labour in Eswatini, the analysis seeks to move beyond deficit framings to interrogate how vaccine engagement is shaped by systemic inequality, cultural translation, and relational trust. In doing so, it contributes to a growing body of scholarship that calls for more nuanced, context-sensitive approaches to vaccine communication in Africa.

Dominant Narratives in Vaccine Communication

Health communication scholarship has long been shaped by dominant narratives that privilege biomedical authority and individual behaviour change. These narratives are evident in models such as the Health Belief Model (Rosenstock, 1974) and the Theory of Planned Behaviour (Ajzen, 1991), which reduce vaccine uptake to questions of risk perception, attitudes, and intention. While influential, such frameworks risk presenting hesitancy as a behavioural deficit, obscuring the systemic, cultural, and relational dimensions of vaccine decision-making. This section examines communication around COVID-19 vaccination specifically, and how nurses' communicative labour mediated uptake and trust during the pandemic.

The persistence of these narratives across epidemics illustrates their power. During HIV/AIDS prevention campaigns, behavioural framings often failed to address stigma and cultural positioning, leading to limited resonance in communities (Campbell, 2003; Parker, 2002). Ebola communication in West Africa similarly emphasised compliance with biomedical directives while neglecting local practices, producing mistrust and resistance (Leach, 2015; Richards, 2016). These precedents show how dominant narratives privilege institutional authority while marginalising lived experience, a dynamic that re-emerged during COVID-19.

Critical communication scholarship has challenged these framings. Dutta (2021) argues that biomedical dominance reduces health communication to awareness campaigns, silencing cultural identity and systemic fragility. Airhihenbuwa et al. (2020) emphasise that health behaviours are embedded in social and cultural contexts, requiring strategies that account for histories of mistrust and inequality. Govender (2021) highlights lessons from HIV communication in Southern Africa, showing that participatory and culturally grounded approaches are essential to build trust. Together, these critiques demonstrate that dominant narratives are not neutral but reflect power relations that privilege certain forms of knowledge while excluding others.

Eswatini's pandemic response illustrates how these narratives were reproduced locally. Public health messaging emphasised compliance, efficacy, and biomedical authority, aligning with global framings. Yet nurses' accounts reveal that vaccine communication was negotiated through cultural remedies, systemic shortages, and contested authority. This case therefore challenges the reduction of hesitancy to individual cognition and demonstrates the need for culturally grounded, participatory approaches. By situating nurses' perspectives within debates

on dominant narratives, the study contributes to re-thinking health communication in fragile systems, showing how frontline realities disrupt and reconfigure prevailing framings.

Although behavioural models such as the Health Belief Model and the Theory of Planned Behaviour have provided valuable insights into vaccine uptake, they also reflect dominant narratives that privilege individual cognition and biomedical authority (Rosenstock, 1974; Ajzen, 1991). These framings risk reducing hesitancy to a behavioural deficit, overlooking the systemic fragility, cultural identity, and relational dynamics that shape health communication (Dutta, 2021; Airhihenbuwa et al., 2020). Situating these models within the broader critique of dominant narratives highlights the need to move beyond individualised approaches and to recognise how power, culture, and trust influence vaccine communication. This critique provides the foundation for examining alternative frameworks, particularly community engagement models, which foreground participation, cultural resonance, and relational credibility in health communication (Parker, 1998; Govender, 2021).

Community Engagement Models

The dominance of deficit framings in vaccine communication has been challenged by scholarship that foregrounds community participation. Rather than treating uptake as a matter of correcting individual attitudes, participatory approaches emphasise collective dialogue, local leadership, and co-production of health messages. Rifkin (2014) argues that community engagement is not simply an adjunct to biomedical interventions but a determinant of their success, particularly in contexts marked by inequality. This perspective reframes communication as a relational process in which communities are active agents rather than passive recipients of information. Perry et al. (2017) similarly highlight the role of community health workers in bridging institutional authority and everyday realities, showing that participatory models can build trust and resilience in fragile health systems. Their work demonstrates that the credibility of health interventions often depends on the extent to which communities are involved in shaping narratives and practices.

This emphasis on participation resonates with broader debates in global health communication. Campbell and Cornish (2010) argue that participatory approaches are grounded in power sharing, enabling communities to contest and reshape dominant biomedical narratives. Such approaches are particularly significant in fragile health systems, where mistrust in institutions is widespread and where top-down messaging often fails to resonate with local realities. George

et al. (2015) extend this argument by showing that community engagement enhances accountability, creating spaces where health workers and communities negotiate meanings and expectations. These studies collectively suggest that participatory communication is not merely a technical strategy but a paradigm shift that redefines the relationship between institutions and communities.

African case studies reinforce this point. In Ghana, Agyekum et al. (2021) found that vaccine campaigns were more effective when they mobilised traditional and religious leaders to endorse vaccination, thereby embedding biomedical narratives in culturally resonant forms. This strategy illustrates how participatory approaches can harness existing structures of authority to build trust and legitimacy. In Nigeria, Afolabi et al. (2021) document how participatory strategies helped counter misinformation by situating communication within trusted community networks. Their findings show that engagement models can mitigate the spread of rumours by embedding vaccine messages in relational contexts of trust. Similar insights emerge from Kenya, where Mutua et al. (2022) highlight the importance of involving community health volunteers in vaccine campaigns, noting that their embeddedness in local networks enhanced credibility and uptake. In Uganda, Ssali et al. (2021) demonstrate that participatory approaches fostered resilience by enabling communities to co-produce narratives that addressed both biomedical concerns and cultural meanings. These examples demonstrate that engagement models are not merely technical alternatives but fundamentally different paradigms of communication, grounded in power sharing and relational trust.

In Eswatini, however, there is little evidence that vaccine communication adopted participatory approaches. Existing accounts emphasise top-down messaging from ministries of health and international agencies (WHO, 2021; Africa CDC, 2021), with limited attention to how communities were engaged in shaping narratives. This absence is significant, as it suggests that opportunities to build trust through participatory communication may have been missed. While Afrobarometer (2024) documents widespread dissatisfaction with healthcare services, including medicine shortages and poor service quality, there is no empirical research on whether participatory strategies were employed to address these concerns during the vaccine rollout. The lack of evidence leaves unanswered questions about whether nurses and frontline staff acted as facilitators of community dialogue or whether communication remained constrained by hierarchical structures.

By interrogating nurses' communicative labour, this study seeks to explore how their experiences of vaccine promotion were shaped by fragile health system conditions, thereby contributing to a more critical understanding of vaccine communication. This focus is significant because it situates nurses not only as institutional representatives but also as mediators of trust and credibility (Denniss and Lindberg, 2025; Chou et al., 2020). Examining their role allows for a deeper analysis of how relational dynamics were negotiated in contexts marked by inequality and contested authority. In doing so, the study addresses a critical empirical gap in the literature on Eswatini and contributes to a more nuanced understanding of vaccine communication in fragile health systems.

Misinformation and trust

The limitations of deficit models of "hesitancy" are compounded by the pervasive circulation of misinformation during the COVID-19 pandemic. In Southern Africa, misinformation did not simply reflect ignorance but was embedded in broader histories of distrust in state institutions, donor-driven health interventions, and uneven access to credible information (Cooper et al., 2018; Raca et al., 2023). Studies in South Africa show that misinformation often intersected with political contestation and socio-economic inequality, amplifying scepticism toward official narratives (Govender, 2021; Lalla-Edward et al., 2022). In Zimbabwe, Murewanhema et al. (2022) highlight how rumours and conspiracy theories circulated through informal networks, shaping vaccine uptake in ways that official communication strategies struggled to counter.

Trust emerges as a critical determinant of vaccine engagement. Larson et al. (2014) argue that trust in health systems, governments, and international agencies is central to vaccine acceptance, yet fragile in contexts marked by inequality and contested governance. In Namibia, Mushaandja and Ithindi (2023) show that the absence of culturally sensitive communication eroded trust in official messaging, while De Schacht et al. (2025) demonstrate that targeted, locally grounded strategies in Mozambique were more effective in building confidence. These findings underscore that misinformation cannot be understood in isolation but must be situated within broader dynamics of trust and mistrust.

Eswatini exemplifies these tensions. With one of the highest HIV prevalence rates globally and a health system already under strain (UNAIDS, 2024; Afrobarometer, 2024), communities entered the pandemic with longstanding scepticism toward state capacity and donor-driven

interventions. Diluxe et al. (2021) note that systemic fragility limited the ability of official communication to counter misinformation, while Afrobarometer (2024) documents widespread dissatisfaction with healthcare services, including medicine shortages and poor service quality. In this context, trust was not a given but had to be actively negotiated. Regional studies suggest that frontline healthcare workers in countries such as South Africa and Zimbabwe were frequently positioned as intermediaries between official biomedical messaging and community concerns (Lalla-Edward et al., 2022; Murewanhema et al., 2022). These accounts highlight the communicative demands placed on healthcare staff in contexts marked by inequality and mistrust. However, there is limited scholarship examining whether and how nurses in Eswatini assumed similar roles. While it is plausible that they faced comparable pressures, given the country's systemic vulnerabilities and high HIV/TB burden (UNAIDS, 2024; Afrobarometer, 2024), this remains under-researched. The absence of empirical studies on nurses' communicative practices in Eswatini constitutes a critical gap that this thesis seeks to address.

Foregrounding misinformation and trust therefore supports the rationale for this study. It highlights the inadequacy of communication models that treat misinformation as a technical problem to be corrected, rather than a relational issue rooted in systemic vulnerability and historical mistrust. By examining how nurses in Eswatini navigated these dynamics, the study contributes to a more critical understanding of vaccine communication that situates misinformation within the politics of trust.

Digital Misinformation and Social Media

The circulation of misinformation during the COVID-19 pandemic was not confined to interpersonal networks but was amplified through digital platforms. In Africa, WhatsApp, Facebook, and Twitter became central channels for the spread of rumours, conspiracy theories, and politicised narratives about vaccines (Wasserman and Madrid-Morales, 2021; Chigwedere et al., 2022). These platforms facilitated rapid dissemination of unverified claims, often outpacing official communication and undermining trust in biomedical authority. The speed and reach of digital communication meant that misinformation could circulate widely before corrective messages were issued, creating an environment in which uncertainty and mistrust flourished.

Studies in South Africa show that WhatsApp groups were key sites where misinformation intersected with political contestation, shaping public perceptions of vaccine safety and government legitimacy (Wasserman and Madrid-Morales, 2021). These findings highlight how digital platforms did not merely transmit false information but became arenas where broader struggles over authority and legitimacy were played out. In Zimbabwe, Chigwedere et al. (2022) document how Facebook and WhatsApp were used to circulate anti-vaccine narratives, which resonated strongly in contexts of systemic distrust and political fragility. Their study illustrates how misinformation gained traction not simply because of its content but because it aligned with existing narratives of marginalisation and suspicion. Research in Nigeria similarly highlights how Twitter amplified both misinformation and corrective messaging, illustrating the dual role of social media as a site of contestation (Afolabi et al., 2021). This duality underscores the complexity of digital platforms: they are simultaneously spaces of misinformation and potential tools for countering it.

Beyond individual case studies, broader scholarship has emphasised the relational dimensions of digital misinformation. Cinelli et al. (2020) show that the spread of COVID-19 misinformation across platforms such as Twitter, Facebook, and WhatsApp was shaped by network dynamics, with echo chambers reinforcing pre-existing beliefs. Jamison et al. (2020) argue that misinformation must be understood as part of the ecology of trust and mistrust, embedded in histories of inequality and contested governance. In fragile health systems, where institutional credibility is already precarious, digital misinformation compounds existing scepticism and amplifies distrust in biomedical authority. This perspective shifts the focus from misinformation as a purely technical problem of false information to a relational issue that reflects deeper social and political dynamics.

African case studies further illustrate this relational dimension. In Kenya, Mutua et al. (2022) found that misinformation on WhatsApp was closely tied to community anxieties about government transparency, with rumours often filling gaps left by inadequate official communication. In Uganda, Ssali et al. (2021) highlight how digital misinformation intersected with local narratives of inequality, reinforcing scepticism about vaccine safety and government accountability. These studies demonstrate that misinformation cannot be separated from the broader social contexts in which it circulates. It is not simply a matter of correcting false claims but of addressing the structural conditions that make such claims resonate. By ‘correcting false claims’ this study refers to the range of communicative strategies nurses may have used to

respond to COVID-19 vaccine misinformation such as interpersonal correction in one-to-one consultations, where nurses may have clarified facts and addressed individual concerns, or networked correction, where nurses may have engaged with misinformation circulating through social networks and community intermediaries.

In Eswatini, scholarship on digital misinformation and its implications for vaccine communication remains limited. This absence is notable given Afrobarometer's (2024) evidence of widespread dissatisfaction with healthcare services and the country's reliance on mobile communication, particularly WhatsApp, as a primary information channel. Existing studies from other African contexts suggest that frontline health workers often encounter misinformation as part of their everyday communicative labour (Ilesanmi et al., 2021; Kok et al., 2015), yet little is known about how these dynamics unfold in Eswatini. The lack of research risks overlooking how digital platforms mediate trust and mistrust in fragile health systems, and how vaccine hesitancy is shaped by narratives circulating both online and offline. By situating nurses' perceptions within this under-explored context, the study responds to a critical empirical gap and extends debates on the intersection of misinformation, trust, and frontline communication in fragile health systems.

The scholarship on digital misinformation highlights that vaccine hesitancy cannot be understood solely as a problem of inaccurate information. Rather, it reflects broader struggles over authority, legitimacy, and trust in fragile health systems. These struggles are deeply embedded in histories of inequality and contested governance, influencing how communities interpret and respond to health communication. Building on this perspective, the following section examines how communication intersects with power and inequality, exploring how structural conditions influence the credibility of health workers and the reception of vaccine messages.

Communication, power, and inequality

The circulation of misinformation and the fragility of trust cannot be separated from broader questions of power and inequality. Vaccine communication is not a neutral process of information transfer but a site where authority is asserted, contested, and negotiated. Critical scholarship in health communication has long argued that public health messaging often reproduces existing hierarchies by privileging biomedical expertise while marginalising local knowledge systems (Airhihenbuwa, 1995; Tufte, 2017). This critique highlights how

communication strategies frequently assume universality, disregarding the cultural and political contexts in which messages are received. In the context of COVID-19, this dynamic was particularly visible in Southern Africa, where communication strategies were frequently designed by ministries of health and international agencies, with limited participation from communities most affected by systemic vulnerability (Govender, 2021; Lalla Edward et al., 2022). The result was messaging that emphasised biomedical efficacy but often failed to resonate with the lived realities of marginalised populations.

Inequality shapes not only the reception of vaccine messages but also the capacity of individuals to act on them. Cooper et al. (2018) demonstrate that vaccine uptake in South Africa was stratified by socio-economic status, with poorer communities facing barriers that were communicative as well as material. These barriers included not only logistical challenges such as transport and access to clinics but also communicative failures, where messages did not adequately address the concerns of disadvantaged groups. In Zimbabwe, Midzi et al. (2024) show that booster uptake was lowest among marginalised groups, reflecting both structural exclusion and the inadequacy of communication strategies that failed to address inequality. Their findings underscore that vaccine communication cannot be understood in isolation from the political economy of health, where access to information and services is unevenly distributed.

Power also operates through the framing of "hesitancy." As Larson et al. (2014) argue, the discourse of hesitancy often functions as a disciplinary tool, locating the problem in individual attitudes rather than systemic failures. This framing obscures the ways in which communities resist or reinterpret biomedical authority, sometimes as a form of agency in contexts where health systems have historically failed them. Gumede (2021) highlights how communities in South Africa interpreted COVID-19 messages through local idioms and socio-economic realities, demonstrating that communication is always mediated by power relations. Such interpretations reveal that vaccine communication is not simply about persuasion but about negotiation, where communities assert their own frameworks of meaning in response to institutional authority.

African case studies further illustrate these dynamics. In Kenya, Mutua et al. (2022) show that community health volunteers were often caught between institutional directives and local scepticism, highlighting how power relations shaped their communicative labour. In Uganda, Ssali et al. (2021) found that vaccine campaigns were resisted when they were perceived as

externally imposed, underscoring how inequality and contested governance mediated trust. These examples demonstrate that communication strategies that fail to address power imbalances risk reinforcing exclusion rather than building trust.

Eswatini illustrates these dynamics in acute form. With one of the highest HIV prevalence rates globally and a health system marked by fragility (UNAIDS, 2024; Afrobarometer, 2024; Diluxe et al., 2021), vaccine communication unfolded within a context of deep inequality and contested governance. Official messaging, shaped by international agencies such as WHO (2021) and Africa CDC (2021), emphasised biomedical efficacy and collective responsibility, but did not adequately address the lived realities of communities facing medicine shortages and systemic distrust. The absence of scholarship on how nurses navigated these power dynamics is striking. Positioned at the intersection of institutional authority and community life, nurses were likely required to mediate between top-down directives and local scepticism, yet their communicative labour remains under-examined.

Foregrounding communication as a site of power and inequality therefore sharpens the rationale for this study. It highlights the inadequacy of approaches that treat vaccine communication as a technical exercise, and instead situates it within broader struggles over authority, trust, and inclusion. By examining how nurses in Eswatini engaged with these dynamics, the study contributes to a more critical understanding of vaccine communication as a relational and political process. It also advances theoretical debates in health communication by showing how power and inequality are not peripheral concerns but central determinants of communicative effectiveness in fragile health systems.

Historical Legacies of Trust in Medicine

Trust in vaccine communication cannot be understood without reference to the historical legacies of medicine in Africa. Colonial medical practices often positioned African communities as subjects of experimentation and control, embedding mistrust that continues to shape contemporary health engagement. Vaughan (1991) and Packard (1989) document how colonial health interventions in Southern Africa were frequently coercive, tied to labour control and political authority rather than community well-being. These interventions were not designed to serve communities but to sustain colonial economies, reinforcing perceptions of medicine as a tool of domination. Such histories left enduring scars, where biomedical authority

was associated with coercion rather than care, and where health interventions were remembered as instruments of surveillance and control.

Anthropological studies highlight how these legacies persist in contemporary vaccine communication. Fairhead et al. (2006) show that mistrust of immunisation campaigns in West Africa was rooted in memories of colonial and postcolonial interventions that disregarded local knowledge and cultural practices. Their work demonstrates that mistrust is not an irrational response but a historically grounded critique of external authority. Similarly, Geissler (2015) argues that global health initiatives often reproduce colonial hierarchies by privileging external expertise over community voices, thereby perpetuating patterns of exclusion. These insights underscore that mistrust is not simply a product of misinformation but is historically embedded in unequal relations of power. Trust in vaccine communication must therefore be analysed in relation to these legacies, which continue to shape how communities interpret biomedical authority.

In Southern Africa, the HIV epidemic further complicated these legacies. Packard (2016) notes that responses to HIV were shaped by earlier histories of medical authority, with communities sceptical of interventions that appeared externally driven. The epidemic exposed deep fractures in trust, as global health programmes often emphasised biomedical solutions while neglecting the social and cultural dimensions of care. Scholars such as Fassin (2007) have argued that HIV responses in Southern Africa reproduced inequalities by framing communities as passive recipients of aid rather than active participants in health governance. These dynamics reinforced scepticism toward externally driven interventions, situating vaccine communication within a broader terrain of contested trust.

In Eswatini, where HIV prevalence remains among the highest globally (UNAIDS, 2024), vaccine communication unfolded within this historical terrain of mistrust. The country's experience with HIV interventions, many of which were externally funded and directed, shaped community perceptions of biomedical authority. Yet scholarship has not examined how nurses navigated these legacies in their communicative practices. This omission is significant, as it risks treating mistrust as a contemporary problem of misinformation rather than a historically conditioned dynamic rooted in colonial medicine and postcolonial global health governance. By overlooking the historical dimensions of mistrust, existing accounts risk flattening vaccine communication into a technical issue of message delivery, rather than recognising it as a relational process embedded in histories of inequality.

Foregrounding historical legacies therefore sharpens the analysis of vaccine communication. It situates Eswatini's challenges within broader trajectories of colonial medicine, postcolonial health governance, and global health interventions. By interrogating how these histories shape communicative practices, this study contributes to a more critical understanding of vaccine engagement in fragile health systems. It also underscores the importance of recognising nurses not only as communicators of biomedical authority but as actors navigating historically conditioned terrains of trust and mistrust. In doing so, the study highlights the need for vaccine communication strategies that acknowledge historical legacies, foreground community voices, and challenge the reproduction of colonial hierarchies in global health.

Critical Paradigm in Communication

Health communication scholarship increasingly recognises that vaccine messaging must be analysed through a critical lens that foregrounds power, inequality, and governance (Jamison et al., 2020; Tufte, 2017; Airhihenbuwa, 1995). Traditional models often treat communication as a neutral process of information transfer, yet critical approaches emphasise that it is embedded in political economies and social hierarchies (Airhihenbuwa, 1995; Tufte, 2017). In the context of COVID-19, vaccine communication in Africa was not only influenced by biomedical imperatives but also by contested authority, donor influence, and systemic inequality (Wei, Kamande and Lang'at, 2023; Kim et al., 2025; Murewanhema et al., 2022; Jamison et al., 2020).

Critical health communication perspectives argue that messaging cannot be divorced from the structures that produce vulnerability. Airhihenbuwa (1995) highlights how dominant paradigms privilege Western biomedical knowledge while marginalising local cultural frameworks. Tufte (2017) similarly critiques development communication models that assume linear flows of information, showing how they reproduce hierarchies rather than fostering dialogue. Applied to vaccine communication, these insights reveal that messages are not simply received or rejected but negotiated within contexts of power and exclusion.

African case studies illustrate these dynamics. Govender (2021) shows how South African communication strategies faltered when they ignored socio-economic realities, while Gumede, Durden and Govender (2022) demonstrate how political leadership styles shaped public reception of health messages. In Zimbabwe, Murewanhema et al. (2022) highlight how frontline healthcare workers were constrained by institutional hierarchies that limited their

communicative agency. These examples underscore that vaccine communication is not only about content but about the structures of authority that determine who speaks, who is heard, and whose knowledge counts.

This critical perspective also clarifies how mistrust links directly to vaccine hesitancy. When communication reproduces inequality or disregards local knowledge, communities may resist biomedical messages not simply because of misinformation but because they perceive them as illegitimate or exclusionary. Hesitancy thus emerges as a relational response to structural conditions: scepticism towards vaccines reflects broader struggles over credibility, governance, and trust in fragile health systems (Jamison et al., 2020; Mutua et al., 2022). In Eswatini, the absence of scholarship on nurses' communicative labour reflects this broader neglect of critical paradigms. Existing accounts emphasise biomedical efficacy and policy directives (WHO, 2021; Africa CDC, 2021), but do not interrogate how communication reproduced or contested power relations within a fragile health system. By adopting a critical paradigm, this study seeks to move beyond technical framings to examine vaccine communication as a relational and political process. In doing so, it contributes to scholarship that situates health communication within the wider struggles over inequality, mistrust, and vaccine hesitancy in Africa.

Cultural Competence in Healthcare

Cultural competence has emerged as a critical dimension of health communication, particularly in contexts marked by diversity and inequality. Betancourt et al. (2003) define cultural competence as the ability of healthcare systems and professionals to deliver services that meet the social, cultural, and linguistic needs of patients. In practice, this requires recognising that communication is not only biomedical but also relational, shaped by cultural frameworks that determine how health messages are interpreted. Health communication is therefore not a neutral process of information transfer but a culturally embedded practice that must account for the meanings, values, and expectations of diverse communities.

In African contexts, cultural competence is especially significant given the coexistence of biomedical and traditional health systems. Airhihenbuwa (1995) argues that health interventions often fail when they disregard local cultural logics, noting that biomedical authority is frequently contested when it does not resonate with community practices. Mackintosh and Tibandebage (2004) show that nurses in Tanzania were required to navigate between biomedical authority and community expectations rooted in traditional practices,

highlighting the everyday negotiations that frontline staff must undertake. These findings illustrate that cultural competence is not abstract but lived in the daily interactions between healthcare workers and communities. Studies in Ghana and Nigeria further demonstrate that vaccine campaigns were more effective when they engaged religious and traditional leaders, embedding biomedical narratives in culturally resonant forms (Agyekum et al., 2021; Afolabi et al., 2021). Such strategies illustrate how cultural competence can enhance trust and legitimacy by aligning health messages with existing structures of authority and meaning.

The absence of cultural competence can undermine trust and exacerbate inequality. Gilson (2003) notes that health systems that fail to recognise cultural diversity often reproduce exclusion, marginalising communities whose cultural frameworks are disregarded. Fairhead et al. (2006) demonstrate that immunisation campaigns in West Africa were resisted when they were perceived as culturally insensitive, showing that lack of cultural competence can generate active opposition rather than passive disengagement. Similarly, Napier et al. (2014) argue that health systems that neglect cultural dimensions risk perpetuating structural inequalities, as communication strategies fail to resonate with the lived realities of diverse populations. These insights underscore that cultural competence is not an optional supplement but a determinant of communicative effectiveness, shaping whether health messages are trusted, contested, or rejected.

African case studies provide further evidence of the importance of cultural competence. In Uganda, Ssali et al. (2021) show that vaccine acceptance was enhanced when campaigns incorporated local cultural narratives and community dialogue, demonstrating that cultural resonance was central to building trust. In Kenya, Mutua et al. (2022) highlight how community health volunteers acted as cultural mediators, translating biomedical messages into locally meaningful forms. These examples reinforce the argument that cultural competence is not simply about linguistic translation but about embedding communication within cultural logics that communities recognise as legitimate.

In Eswatini, where linguistic diversity and strong traditional health practices coexist with biomedical systems, cultural competence is particularly critical. The country's health system operates within a pluralistic landscape in which traditional healers continue to play a significant role in community health practices. Yet scholarship has not examined how nurses navigated cultural frameworks in their communicative labour during the vaccine rollout. This omission risks treating communication as a technical exercise rather than a culturally embedded practice.

Without attention to cultural competence, analyses of vaccine communication may overlook how nurses mediated between biomedical authority and community cultural logics, and how these negotiations shaped trust and credibility.

Foregrounding cultural competence therefore sharpens the analysis of vaccine communication. It situates Eswatini's challenges within broader debates on diversity, inequality, and health system responsiveness. By interrogating how nurses engaged with cultural frameworks, this study contributes to a more nuanced understanding of vaccine communication in fragile health systems. It also highlights the need for health communication strategies that recognise cultural diversity as a determinant of effectiveness, ensuring that messages resonate with communities rather than reproduce exclusion. In doing so, the study advances theoretical debates on cultural competence while addressing a critical empirical gap in the literature on Eswatini.

Towards contextualised vaccine communication in Eswatini

This expanded review demonstrates that vaccine communication in Africa is influenced by systemic vulnerability, inequality, misinformation, and contested power relations. Comparative case studies from Ghana, Nigeria, Kenya, and Tanzania illustrate continental patterns of mistrust, digital misinformation, and the importance of participatory approaches, while also underscoring Eswatini's distinctive vulnerabilities as a small state with one of the highest HIV prevalence rates globally (UNAIDS, 2024; Afrobarometer, 2024; Diluxe et al., 2021).

Across the literature, deficit framings of "hesitancy" and top-down communication models dominate, privileging biomedical authority while neglecting relational and cultural dimensions (Larson et al., 2014; WHO, 2021; Africa CDC, 2021). Yet alternative paradigms exist. Community engagement models in Ghana and Nigeria demonstrate the value of participatory strategies (Agyekum et al., 2021; Afolabi et al., 2021), while intersectional analyses reveal how gender, class, and professional identity shape nurses' communicative roles (Crenshaw, 1989; Mackintosh and Tibandebage, 2004). Perceptions of healthcare workers further condition vaccine communication, with trust and credibility negotiated within contexts of inequality and systemic fragility (Gilson, 2003; Murewanhema et al., 2022; De Schacht et al., 2025).

Digital misinformation studies highlight the role of WhatsApp, Facebook, and Twitter in amplifying mistrust and contesting biomedical authority (Wasserman and Madrid-Morales, 2021; Chigwedere et al., 2022), while historical scholarship reminds us that mistrust is deeply

rooted in colonial medical practices and their postcolonial legacies (Vaughan, 1991; Packard, 1989; Geissler, 2015). Critical health communication perspectives emphasise that vaccine messaging is embedded in political economies and hierarchies of power (Airhihenbuwa, 1995; Tufte, 2017), and cultural competence scholarship underscores that communication must be culturally embedded to be effective (Betancourt et al., 2003; Fairhead et al., 2006).

Taken together, these insights point to the inadequacy of narrow biomedical framings. Vaccine communication is not a neutral process of information transfer but a relational and political practice shaped by inequality, power, history, and culture. Nurses and frontline healthcare workers, positioned at the intersection of institutional authority and community life, embody these tensions. Regional evidence suggests they often mediated between official directives and local realities (Lalla-Edward et al., 2022; Murewanhema et al., 2022; De Schacht et al., 2025), yet in Eswatini their communicative labour remains under-examined.

Foregrounding nurses as communicators therefore offers a critical lens for contextualising vaccine communication in Eswatini. It situates their practices within systemic fragility, digital misinformation, historical mistrust, intersectional identities, community engagement, and cultural competence, while also challenging dominant hierarchies that privilege top-down messaging. By interrogating how nurses navigated these dynamics, this study contributes to a more nuanced understanding of vaccine engagement in fragile health systems. In doing so, it positions Eswatini not as an isolated case but as part of broader continental debates, while highlighting the country's distinctive vulnerabilities and the urgent need for scholarship that foregrounds communicative labour.

Conclusion

This chapter has critically reviewed the literature relevant to COVID-19 vaccine communication, with a particular focus on healthcare workers and nurses in Eswatini. It began by situating health communication within broader development and social change discourses, highlighting how structural inequalities, colonial legacies, and socio-political contexts shape public health responses in African settings. The evolution of health communication was traced from early behaviourist models to participatory and culturally grounded paradigms, with emphasis on the importance of inclusive and context-sensitive messaging.

Global perspectives revealed that dominant vaccine communication strategies during the COVID-19 pandemic were largely biomedical and top-down, often failing to resonate with

communities facing historical mistrust and systemic exclusion. Vaccine hesitancy among healthcare workers was explored as a complex and legitimate response to concerns about safety, institutional trust, and exclusion from decision-making processes. Comparative studies from the Global South underscored the limitations of expert-driven messaging and the need for culturally relevant engagement.

In African contexts, health communication is further complicated by under-resourced systems, diverse cultural logics, and the dual roles of nurses as both clinical professionals and embedded community members. Nurses often serve as informal counsellors, cultural brokers, and trusted sources of health information. Their ability to influence vaccine uptake depends not only on clinical expertise but also on their credibility within communities and their sensitivity to local norms.

Eswatini-specific literature highlighted the country's pandemic response and vaccine rollout, but revealed a significant gap in understanding how nurses perceived and experienced vaccine messaging. While official reports documented vaccination rates and campaign logistics, they did not capture the lived realities of healthcare workers or their engagement with communication strategies. There is limited documentation of culturally grounded initiatives during the vaccine rollout, and few studies have centred the voices of nurses in analysing vaccine communication.

In summary, the literature reveals that vaccine communication is most effective when it is participatory, culturally competent, and responsive to the lived experiences of healthcare workers. What remains unexplored; particularly in Eswatini, is how nurses interpreted and engaged with vaccine messaging during the pandemic, and how their positionality influenced public health outcomes. This study seeks to address that gap by foregrounding nurses' experiences and contributing to the development of inclusive and contextually grounded communication strategies.

CHAPTER THREE

CONCEPTUAL FRAMEWORK

Introduction

During public health emergencies, governments and health practitioners typically promote healthy behaviours and preventive measures through behaviour change interventions. Key strategies often involve biomedical treatments and information dissemination (Weston et al., 2020), guided by health behaviour models adapted from multiple disciplines. While effective in some contexts, these approaches leave gaps that enable the persistence of infection (Haberer et al., 2021). A critical shortcoming is their tendency to emphasise biomedical treatments without accounting for cultural perceptions of disease (Airhihenbuwa et al., 2020; Airhihenbuwa et al., 2014; Dutta, 2008).

From the discovery of COVID-19 in March 2020, global agencies such as the World Health Organisation (WHO) and the Centres for Disease Control and Prevention (CDC) led pandemic responses. By March 2021, as infections surged, communication efforts increasingly emphasised individual behaviour choices, implicitly suggesting that prevention was largely under personal control (Airhihenbuwa et al., 2020). This perspective contrasts with health communication scholarship that stresses the importance of culture in shaping understanding of disease and enhancing intervention effectiveness (Airhihenbuwa et al., 2020; Kreuter and McClure, 2004).

Culture strongly influences health-seeking behaviour, particularly in African contexts (Takeyama et al., 2022; Adeyanju et al., 2021; Chukwuneke et al., 2012). Symptoms of illness are often interpreted within cultural belief systems, guiding therapeutic decisions (Mason et al., 2022; Airhihenbuwa et al., 2020). Perceptions of preventive interventions also affect healthcare workers' communication with patients and the quality of care. It is therefore essential to account for cultural contexts alongside individual behaviour (Airhihenbuwa et al., 2014).

In Eswatini, nurses' perceptions of COVID-19 prevention information and their experiences with vaccines have not been documented since vaccines became available in March 2021. For this study, healthcare workers refer to nurses at Mbabane Government, Hlatikulu Government, and Raleigh Fitkin Memorial hospitals. Effective health communication during emergencies is vital for informing, empowering, and influencing communities (Schiavo, 2013). To ensure successful pandemic responses, social and community influences must be considered alongside biomedical aspects (Govender, 2021). However, the lack of documentation of nurses'

perspectives in Eswatini has limited opportunities to incorporate diverse viewpoints, potentially constraining the public health sector's capacity to manage COVID-19 prevention and control.

This chapter examines the conceptual framework applied in this study and outlines the key constructs utilised to explore the perceptions and experiences of nurses in Eswatini regarding the COVID-19 vaccines during the period from March 2021 to September 2021. This timeframe is particularly significant as it marks the commencement of Eswatini's COVID-19 vaccination campaign in March 2021, a period characterised by the introduction of various COVID-19 vaccines amidst widespread uncertainty surrounding their efficacy and potential side effects, exacerbated by misinformation and propaganda.

Furthermore, the chapter elaborates on the concept of culture as it pertains to this study and evaluates the applicability of these conceptual frameworks in diverse contexts. It concludes by delineating the specific application of the theoretical constructs within the scope of this research. The study appropriates the Health Belief Model and The Process of Cultural Competence in the Delivery of Healthcare Services model as a lens to explore specific phenomena as described in the following sections. Table 3.1 below outlines the research questions of this study and illustrates how the conceptual framework is applied to answer the research questions.

Table 1 Research questions and the constructs that apply in this study

Research Question	**Theoretical construct**
a) What are the perceptions of COVID-19 among healthcare workers at the Raleigh Fitkin Memorial, Hlatikulu and Mbabane Government Hospitals?	i. Perceived susceptibility ii. Perceived severity
b) What are the experiences of the COVID-19 vaccines among healthcare workers at Raleigh Fitkin Memorial, Hlatikulu and Mbabane Government Hospitals?	i. Perceived benefits ii. Cues to action iii. Cultural awareness
c) What are the concerns about the COVID-19 vaccines among healthcare workers at the	i. Perceived barriers ii. Self-efficacy

Raleigh Fitkin Memorial, Hlatikulu and Mbabane Government Hospitals?	
d) In what ways can healthcare workers at the Raleigh Fitkin Memorial, Hlatikulu and Mbabane Government Hospitals enable and promote more effective COVID-19 prevention?	i. Cultural knowledge, ii. Cultural skill, iii. Cultural encounters, iv. Cultural desire

Description of the Health Belief Model

Developed in the 1950s by social psychologists in the United States Public Health Service, the Health Belief Model (HBM) remains one of the most widely utilised frameworks for understanding health behaviours. The model is grounded in the assumption that individuals' engagement in health- related behaviours is influenced by their perceptions of susceptibility to a condition, the severity of its consequences, the benefits of taking preventive action, and the barriers to performing such a behaviour (Anuar et al., 2020; Zewdie et al., 2024). Additionally, cues to action and self-efficacy play crucial roles in shaping health decisions.

The present study employs the Health Belief Model as one of its guiding theoretical frameworks due to its predictive ability to explain health-related decision-making processes. Given that this research examines the perceptions and experiences of nurses in Eswatini regarding the COVID-19 pandemic, the HBM provides a structured approach to assessing the psychological and social factors influencing individuals' adoption of preventive behaviours. By applying this model, the study seeks to explore how perceived risk, benefits, and barriers contribute to behavioural outcomes, offering insights that may inform health interventions in Eswatini.

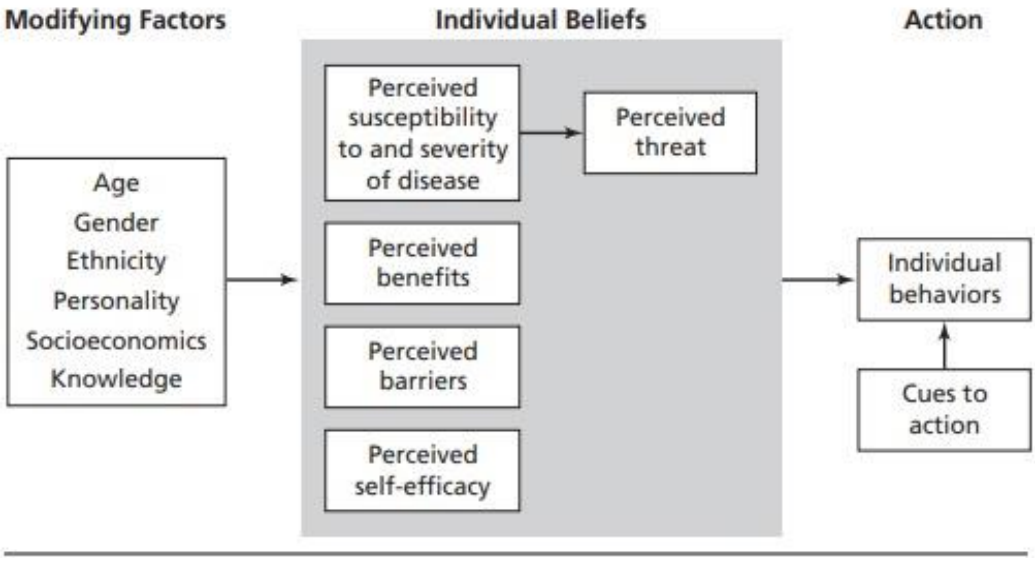
In this section of the chapter, the study will specifically explore how the six components of the HBM – perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy – shape individual attitudes and behaviours regarding COVID-19 vaccination among nurses in Eswatini. Through this theoretical lens, the research aims to

provide a nuanced understanding of the psychological determinants influencing health behaviour within the targeted population.

Key constructs and application of the HBM in this study

The HBM encompasses six fundamental concepts that explain and predict the factors influencing individuals to take action aimed at preventing, screening for, or managing illness or disease (Champion and Skinner, 2008). These constructs, outlined below, are: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Janz and Becker, 1984).

Figure 3:1 Health Belief Model Components and Linkages. Adapted from Champion and Skinner (2008).



The HBM provides a framework for understanding how individuals evaluate and respond to perceived health risks. Perceived susceptibility refers to beliefs about the likelihood of acquiring a disease or condition (Champion and Skinner, 2008). For instance, a woman must perceive the possibility of contracting HIV before she considers using oral Pre-Exposure Prophylaxis (PrEP). As perceived susceptibility emphasises an individual's evaluation of their risk of experiencing a negative outcome, (Dutta, 2008), in the context of this study, it pertains to nurses' assessment of their risk of contracting COVID-19.

Conversely, perceived severity reflects an individual's beliefs about the seriousness of contracting an illness or the consequences of leaving it untreated (Champion and Skinner, 2008). This construct includes evaluations of both medical and clinical outcomes (for example, death, disability, and pain) as well as potential social repercussions (the impact of work, family life, and social relationships) (Strecher and Rosenstock, 1997). Within the scope of this study, perceived severity refers to the nurses' assessments of the seriousness of COVID-19 infection.

Together, perceived susceptibility and severity form the concept of perceived threat (Champion and Skinner, 2008). An individual may perceive themselves as personally susceptible to a severe health condition (perceived threat), but whether this leads to behaviour change often depends on their beliefs about the perceived benefits of actions to mitigate the disease or threat. Non-health-related factors, such as the financial savings from quitting smoking or a desire to please a family member by taking oral PrEP, may also influence behavioural decisions. Consequently, even when individuals strongly believe in their susceptibility and the severity of a condition, they are unlikely to adopt any recommended health actions unless they perceive the actions as beneficial by reducing the threat (Champion and Skinner, 2008).

In the decision-making process for adopting preventive health behaviours, individuals often face perceived barriers. These barriers represent the potential negative aspects of a health action, and may act as obstacles to undertaking recommended behaviours (Champion and Skinner, 2008, Glanz et al., 2008). This involves a subconscious cost-benefit analysis, whereby individuals weigh the anticipated benefits of the action against the perceived barriers. Within the context of this study, perceived barriers could encompass negative experiences with the COVID -19 vaccine, challenges in accessing vaccines, and fears about potential side effects of the vaccines among healthcare workers (Gadoth et al., 2020).

Early iterations of the Health Belief Model (HBM) posited that the adoption of preventive health behaviours or actions to mitigate severity relies on cues that trigger behaviours (Rosenstock, 1974). Dutta (2008) asserts that cues to action function as explicit motivations essential for prompting appropriate health behaviours. They are strategies designed to activate "readiness" (Glanz et al., 2008). This interpretation aligns with Hochbaum's (1958) conceptualisation of cues to action, although he suggested that the willingness to take action could only be enhanced by other influences such as media publicity, bodily events or environmental factors. While useful for understanding why individuals may demonstrate readiness to reduce perceived susceptibility or severity, researchers note two key limitations of cues to action; they are difficult to assess through explanatory surveys, and they have not been systematically studied (Champion and Skinner, 2008). In contrast, self-efficacy- a related concept- refers to an individual's belief in their ability to successfully perform behaviours that produce positive outcomes (Janz and Becker, 1984; Bandura, 2004), such as receiving the vaccine. Within this study, cues to action encompass factors such as positive experiences with the COVID-19 vaccine from others in the individual's social network, minimal vaccine side effects and confidence in the vaccine's efficacy (Holzmann-Littig, 2021).

It is important to acknowledge that even when individuals perceive themselves as susceptible to a serious health condition (perceived threat) and possess self-efficacy, they may still fail to adopt behaviours prompted by cues to actions. This is often due to their beliefs about the perceived benefits of available actions in mitigating the disease threat. As Champion and Skinner (2008 p.47) explain, an individual's perceived susceptibility may be influenced "by the person's beliefs regarding perceived benefits of the various available actions for reducing the disease threat". For instance, perceived benefits in this study may include the individual nurses' beliefs about the efficacy of the COVID-19 vaccines.

Beyond these six constructs, the HBM also incorporates modifying factors that influence how individuals interpret health threats and make decisions. These include demographic characteristics such as age, gender, and education; socio-psychological attributes such as personality, peer influence, and social support; and structural variables such as access to healthcare services and prior contact with illness (Champion and Skinner, 2008). While these variables situate health behaviour within individual contexts, they also highlight the model's tendency to remain highly individualised. Culture, as a collective and dynamic determinant of behaviour, is not explicitly addressed within the HBM. This omission limits its capacity to account for the broader cultural environments in which health decisions are made.

These limitations are particularly relevant in the context of Eswatini, where nurses' perceptions of vaccination are shaped not only by individual risk assessments but also by cultural narratives, institutional practices, and community trust. As Dutta (2008) notes, the HBM's neglect of cultural contexts restricts its explanatory power in settings where behaviour is embedded within broader cultural practices. To address this gap, the present study integrates the Campinha-Bacote (2002) model of cultural competence in the delivery of healthcare services. By foregrounding cultural awareness, knowledge, skill, encounters, and desire, this model extends the explanatory scope of the HBM beyond individual cognition to encompass sociocultural realities. In doing so, it bridges the gap between individual perceptions and collective cultural contexts, enabling a more comprehensive understanding of nurses' experiences with COVID-19 vaccination in Eswatini.

Historical development of the Health Belief Model

Various health behaviour theories such as the Theory of Planned Behaviour (TPB), the Transtheoretical Model (TTM), and the Health Belief Model (HBM) have been employed to guide health intervention designs. This study utilizes the constructs of the Health Belief Model

(HBM) to examine how perceptions of the benefits and barriers associated with receiving the COVID-19 vaccine influenced the actions of individual nurses in three hospitals in the Kingdom of Eswatini.

The Theory of Planned Behaviour (TPB) was formulated in 1985 by Icek Ajzen as an advancement of the Theory of Reasoned Action (TRA), a conceptual framework developed in 1975 by Azjen and Martin Fishbien. The TPB emphasises the importance of intention as a predictor of behaviour integrating attitudes, subjective norms and perceived behavioural control to explain actions (Ajzen, 1991; Fishbien et al, 2007; Al-Suqri and Al-Kharusi, 2015; LaCaille, 2020). Additionally, the TPB strongly considers the impact of social pressures on behaviour (Hagger, 2019). Since its inception, the TPB has become a widely used framework in health sciences and social psychology for predicting and understanding human behaviour. It has been applied in various domains including health interventions, environmental sustainability, marketing and organisational behaviour (Tarkang et al, 2024; Maziriri, 2024; Correia et al, 2024; Palamuleni, 2024). Conversely, the Transtheoretical Model TTM, developed by James O. Prochaska and Carlo DiClemente in the late 1970s, views behaviour change as a dynamic, staged process with distinct phases that include pre-contemplation, contemplation, preparation, action and maintenance (Mullan, 1998; Sutton, 2015; Li, 2024).

The TTM is widely used for behaviours that involve gradual change over time, such as interventions that target addiction recovery, chronic disease management and weight management (Kim et al, 2024; Okube and Kimani, 2024; Zimu et al, 2024). Among these, the HBM remains one of the most widely applied frameworks to develop interventions aimed at preventive health behaviours, such as vaccination campaigns, cancer screenings, and disease prevention efforts. While all three models aim to create targeted interventions by understanding the factors that influence behaviour, the HBM is the most suitable framework to explore individuals' perceived barriers, benefits and susceptibility, hence its adoption within this study .

The Health Belief Model (HBM) is grounded in psychological and behavioural theory and posits that health related behaviour is driven by two key components:

a) the desire to avoid illness, or conversely get well if already ill; and,

b) the belief that a specific health action will prevent, or cure, illness (Champion and Skinner, 2008).

This framework is particularly relevant to COVID-19 vaccine communication and the present study. According to the HBM, individuals who wish to avoid illness or recover from it and believe that a specific action – such as vaccination – can achieve this, should result in a high uptake of COVID-19 vaccines. However, despite this theoretical expectation, healthcare workers in Eswatini expressed scepticism and doubt about the COVID-19 vaccine , which could have influenced their vaccination rates (Ndzinisa and Govender, 2024). There is currently a lack of specific statistical data regarding the COVID-19 vaccine uptake rate among nurses in the country, however, while the overall vaccination coverage in Eswatini was above 70% for people aged 40 and older, only 36.9% of the general population was vaccinated by June 2023 (WHO Eswatini, 2024). While comprehensive studies on this specific demographic in Africa are limited, existing data indicates a generally low acceptance of the vaccine among healthcare workers across the continent (Ackah et al., 2022). This situation highlights the importance of understanding the perceived vulnerabilities and barriers contributing to concerns about the vaccine among nurses in Eswatini.

The Health Belief Model (HBM) posits that an individual's health-related decisions are influenced by their perceptions of the benefits and barriers associated with engaging in specific health behaviours. Developed by social psychologists Godfrey Hochbaum, Irwin Rosenstock, and Stephen Kegels, the HBM arose in response to the failure of a conveniently located and free tuberculosis (TB) health screening programme in the United States of America (Hochbaum, 1958, Rosenstock, 1974, Champion and Skinner, 2008).

Hochbaum (1958) investigated the ‘readiness’ of adults to get X-rays, examining their beliefs about their susceptibility to TB and their perceived benefits of early detection (Strecher and Rosenstock, 1997). His findings revealed that individuals who believed themselves to be susceptible to TB and recognised the benefits of screening were more likely to take the recommended action by undergoing X-ray examinations (Baum et al., 1997). Conversely, those who did not perceive themselves at risk or doubted the advantages of early detection were unlikely to participate in the screening programme (Champion and Skinner, 2008).

Based on these observations, Hochbaum (1958) concluded that individuals were more likely to engage in health-promoting behaviours when they:

a) perceive themselves at high risk of a condition,

b) believe the condition could have possibly serious consequences,

c) believe that a course of action available to them would effectively reduce their susceptibility to or severity of the condition, and

d) believe the anticipated benefits of taking action outweigh the barriers or costs associated with it (Champion and Skinner, 2008).

The model was subsequently expanded to study individuals' responses to symptoms (Kirscht, 1974) and later applied to behaviours following the diagnoses of an illness, particularly in adherence to prescribed medical routines (Becker, 1974). Over time, the model has evolved to address a wide range of public health concerns, including behavioural responses to other health-related conditions (Glanz et al., 2008).

Originally, Hochbaum (1958) focused on perceptions regarding susceptibility to tuberculosis and the personal benefits of early detection. In contrast, for medically recognied illnesses, rather than preventive risk reduction, the model has been adapted to incorporate acknowledgment of the diagnosis, personal estimations of susceptibility to the consequences of the illness, and susceptibility to illness more broadly (Champion and Skinner, 2008). Recognised illnesses can include conditions such as COVID-19, which emerged as a global pandemic in 2020. While the HBM has had utility in public health for over four decades, cultural competence represents a comparatively recent development in healthcare.

The application of the HBM in other studies

Over the past seven decades, the Health Belief Model (HBM) has been expanded, compared to other frameworks, and widely applied to support interventions aimed at changing health behaviour. Its enduring relevance lies in its ability to provide a structured lens for understanding how perceptions of risk, benefit, and barriers shape individual decision-making. In the African context, the HBM has been particularly influential in HIV prevention research. For example, it has been used to explore students' responses to HIV/AIDS and voluntary testing and counselling among university students in South Africa (Buldeo and Gilbert, 2015), predict safer sexual behaviour among African immigrants (Tlou, 2005), assess the effectiveness of educational programmes about HIV/AIDS among high school students in Cameroon (Asare, 2011), and examine factors associated with condom use in Kenya (Volk and Koopman, 2001). These studies illustrate the adaptability of the HBM in contexts where behavioural decisions are shaped by both biomedical risk perceptions and socio-cultural influences.

Other applications of the HBM have focused on more specific aspects of HIV prevention and sexual health. Research has assessed health beliefs about male condom use and negotiation among women (Takeyama et al., 2022), explored female condom use among tertiary students (Patterson, 2022), and evaluated peer-led, theoretically designed HIV prevention interventions among students (Mason et al., 2022). More recently, the model has been applied to understand the role of religious leaders in shaping pregnant and breastfeeding women's decision-making and willingness to use biomedical HIV strategies (Young et al., 2022). These studies highlight the breadth of contexts in which the HBM has been deployed, from individual decision-making to community-level influences, and underscore its utility in identifying barriers to preventive action.

Applications of the HBM consistently reveal that personal fears and misconceptions can act as significant barriers to action. Beliefs that are factually incorrect—such as exaggerated concerns about side effects or doubts about efficacy—can nonetheless exert powerful influence over behaviour. This suggests that barriers to action are not merely logistical but also cognitive and emotional, and that they can prevent the uptake of prevention measures even when services are available. Such insights are particularly relevant to vaccine communication, where misinformation and mistrust often shape perceptions of risk and benefit.

In recent years, the HBM has been applied to explore factors associated with COVID-19 vaccine hesitancy in diverse contexts. Studies in Ethiopia and Nigeria, for example, have shown that perceptions of susceptibility and severity strongly influenced willingness to vaccinate, while perceived barriers such as fear of side effects reduced uptake (Zewdie et al., 2024; Afolabi et al., 2021). Research in the United States and Europe has similarly demonstrated that HBM constructs predict vaccine acceptance, but also highlighted the importance of contextual factors such as political trust and cultural identity (Shmueli, 2021; Wong et al., 2020). These findings reinforce the model's utility in analysing vaccine hesitancy but also point to its limitations in accounting for broader socio-political dynamics.

This study applied the HBM to explore perceptions of susceptibility and severity of COVID-19 among healthcare workers three hospitals in Eswatini. While the broad application of the HBM to explore COVID-19 vaccine hesitancy is not unique, this study contributes to the literature by examining the influence of HBM constructs among nurses in the Kingdom of Eswatini—a context that has consistently been under-researched. Research suggests that the HBM is useful in predicting vaccine hesitancy, but there is also a need to explore how the experiences of

nurses and their cultural competency influenced their communication of COVID-19 vaccines and vaccine-related information at the height of the pandemic, when vaccination had just been introduced as a means to mitigate serious disease and death.

Campinha Bacote's (2002) Cultural Competency Model in the Delivery of Healthcare Services

To account for this gap, this study applied Campinha-Bacote's (2002) Cultural Competency Model in the Delivery of Healthcare Services. Cultural competence is defined as the ability of health systems to provide care to patients with diverse values, beliefs, and behaviours by tailoring delivery to meet patients' social, cultural, and linguistic needs (Betancourt et al., 2002). Put differently, cultural competence in the delivery of health services refers to the capacity of the health system to link with and respond to the unique attributes and principles of the community, populace, or ethnic group, and to communicate with them in ways that build and sustain relationships across different opinions, cultures, and practices.

In public health generally, and health communication specifically, cultural competence has become increasingly significant due to the diversity of many urban and rural settings, as well as the persistence of inequality in fragile health systems (Schiavo, 2013). Scholars argue that cultural competence is not simply an ethical imperative but a determinant of effectiveness, shaping whether health messages resonate with communities or are resisted as culturally alien (Airhihenbuwa et al., 2020; Napier et al., 2014). In vaccine communication, cultural competence is particularly critical because decisions about uptake are rarely based on biomedical information alone; they are filtered through cultural frameworks, historical legacies, and relational trust.

By integrating Campinha-Bacote's model, this study moves beyond the cognitive emphasis of the Health Belief Model to foreground the relational and cultural dimensions of communication. Whereas the HBM explains perceptions of risk and benefit at the individual level, the Cultural Competency Model situates communication within broader social contexts, emphasising the need for responsiveness to cultural diversity and community values. This methodological shift is essential in Eswatini, where linguistic plurality, strong traditional health practices, and historical mistrust of biomedical authority shape the terrain of vaccine communication.

This is in keeping with recent consensus among public health and health communication organisations and experts that culture plays a considerable role in health behaviours and outcomes as well as in expanding the efficacy of health communication interventions (Schiavo, 2013, Kreps and Sparks, 2008, Dutta-Bergman, 2005, Kreuter and McClure, 2004). In this study, the cultural competence of the nurses in the three hospitals with reference to COVID-19 vaccination was explored. The aim was to understand how their experiences informed the nurses' own perceived role in communicating COVID-19 prevention with their patients and vaccines.

This is in keeping with recent consensus among public health and health communication organisations and experts that culture plays a considerable role in shaping health behaviours and outcomes, as well as in expanding the efficacy of health communication interventions (Schiavo, 2013; Kreps and Sparks, 2008; Dutta-Bergman, 2005; Kreuter and McClure, 2004). Increasingly, scholars and practitioners recognise that communication strategies which fail to account for cultural diversity risk reproducing exclusion and mistrust, particularly in fragile health systems. Cultural competence is therefore not simply an ethical aspiration but a practical determinant of effectiveness, influencing whether communities perceive health messages as credible, relevant, and actionable.

In the context of vaccine communication, cultural competence has been identified as a critical factor in building trust and countering hesitancy. Studies show that interventions which integrate cultural frameworks—such as engaging religious leaders, acknowledging traditional practices, or tailoring messages to linguistic diversity—are more likely to resonate with communities and promote uptake (Airhihenbuwa et al., 2020; Napier et al., 2014). This consensus underscores the need to move beyond purely biomedical framings of vaccine communication and to situate health messages within the lived realities of diverse populations.

In this study, the cultural competence of nurses in the three hospitals—Mbabane Government, Hlatikulu Government, and Raleigh Fitkin Memorial—was explored with reference to COVID-19 vaccination. The aim was to understand how their experiences informed their perceived role in communicating COVID-19 prevention with patients. Nurses occupy a dual position as both institutional representatives and community members, making them critical mediators of cultural competence in practice. By examining how nurses navigated cultural frameworks in their communicative labour, the study contributes to a more nuanced

understanding of vaccine communication in Eswatini, highlighting the relational and cultural dimensions that shaped trust, credibility, and uptake during the pandemic.

Conceptualising culture and its relevance in this study

In 2001, the United Nations Education, Scientific and Cultural Organisation (UNESCO) characterised culture as the collection of unique spiritual, material, intellectual, and emotional attributes that define a society or social group (UNESCO, 2001). This definition goes beyond art and literature to include lifestyles, social interactions, value systems, traditions, and beliefs. Similarly, in academic discourse, culture is typically defined as the shared beliefs, values, norms, customs, behaviors, and artifacts that characterise a group or society (Faulkner et al. 2006; Lewis, 2008). It encompasses both tangible and intangible elements including language, traditions, social institutions and collective knowledge (Lewis and Lewis, 2014). While there is no single definition of culture, it has been framed in diverse ways across various academic disciplines, each defining it to suit varied scholarly perspectives. Scholars across various disciplines – such as anthropology, sociology, and cultural studies – analyse culture as a dynamic construct that influences human interaction, identity formation, and societal development. In this way, culture is understood as both a product and process, shaped by historical context, social structures and individual agency (Patterson, 2014). This understanding of culture is adopted for this study.

Research suggests that culture has been understood either as a fixed attribute inherent to a particular group or as an evolving process (Kao et al., 2004). The static perspective of culture views it as an external, independent entity governed by its own laws, with individuals merely carrying and transmitting it rather than shaping it (Lu, 2023). Conversely, the dynamic perspective of culture argues that culture is not a fixed reality but rather an abstract, cognitive system shaped by shared symbols, meanings, and human creativity (Hsieh and Kramer, 2021). This tradition treats culture as a symbolic meaning system encompassing elements like myth, art, kinship, and language. Exploring these perspectives was imperative in the current study to aid an understanding of cultural influences on healthcare practices among the nurses selected for this study.If culture is viewed as a fixed trait, healthcare workers in Eswatini may adhere to deeply embedded traditions and values that shape patient interactions, treatment preferences, and health beliefs. Additionally, consideration of these perspectives allows for an exploration into the adaptability of healthcare delivery. If culture is understood as an evolving process, healthcare workers may continuously adjust their practices in response to changes in societal

norms, global health developments, and policy shifts. This perspective allows for exploring how external influences—such as modernisation, migration, or new healthcare technologies—shape medical practices and patient-provider relationships.

Moreover, the distinction between these two cultural frameworks has implications for how healthcare workers are trained and how policies are designed. This is because institutions, professional fields and organisations cultivate distinct cultures and micro cultures, characterised by specific modes of thinking and established practises (Napier et al., 2017). These cultural frameworks shape norms, values and behaviours within each domain, influencing decision making processes and interactions among members. However, it is concerning to observe that current nursing programmes often assume a one-size fits all approach, neglecting indigenous knowledge systems (Mhlongo, 2016). This approach can be problematic because it disregards the historical, social, and cultural experiences of indigenous communities, which differ significantly from the Western medical framework. In Eswatini, research suggests that nursing programmes emphasize transcultural to prepare students for diverse patient interactions, however, due to significant resource constraints, advanced cultural competency training can be limited (Al-Worafi, 2024).

A static view may lead to culturally rooted, tradition-focused training, while a dynamic view may emphasize ongoing professional development and responsiveness to emerging health challenges. Cultural assumptions influence how healthcare workers interact with patients, particularly in diverse settings (Betancourt, 2006; Matthews and Van Wyk, 2018; Shopo et al., 2023. Without a concerted effort to explore, critically engage and challenge both the explicit and implicit beliefs within organisational cultures, “counter-productive biases and behaviours can persist” (Napier et al., 2017 p1). Public health professionals increasingly acknowledge that disregarding the cultural dimensions of their practices can hinder their ability to refine operational approaches, develop effective innovations, and expand successful interventions. Therefore, recognising whether they operate within a more rigid cultural framework or a fluid, evolving approach can improve communication strategies, patient trust, and adherence to medical recommendations, particular in pandemic situations like that of COVID-19.

In this study, culture is understood as the broader set of shared beliefs, values, and traditions that shape social life (UNESCO, 2001), while indigenous knowledge systems refer more specifically to the cumulative body of practices and beliefs developed through long-term interaction with the local environment (Gaurav and Gaurav, 2025; Khupe, 2020). Thus,

indigenous knowledge systems are situated within culture, operationalising cultural worldviews into practical remedies and health practicesTo examine how healthcare workers at Raleigh Fitkin Memorial, Hlatikulu, and Mbabane Government Hospitals contributed to the expansion of COVID-19 prevention efforts, this study emphasised the need to assess their cultural competence in the delivery of healthcare. The analysis focused on their practices and patient interactions during the period from March to September 2021, ensuring a comprehensive understanding of their ability to integrate culturally responsive approaches in pandemic response.

Cultural competence in healthcare

For many years, educators and those in healthcare leadership have recognised that cultural and linguistic barriers between healthcare providers - such as doctors and nurses - and their patients can hinder the effective delivery of health services (Saha et al., 2008). In response, various programmes and curricula were developed under the frameworks of cross-cultural medicine, cultural sensitivity, transcultural nursing and multicultural counselling. These were initiatives that targeted immigrant populations with limited English proficiency and minimal exposure to Western cultural norms and practices (Tucker et al., 2013). To support these efforts, numerous frameworks and guidelines were proposed to help healthcare practitioners consider patients' cultural context and conduct cultural assessments (Matthews and Van Wyk, 2018, Saha et al., 2008). One notable example is the Purnell Model for Cultural Competence, introduced by Larry D. Purnell in the late 20th century. Although initially designed for nursing students, this model has since been widely adopted in healthcare settings to foster cultural awareness and sensitivity (Purnell, 2002; Black and Purnell, 2002; Gürsoy and Tanrıverdi, 2020; Woods Sr, 2024). It offers healthcare providers a systematic approach to understanding cultural differences and similarities across various domains such as communication, family roles, and healthcare practices, underscoring the importance of cultural awareness and sensitivity in delivering effective care.

Madeleine Leininger pioneered Leininger's Transcultural Nursing Theory in 1961, marking one of the earliest efforts to integrate cultural values and practices into nursing care (Leininger, 1997; Gonzalo, 2019). This theory emphasises the significance of culturally congruent care by advocating for the integration of patients' cultural values, beliefs and practices into nursing care, ultimately aiming to improve patient outcomes (Leininger, 2001; Lasmaida and Dedi, 2024). Other influential models of cultural competence in healthcare include Giger and Davidhizar's Transcultural Model and the Cultural Safety Model. The Giger and Davidhizar

Transcultural Model, introduced in 1988 by Joyce Newman Giger and Ruth Elaine Davidhizar, identifies six cultural phenomena- communication, space, social organisation, time, environmental control and biological variations - that shape healthcare delivery (Giger and Davidhizar, 2002). This model provides a framework for healthcare providers to assess and address cultural factors in patient care (Davidhizar and Giger, 2001; Astuti and Alzate, 2022; Arayathanitkul et al, 2024).

Conversely, the Cultural Safety Model, which originated in New Zealand in the late 1980s, was first introduced by Maori nursing student Hinerangi Mohi (Heckenberg, 2020). Predominantly applied in Indigenous healthcare contexts, this model emphasises fostering a respectful and safe environment for patients, free from discrimination and judgement. It highlights the importance of understanding power dynamics and addressing systematic inequalities in healthcare systems (Nolan-Isles et al, 2021; Espiner et al, 2021).

Evidently, cultural competence has evolved from its foundations in early models of cross-cultural healthcare. During the late 1980s through the 1990s, its scope expanded in three key ways. First, the range of populations benefitting from cross-cultural care broadened considerably. Second, the concept of cultural competence extended beyond culture to encompass social determinants of health. Finally, its focus shifted from interpersonal aspects of cross-cultural care to include health systems and communities (Saha et al., 2008). Schiavo (2013) highlights that while shared values and other cultural expressions are often associated with age, race, religion, gender, and geographical boundaries, distinct subgroups with unique cultural perspectives may emerge based on their understanding and engagement with specific health issues. This observation supports the integration of culture as a vital component of health communication (Dutta, 2008). Consequently, health communication cannot be divorced from cultural considerations if messages are to effectively influence the behaviours of targeted populations.

Importance of culture in health communication

This study is grounded in Social Change Communication (SCC); an approach that has evolved from Behaviour Change Communication (BCC) and Social and Behaviour Change Communication (SBCC). BCC, rooted in the dominant model of public health, traditionally utilised communication to persuade individuals to adopt healthier behaviours and lifestyles (Green et al., 2015). However, traditional health communication often struggles to drive long term behavioural change to several limitations. First, conventional health messaging typically

follows a top-down approach, where experts design messages and disseminate them to the public. This results in a one-way information flow. This method assumes that simply providing information will lead to behaviour change, overlooking individual motivations, cultural values, and lived experiences (Rimer and Kreuter, 2006; Shiavo, 2013; Laverack, 2017).

Second, traditional health campaigns often use standardised messaging that does not consider diverse cultural backgrounds or social realities (Dutta, 2007; Airhihenbuwa et al., 2020). Without local adaptation, messages may not resonate with target audiences, leading to low engagement (Gumede and Govender, 2024). Third, communication campaigns that are rooted in the behaviour change communication perspective focus on individual responsibility over structural barriers. Countless health campaigns, evident even during the COVID-19 pandemic, emphasize individual behaviour modification without acknowledging systemic issues such as economic constraints, healthcare access or social norms (Dutta, 2021; Govender, 2021). This approach can make people feel blamed for unhealthy behaviours rather than empowered to make sustainable changes. Fourth, traditional health communication often excludes community voices in designing interventions, leading to limited community involvement (Goggin and Ellis, 2021; Elers et al., 2024; Govender, 2025). Without active participation, people may be less likely to trust or engage with health messages (Dutta, 2021).

In contrast, SBCC recognises that social change communication is "influenced by the social sciences' focus on social determinants or enablers of change" (McKee et al., 2014 p.278). Accordingly, SBCC prioritises engaging communities and key stakeholders, advocating for the establishment of new policies and social norms, and addressing misinformation, which is essential in outbreak and pandemic preparedness and response (Health and Behaviour Change Network, 2021). Consequently, the evolution of Social Change Communication (SCC) from Social and Behaviour Change Communication (SBCC) reflects a shift from individual-focused interventions to structural and systemic approaches that address broader social determinants of health and development (Figueroa et al., 2003, Melkote, 2018; Servaes, 2022; Govender, 2024).

Social Change Communication (SCC) extends the scope of Social and Behavior Change Communication (SBCC) by shifting the focus from individual behavioral modification to systemic transformation, addressing structural inequalities, advocating for policy reforms, and fostering community-driven change. Central to SCC is the principle of community engagement, ensuring that marginalized voices play an active role in shaping health and

development strategies. This approach aligns closely with culture-centered communication frameworks, which emphasize community-led health narratives and structural interventions (Dutta, 2021).

The principles of SCC offer valuable insights for this study, particularly in examining Eswatini nurses' perceptions and experiences of the COVID-19 vaccine as well as the influence of their cultural competency on promoting COVID-19 prevention. Nurses in Eswatini function within social networks and cultural systems that influence their vaccine-related attitudes. SCC encourages an exploration of peer influence, collective narratives, and historical trust in healthcare systems, as these factors significantly shape vaccine acceptance or reluctance. Additionally, government policies, public health campaigns, and institutional mandates contribute to nurses' attitudes toward vaccination (Quan et al., 2012; Maltezou et al., 2019; Peters, 2022). SCC highlights the intersection between health governance and political discourse, emphasising their role in shaping trust in vaccines and public health communication strategies.

Moreover, economic constraints, such as vaccine accessibility, workplace incentives, and financial barriers, may affect nurses' willingness to receive the vaccine. SCC reframes a lack of enthusiasm for vaccination as not merely an individual decision but rather a consequence of systemic accessibility challenges and economic pressures. By integrating an SCC lens into this study, a more holistic understanding of how social, political, and economic structures influence healthcare professionals' engagement with vaccination efforts can be developed. This approach contributes to critical discourse surrounding effective vaccine communication strategies and health policy interventions in Eswatini. Therefore, due to the emphasis placed by SCC on structural, sociocultural, and economic factors that shape health attitudes and behaviours, it remains a relevant lens for examining vaccine uptake among healthcare workers.

In Eswatini, several cultural factors significantly influence healthcare delivery and outcomes (Dlamini et al., 2020). These include traditional beliefs and practices, language and communication, cultural norms related to health, and religious beliefs. Traditional healers and herbal remedies remain central to the healthcare practices of many individuals (Green and Makhubu, 1984; Mutasa, 20212; Schausberger, 2021). Integrating these practices into modern healthcare systems can foster trust and collaboration (Hoff and Maseko, 1986; Schausberger, 2021). Language and communication also play a critical role in the delivery of healthcare. Clear communication, particularly when explaining complex medical concepts, is essential to

avoid misunderstandings (Penn and Watermeyer, 2018). Moreover, cultural norms and religious beliefs heavily influence healthcare delivery and care. Cultural perceptions of illness, wellness and preventive measures shape how individuals approach healthcare services while religious influences can impact health seeking behaviours (Nyawo, 2025). This is particularly relevant for Eswatini where Christianity predominates, yet traditional spiritual beliefs continue to coexist and shape healthcare interactions.

This study utilises Camphinha Bacote's 2002 framework, The Process of Cultural Competence in the Delivery of Healthcare Services model, to examine how healthcare workers at the Raleigh Fitkin Memorial, Hlatikulu and Mbabane Government Hospitals practised cultural competency to enable and promote more effective COVID-19 prevention efforts in Eswatini. As indicated, numerous models offer diverse approaches to integrating cultural competence into health practices, ensuring that care is tailored to the unique needs of patients from various cultural backgrounds. However, the Campinha-Bacote Model of Cultural Competence is particularly well-suited for this study for several reasons. First, it conceptualises cultural competence as a dynamic and ongoing process rather than a finite state (Campinha-Bacote, 2002). This perspective aligns with the study's objective of exploring the evolving perceptions and practices of healthcare workers, particularly in the context of a rapidly changing pandemic such as COVID-19. Second, the model offers a comprehensive framework through its five interconnected constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire (Campinha-Bacote, 2002). This holistic approach is ideal for examining how local nurses' cultural competencies and lived experiences influenced their communication about COVID-19 prevention and vaccination.

Third, the model emphasises practical engagement through cultural encounters, which encourages healthcare providers to interact actively with individuals from diverse cultural backgrounds (Okere, 2022; Tran, 2024). This focus is highly relevant to the study as it addresses the ways nurses in Eswatini navigated interactions with patients of varying cultural contexts, particularly in disseminating vaccine-related information. Fourth, the model integrates both individual and systematic factors, acknowledging the role of personal competencies and the broader healthcare system's adaptability (Campinha-Bacote, 2002). This dual perspective was crucial for understanding nurses' roles within the specific settings of Eswatini's hospitals. Lastly, the model's flexibility makes it particularly applicable in under-researched contexts, such as the Kingdom of Eswatini. It facilitated an in-depth exploration of cultural and contextual influences on healthcare delivery, offering valuable insights into

vaccine communication and uptake among nurses in the study. Therefore, by applying the Campinha-Bacote model, this research provides a structured yet adaptable framework for understanding the interplay between cultural competence and healthcare communication, particularly in the context of COVID-19.

History and development of the Process of Cultural Competence in the Delivery of Healthcare Services Model

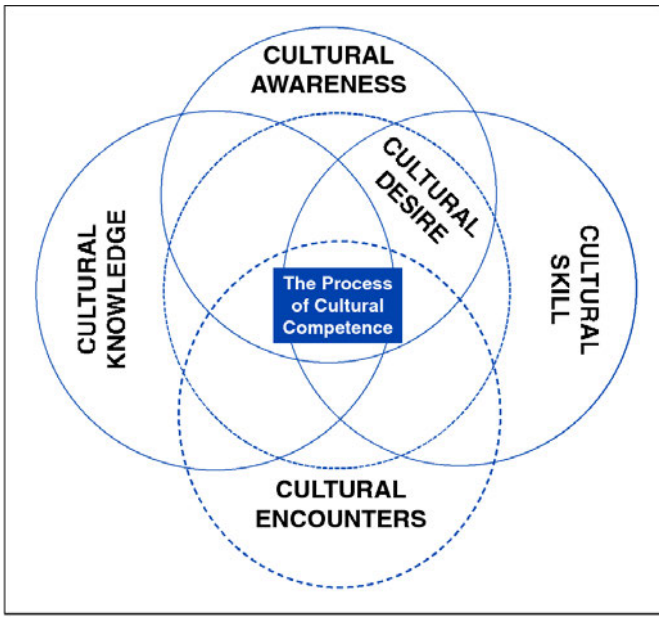
The development of the Campinha-Bacote model, The Process of Cultural Competence in the Delivery of Healthcare Services, began in 1969 when its proponent was pursuing her undergraduate nursing degree in Connecticut, United States of America (Campinha-Bacote, 2002). Her exploration of the field of multicultural counselling combined with her experience as a psychiatric nurse, led to the creation of the model. It integrates principles from transcultural nursing, medical anthropology, and multicultural counselling (Campinha-Bacote, 2002). This study employs the model to achieve two objectives: to assess the cultural competence of participants and to examine how cultural competence influenced provider-patient communication among nursing professionals in three hospitals in Eswatini.

First introduced in 1998, the 2002 version builds on the original framework by reinforcing the idea that cultural competence is a continuous process rather than a fixed achievement. The Campinha-Bacote model consists of five constructs designed to help professionals ensure cultural competence when providing care (Campinha-Bacote, 2002). In this study, the model is used in conjunction with the Health Belief Model (HBM). While the HBM assesses how nurses at the Raleigh Fitkin Memorial, Mbabane Government and Hlatikulu Government Hospitals perceived their risk and susceptibility to COVID-19, and how these perceptions influenced their decisions to either get vaccinated or abstain, the Campinha-Bacote model evaluates how their cultural competence shaped the way they acquired and shared COVID-19 vaccine-related information with their patients

The Process of Cultural Competence in the Delivery of Healthcare Services model

The Campinha-Bacote model, the Process of Cultural Competence in the Delivery of Healthcare Services model, provides a theoretical framework for understanding and assessing cultural competence in healthcare contexts. This study adopts the Campinha-Bacote model to evaluate the cultural competence of nursing professionals in the selected hospitals. By employing this framework, the study aims to assess participants' cultural awareness, knowledge, skill, encounters, and desire –constructs central to the model – and to explore the influence of cultural competence on communication between healthcare providers and patients.

Figure 3:2 a visual representation of the five key constructs of the Process of Cultural Competence in the Delivery of Healthcare Services model. Source: Campinha-Bacote (2009).



The Process of Cultural Competence in the Delivery of Healthcare Services model is particularly suited to the aims of this research. The model comprises five key constructs, described as follows:

a) Cultural awareness: This involves recognising one's own biases, prejudices, and assumptions about individuals who differ from oneself. A lack of awareness regarding the influence of personal cultural or professional values may lead healthcare workers (HCW's) to impose their own cultural norms on others.

b) Cultural knowledge: This refers to the process of acquiring information about diverse cultures

c) Cultural skill: This entails the ability to perform culturally appropriate assessments of a patient's cultural data;

d) Cultural encounters: These are the personal interactions and experiences with patients from diverse cultural backgrounds; and

e) Cultural desire: This reflects a genuine motivation to become culturally competent (Wall-Bassett et al., 2018).

In delivering culturally competent healthcare, it is essential to consider various risk factors, including comorbidities, ethnicity, age and access to local facilities (Hanif et al., 2020). Furthermore, individuals with legitimate concerns about vaccination "should not be dismissed as an 'anti-vaxxer', but heard and responded to respectfully," (ibid, p.1). Doubts about vaccines and vaccinations must be understood in context. Thus, the model emphasises cultural competence as an ongoing process in which the healthcare providers continually strive to effectively operate within the cultural contexts of their clients, including individuals, families, and communities (Campinha-Bacote, 2002).

Later iterations of the model merged the concepts of cultural competence with cultural humility. The model is coined the 'cultural competemility', a combination of competence and humility- which is described as, a biblical model that "adds biblical components, such as humility, compassion, social justice, Imago Dei (image of God), and teachableness in defining the process of cultural competence" (Campinha-Bacote, 2019 p.3). This later model defines cultural competence as a process characterised by the interconnected relationship among the six constructs. It additionally incorporates:

> "…specific intellectual and moral virtues: love, caring, social justice, humility, love of truth, teachableness, intellectual honesty, wisdom, discernment, prudence, attentiveness, studiousness, practical wisdom, understanding, temperance, patience, and compassion into these six constructs" (Campinha-Bacote, 2019 p.3).

According to Campinha- Bacote (2019), this shift towards 'cultural competemility' reflects a shift towards a more holistic and reflective approach to understanding and addressing cultural diversity in healthcare. By incorporating virtues and humility, this later model moves beyond a traditional focus on cultural knowledge and skills to advocate for deeper awareness and respect for others. However, for purposes of this research, the 2002 model will be employed in this study.

Application of The Process of Cultural Competence in the Delivery of Healthcare Services model in other studies

The Campinha-Bacote framework has been widely utilised across academic, educational, and professional healthcare contexts to assess and enhance cultural competence. One notable area of application has been interdisciplinary, international service-learning programmes, where the model has been employed to examine the impact of experiential learning on students' cultural awareness and competence (Wall-Bassett, 2018; Huye, 2023). By applying the model's

constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire, to reflective journals and qualitative assessments, these studies demonstrated that the framework is effective in enhancing students' sensitivity to cultural diversity and their ability to engage meaningfully with communities in global health contexts. This underscores the model's utility in bridging theoretical learning with practical, relational experiences.

The framework has also been applied extensively in nursing education, where cultural competence is recognised as a critical skill for professional practice. Studies in South Africa, New Zealand, and the United States have employed the Campinha-Bacote model to evaluate the outcomes of educational interventions aimed at improving nursing students' cultural competence (Mhlongo, 2016; Otuata, 2019; Nourse, 2022; Coakley, 2024). These interventions often included structured curricula, workshops, and clinical placements designed to expose students to diverse patient populations. Findings consistently indicated significant enhancements in participants' cultural knowledge, sensitivity, and skills, thereby underscoring the model's applicability to academic healthcare settings. Importantly, these studies highlight that cultural competence is not static but a process of continual learning and reflection, aligning with Campinha-Bacote's emphasis on cultural desire as a driving force for professional growth.

Beyond education, the Process of Cultural Competence in the Delivery of Healthcare Services model has been compared with other cultural competence frameworks in transcultural nursing to assess its effectiveness in promoting culturally congruent care (Albougami, 2016; Botelho and Lima, 2020; Tosun et al., 2021). Comparative analyses have examined the model alongside frameworks such as Leininger's Culture Care Theory and Purnell's Model for Cultural Competence, with findings emphasising the Campinha-Bacote model's strength in operationalising cultural competence as an ongoing process rather than a fixed outcome. These studies suggest that the model is particularly effective in helping healthcare providers adapt to diverse patient populations, implement culturally informed care practices, and address disparities in health outcomes.

Applications of the model have also extended to clinical practice and organisational contexts. For example, it has been used to evaluate hospital policies on cultural competence, assess the preparedness of healthcare teams to serve multicultural communities, and guide professional development programmes aimed at reducing health disparities (Albougami, 2016; Botelho and Lima, 2020). In these settings, the model has provided a structured framework for identifying

gaps in cultural responsiveness and for designing interventions that foster inclusivity and patient-centred care.

Together, these applications illustrate the model's adaptability and efficacy in fostering cultural competence across various academic and professional domains. Whether in student education, comparative theoretical analysis, or clinical practice, the Campinha-Bacote framework has proven to be a robust tool for advancing culturally congruent care. Its emphasis on cultural encounters and cultural desire situates competence as a dynamic, relational process, making it particularly relevant for contexts such as vaccine communication in Eswatini, where nurses must navigate pluralistic health systems and diverse cultural frameworks.

Application of The Process of Cultural Competence in the Delivery of Healthcare Services model in this study

The application of The Process of Cultural Competence in the Delivery of Healthcare Services model in this research differs from the way the model has been employed in previous studies primarily in terms of focus, context and objectives.

In other studies, the model has often been applied to evaluate the cultural competence of students or healthcare providers in general, often emphasising educational interventions or interdisciplinary learning. However, this research uniquely focuses on the cultural competence of nursing professionals in Eswatini and directly examines its influence on provider-patient communication within a specific context: the COVID-19 pandemic and vaccine-related information sharing. This study applied all five elements of the Process of Cultural Competence in the Delivery of Healthcare Services Model. Cultural awareness was reflected in healthcare workers' recognition of their own biases; cultural knowledge in their understanding of patients' traditional beliefs; cultural skill in their ability to adapt communication; cultural encounters in their direct engagements with diverse patients; and cultural desire in their expressed commitment to respectful, empathetic care. Together, these elements provided a comprehensive lens for analysing vaccine perceptions in Eswatini's hospital contexts. Additionally, many prior applications of the model are situated in general healthcare or academic settings, often addressing a broad spectrum of cultural competence without a specific crisis or public health issue as a backdrop; in contrast, this study situates the model with the specific context of the COVID-19 pandemic, a critical global health crisis, adding a unique layer of relevance and urgency to the research.

While other studies often employ the Campinha-Bacote model in isolation, this study integrates it with the Health Belief Model (HBM). This dual framework approach allows not only the investigation of cultural competence, but also risk perception, susceptibility, and decision-making regarding vaccination among nurses, offering a comprehensive perspective. Finally, studies using this model are often conducted in global North contexts, such as the United States, focusing on multicultural care in diverse but developed healthcare systems. This research, however, is grounded in Eswatini, offering insights into cultural competence within a sub-Saharan African setting. This geographic and cultural specificity adds to the body of knowledge by highlighting how the model applies in different socio-cultural and healthcare environments.

These distinctions make this study both contextually unique and academically significant, particularly in its contributions to understanding cultural competence in under-represented global contexts.

Limitations of The Process of Cultural Competence in the Delivery Of Healthcare Services Model

Like any other framework in research and practice, the Process of Cultural Competence in the Delivery of Healthcare Services model is by no means perfect, and several limitations have been noted. A central critique, articulated by Beagan (2018), argues that cultural competence models tend to oversimplify culture. According to Beagan;

> "Culture is reduced to race and ethnicity, ignoring other identities and framing race and ethnicity as residing only in the 'Other,' leaving dominant cultures unproblematised*"* (2018, p.123).

This observation highlights a reductionist tendency within cultural competence frameworks, where culture is narrowly defined in terms of racial and ethnic difference, while other identity dimensions such as gender, socio-economic status, sexual orientation, religion, and disability are overlooked (Beagan, 2018; Botelho and Lima, 2020). Such a narrow interpretation risks neglecting the complexity and multidimensional nature of cultural identities, which are shaped by intersecting social, structural, and individual factors.

By limiting the scope of culture to race and ethnicity, the model fails to capture the intricate ways in which diverse identities influence lived experiences and healthcare interactions. This can be problematic in practice, as it may inadvertently reinforce stereotypes or marginalise individuals whose identities fall outside the narrowly defined parameters of race and ethnicity.

In healthcare settings, this incomplete understanding undermines the goal of providing equitable and inclusive care that addresses the needs of diverse populations (Campinha-Bacote, 2002; Rober and De Haene, 2014). To mitigate these concerns, scholars have argued for an intersectional approach to cultural competence, one that recognises the dynamic interplay of multiple identity dimensions and situates health behaviours within broader social contexts (Crenshaw, 1991; Napier et al., 2014). Such an approach ensures a more nuanced and holistic understanding of individuals and their experiences, thereby enhancing the inclusivity and effectiveness of healthcare practices.

The current study transcends this limitation by situating cultural competence within the Eswatini context, where race and ethnicity between healthcare workers and patients are not salient issues due to the relative homogeneity of the population. Instead, the study explores cultural competence beyond this narrow framing, focusing on how nurses navigated cultural frameworks shaped by linguistic diversity, traditional health practices, and historical legacies of mistrust. This allows for a broader interpretation of culture that incorporates social and institutional dynamics, rather than reducing it to ethnicity alone.

Another limitation of cultural competence models is their emphasis on individual competence. While the Campinha-Bacote framework positions cultural competence as a process of continual learning and reflection, research highlights that systemic issues such as institutional biases, resource constraints, and organisational cultures often hinder effective implementation. For example, a study evaluating the effectiveness of an educational intervention based on the Campinha-Bacote model among nursing students in Iran demonstrated that while the intervention improved cultural competence, challenges were noted in applying the model across diverse clinical settings, emphasising the need for tailored approaches (Nearagh, 2025). Similarly, Gardner and Almutairi (2014) explored the application of the model in a multicultural nursing workforce in Saudi Arabia. Their findings revealed limitations in adapting the framework to non-Western contexts, suggesting that organisational support and structural change are necessary to address cultural diversity challenges. These examples underscore that cultural competence cannot be achieved solely through individual effort; it requires systemic commitment and institutional investment.

In practice, the demand for healthcare providers to actively engage in cultural encounters while continuously developing their skills may not always be feasible in busy healthcare settings. High patient loads, limited staffing, and resource constraints can restrict opportunities for

meaningful cultural engagement, thereby limiting the model's applicability. This points to the need for integrating cultural competence into organisational policies and practices, ensuring that healthcare systems provide the structural support necessary for providers to deliver culturally responsive care.

Altogether, these critiques highlight both the strengths and limitations of the Campinha-Bacote model. While it offers a valuable framework for conceptualising cultural competence as a dynamic and ongoing process, its reductionist tendencies and emphasis on individual competence risk overlooking the broader social, structural, and institutional dimensions of healthcare. By acknowledging these limitations, the current study positions itself to extend the model's applicability, situating cultural competence within the lived realities of nurses in Eswatini and foregrounding the intersection of culture, trust, and communication in vaccine engagement.

Conclusion

Biomedical interventions remain indispensable in public health emergencies, yet their impact is limited when cultural perceptions and contextual realities are neglected. The COVID-19 pandemic underscored how strategies centred on individual responsibility often fail to address broader social determinants of health. This study therefore adopted a Social Change Communication (SCC) framework, which advances beyond Behaviour Change Communication (BCC) and Social and Behaviour Change Communication (SBCC) by foregrounding equity and systemic influences. SCC provides a critical lens for understanding how social networks, cultural systems, and collective narratives shape vaccine acceptance among nurses in Eswatini, while also drawing attention to the role of governance, policy, and public trust in health communication.

The integration of the Health Belief Model (HBM) and the Process of Cultural Competence in the Delivery of Healthcare Services model strengthened this analysis. The HBM remains a foundational framework for examining preventive behaviours, highlighting perceptions of susceptibility, severity, benefits, barriers, and self-efficacy. Its application to nurses' experiences during the pandemic illuminated risk perceptions and vaccination decisions, though its cognitive focus requires supplementation. The Campinha-Bacote model addressed this need by emphasising cultural awareness, knowledge, skill, encounters, and desire, situating health communication within dynamic sociocultural contexts. While critiques note its tendency

to simplify culture and its challenges in non-Western settings, its emphasis on responsiveness and adaptability remains essential for fostering trust and effective communication.

Together, these frameworks demonstrate the necessity of culturally informed health strategies that move beyond standardized biomedical messaging. In Eswatini, where healthcare workers' perspectives on vaccination are underexplored, embedding cultural competence into public health practice is vital. This study shows that culturally responsive communication enhances trust, strengthens engagement, and improves adherence to preventive measures. Recognizing culture as dynamic and multidimensional ensures that interventions align with diverse values, beliefs, and linguistic needs, while institutional cultures and professional training must adapt to incorporate indigenous knowledge systems and inclusive methodologies.

Ultimately, this conceptual framework advances a comprehensive approach to vaccine uptake among nurses in Eswatini by combining psychological insights from the HBM with the sociocultural orientation of the Campinha-Bacote model. It contributes to the wider discourse on culturally responsive healthcare in sub-Saharan Africa, reinforcing the imperative that public health interventions engage with both individual perceptions and collective cultural contexts. In doing so, it strengthens pandemic preparedness and healthcare delivery through strategies that are scientifically rigorous and socially resonant

CHAPTER FOUR

METHODOLOGY

Introduction

This chapter outlines the research methodology employed to examine healthcare workers' perceptions and experiences regarding the COVID-19 vaccine in Eswatini, as well as how these perceptions and experiences influenced their patient communication. Healthcare workers, in the context of this study, refer to nurses employed in the hospitals selected for this study. Given the inherently subjective and socially constructed nature of health beliefs and communication practices, a qualitative approach was selected to provide in-depth insights into these dynamics.

The Health Belief Model (HBM) serves as a theoretical lens for understanding how healthcare workers' perceptions of vaccine-related risks, benefits, and barriers may have impacted their acceptance of the vaccine and their subsequent prevention communication with patients. The model's constructs –including perceived susceptibility, perceived severity and cues to action – offer valuable insights into the decision-making processes of healthcare professionals. Additionally, the study integrates Campinha-Bacote's (2002) Process of Cultural Competency in the Delivery of Healthcare Services Model to explore how nurses navigated patient interactions in a culturally responsive manner. Given the diverse health beliefs and concerns surrounding vaccination, this model helped to frame how healthcare providers developed cultural awareness, knowledge, skills and encounters to ensure meaningful and effective vaccine-related communication with patients.

This study is situated within the field of health communication, a discipline concerned with how health-related information is constructed, transmitted, received, and interpreted across diverse cultural and institutional contexts. It adopts an integrated interpretivist–constructivist paradigm to explore how health care workers in Eswatini perceive and experience COVID-19 vaccines. This paradigm is epistemologically grounded in the belief that reality is socially constructed, shaped by cultural narratives, and subjectively interpreted through lived experience (Lincoln and Guba, 1985; Creswell, 2013). The study further draws on critical theory to examine the influence of systemic power structures and historical legacies—including colonial medicine, global health governance, and national vaccination policies—on individual and collective meaning-making (Kincheloe and McLaren, 2002; Carspecken, 1996). The combined paradigmatic framing allows for a multi-layered analysis that not only captures personal experience but also interrogates the institutional and discursive forces that reproduce

inequity and shape vaccine perceptions. Framing this study in this manner serves to acknowledge that healthcare workers' perspectives on vaccination are shaped by individual experiences, socio-cultural contexts, and institutional influences.

Additionally, this chapter outlines the process of data collection and the methodologies employed for organising and analysing the data. A qualitative research approach is introduced, incorporating focus group discussions as the primary data collection method and semi-structured interviews as a complimentary method. The sampling strategy is specified and the rationale for selecting a phenomenological research design is provided, demonstrating its suitability for the investigation. Additionally, the researcher's positionality within various research processes is articulated to ensure methodological rigour. The chapter concludes with a discussion of ethical considerations relevant to the study and measures taken to uphold ethical standards throughout the research. Table 4.1 below shows a summary of the methodology.

Table 2 a summary of the research methodology

Summary of the Methodology	
Research Paradigms	Interpretivist-Constructivist Paradigm with elements of Critical Theory
Research Approach	Qualitative
Research Design	Phenomenology
Methods of Data Collection	Focus Group Discussions and Semi-Structured Interviews
Selection of Participants	Purposive Sampling
Data Analysis	Interpretative Phenomenological Analysis

Unlike the preceding chapters, some parts of this chapter are intentionally written in the first person. Adopting the pronoun "I" emphasises my agency as a researcher and acknowledges my positionality, biases, and influence on the research process (Bagheri and Deng, 2019). It reinforces my role as an embodied, situated researcher and supports the interpretivist–constructivist lens I have adopted.

Research paradigms in this study

This study is situated within an integrated interpretivist–constructivist research paradigm, reflecting ontological and epistemological orientations that underpin qualitative inquiry in health communication. Within this domain, such a paradigm facilitates nuanced exploration of how individuals engage with health messages, interpret risk, and construct meaning from their lived experiences. It underscores the premise that reality is socially constructed and contextually situated, and that individuals both shape and are shaped by their socio-cultural environments (Lincoln and Guba, 1985; Creswell, 2013).

Qualitative research is shaped by diverse paradigms that influence inquiry design, data analysis, and knowledge construction. This study acknowledges the foundational contributions of scholars who identify key paradigms—including positivism, post-positivism, constructivism, critical theory, interpretivism, and pragmatism—each defined by distinct ontological and epistemological assumptions (Guba and Lincoln, 1994; Creswell, 2013; Neumann, 2014). These paradigms underscore the significance of subjectivity, multiplicity of realities, and the interpretive nature of qualitative inquiry (Denzin and Lincoln, 2018). Blaikie (2007) further categorises paradigms as realist, constructionist, or subjectivist orientations, while pragmatic perspectives advocate methodological fluidity guided by research aims (Tashakkori and Teddlie, 1998). The present study situates itself within this philosophical landscape, drawing on selected paradigms to support its methodological and analytical choices.

The interpretivist dimension seeks to uncover how healthcare workers understood and navigated their experiences of the COVID-19 vaccine within the social systems they inhabited (Gichuru, 2017; Schwandt, 1994). Complementing this, the constructivist lens highlights the dialogical and relational nature of meaning-making, where knowledge emerges through engagement and shared narratives (Adom, 2016; Riegler, 2011). Building on this foundation, scholars such as Van der Walt (2020) and Tanlaka and Aryal (2025) advocate for an integrated interpretivist–constructivist stance that not only captures individual perceptions, but also situates them within broader socio-cultural environments. This dual lens provides an avenue for understanding how health care workers both shape and are shaped by institutional policies, cultural beliefs, and historical legacies—an essential perspective for analyzing vaccine-related attitudes and experiences in Eswatini.

In applying this paradigm to the study of COVID-19 vaccine perceptions among healthcare workers in Eswatini, I adopt a phenomenological approach that privileges subjective narratives

as central to understanding communicative behaviour in health contexts. This orientation is consistent with health communication research that attends to the interaction between personal experience and broader health systems, media narratives, and policy frameworks.

Recognising that vaccine-related perceptions are embedded within structural realities, the study also draws on elements of critical theory to interrogate how global health agendas, historical legacies, and institutional power structures influence the reception and negotiation of health information. This dual paradigm—interpretivist–constructivist and critical—is increasingly acknowledged in health communication scholarship as essential for addressing equity, voice, and representation in health discourses (Kincheloe and McLaren, 2002; Carspecken, 1996).

Furthermore, this paradigmatic positioning aligns with literature that conceptualises health communication not merely as the transmission of information but as a dialogic, culturally contingent process involving meaning-making, trust, and socio-political engagement (Dutta, 2008; Lupton, 1994). By integrating interpretive depth with structural critique, the study contributes to a multi-layered understanding of vaccine narratives, revealing how personal meaning intersects with institutional mandates and global communication mandates.

By weaving together these theoretical strands, the study foregrounds the complex interplay between personal meaning and structural context, ensuring that both subjective experience and embedded social realities are brought into analytical focus.

Ontological stance

Ontology refers to the nature of reality and what is considered to exist within a given paradigm (Kincheloe and Mclaren, 2011). This study is grounded in an interpretivist–constructivist ontology, which posits that reality is socially constructed, multiple, and contextually situated. From this perspective, reality does not exist independently of human perception; rather, it is continuously shaped through individuals' interactions, cultural norms, and lived experiences (Lincoln and Guba, 1985; Creswell, 2013). In contrast to positivist ontology; which assumes a singular, objective reality, this stance recognises that individuals interpret and experience the world in diverse ways, informed by their social environments and historical positioning.

Within the context of health communication, this ontological orientation supports the view that healthcare workers' perceptions of the COVID-19 vaccine are not fixed or universal, but rather emergent and relational, shaped by institutional narratives, community discourses, and personal histories. The interpretivist stance emphasizes the contextual nature of –meaning-making, recognizing that individuals engage with their environment through shared cultural and social

lenses (Van der Walt, 2020; Pervin and Mokhtar, 2022). In parallel, the constructivist perspective underscores the active role that individuals play in shaping their understanding of the world through personal experiences and interactions (Ubbes and Ausherman, 2022; Matteucci, 2015; Riegler, 2011; Schwandt, 1994).

To deepen this ontological foundation, I incorporated elements of critical theory, which challenge the notion of neutral or apolitical reality. Critical ontology asserts that social reality is also shaped by power relations, structural inequities, and historical legacies (Kincheloe and McLaren, 2002; Carspecken, 1996). In this view, reality is not only constructed through interaction but also mediated by dominant ideologies and institutional structures that influence how individuals perceive themselves and their roles within society.

By integrating these ontological positions, my study acknowledges that healthcare workers' vaccine experiences are shaped by both personal meaning-making and systemic forces. This dual stance allows for a richer, more nuanced understanding of reality—one that is subjective, dynamic, and embedded within broader socio-political contexts.

Epistemological assumptions

Epistemology refers to the nature and construction of knowledge (Greco, 2017; Cresswell, 2013). In this study, I adopted an integrated interpretivist–constructivist epistemological orientation, which recognises that knowledge is inherently subjective and co-constructed through social interaction, cultural context, and reflective engagement. The integrated interpretivist–constructivist research paradigm underscores the belief that reality is socially constructed and context-dependent, and that individuals both shape and are shaped by the socio-cultural environments in which they operate (Lincoln and Guba, 1985; Creswell, 2013). From this standpoint, I believe that reality is not discovered through detached observation but is shaped and reshaped through meaning-making processes that are dialogic, relational, and deeply embedded in the lived experiences of individuals (Lincoln and Guba, 1985; Creswell, 2013).

Within the realm of health communication, this epistemological stance supports the view that vaccine-related perceptions are formed not in isolation but through ongoing exchanges with peers, institutional narratives, cultural beliefs, and socio-political discourses. Interpretivism emphasizes understanding how individuals make sense of their experiences within specific social contexts (Schwandt, 1994), while constructivism stresses that such understanding emerges through iterative processes of interaction and reflection (Adom, 2016; Riegler, 2011).

In health communication, interpretation is never neutral; it is embedded in social interaction, shaped by historical experiences, and influenced by dominant health discourses (Zoller and Kline, 2008). To this end, I embraced a multi-layered hermeneutic approach to reflect the complexity of meaning-making in my engagement with research participants. First-order hermeneutics refers to how participants interpreted their own experiences—framing beliefs, motivations, and attitudes through personal and culturally informed lenses (Schneider and Sting, 2020). Second-order hermeneutics involved my interpretation of participants' narratives. It emphasizes a relational process in which knowledge is co-constructed through attentive listening, thematic analysis, and contextual understanding (Schwandt, 1994; Lincoln and Guba, 1985). Third-order or critical hermeneutics draws from critical theory to interrogate how participants' experiences and expressions are conditioned by broader socio-political structures, such as colonial legacies, professional hierarchies, and global health policies (Kincheloe and McLaren, 2002; Carspecken, 1996).

These layers were activated through this study's focus group discussions and semi-structured interviews, which allowed participants not only to reflect individually, but also to co-construct meaning with peers. The dialogic nature of focus groups revealed how shared narratives evolved, contested assumptions surfaced, and collective interpretations were shaped through interaction (Denzin and Ryan, 2007). Semi-structured interviews, on the other hand, facilitated deeper personal reflection; capturing individual interpretive nuance that complements the group discourse (Ennis and Chen, 2012).

By weaving together these hermeneutic levels, my study offers a contextually grounded and critically engaged analysis of how health care workers understood and communicated their COVID-19 vaccine experiences. This interpretive process acknowledges that meaning is emergent, layered, and shaped by institutional memory, social influence, and discursive tension. Together, these perspectives frame the researcher–participant relationship as one of active co-participation in knowledge production, acknowledging the influence of both parties' values, backgrounds, and positionalities (Tomaselli, Dyll-Myklebust and van Grootheest, 2016).

Critical theorists argue that dominant narratives often obscure or reproduce systemic inequities, and that research must be oriented toward exposing and confronting these underlying structures (Kincheloe and McLaren, 2002; Carspecken, 1996). In the context of COVID-19 vaccination in Eswatini, this entails examining how historical legacies such as colonial medical mistrust,

global power imbalances in health policy, and professional hierarchies inform—and sometimes constrain—healthcare workers' agency and interpretive autonomy. Thus, the epistemology guiding this research is not only interpretive and relational but also critical and emancipatory. It seeks to uncover both individual meaning and collective silencing, providing space for voices that may be marginalised within dominant health discourse. By doing so, the study aligns with an ethical commitment to reflexivity, equity, and transformative understanding in health communication research.

Research approach: qualitative

I adopt a qualitative research approach to explore the nuanced experiences and perspectives regarding the COVID-19 vaccine in three hospitals in Eswatini. I preferred qualitative research for this study because it I inherently interpretive, aiming to understand phenomena through the meanings that individuals assign to them (Denzin and Lincoln, 2011). While some methodological critiques may highlight the limited generalizability of qualitative findings as a potential weakness, this concern reflects a misalignment with the epistemological foundations of qualitative inquiry (Carminati, 2018; Lueng, 2015; Schofield, 2000). As Tracy (2013) argues, qualitative research should not be evaluated using the same criteria as quantitative paradigms, such as generalizability, objectivity or reproduction of bias. These standards are rooted in positivist traditions that prioritise statistical replication and universal, goals which are fundamentally at odds with the interpretive and context-sensitive nature of qualitative work.

Instead, qualitative research seeks transferability rather than generalizability, aiming to provide rich, situated insights that resonate with readers and allow them to determine relevance to other contexts (Tracy, 2013). This means that the emphasis is on depth, nuance and the co-construction of meaning, rather than on producing findings that are universally applicable. Therefore in this study, I have made methodological choices that reflect these principles by privileging the lived experiences of healthcare workers, specifically nurses, within specific contextual setting in Eswatini, rather than attempting to generalize across all healthcare contexts.

Research design: Phenomenology

I adopt a qualitative phenomenological design to understand the perceptions and experiences regarding the COVID-19 vaccines among health care workers in three hospitals in Eswatini. Phenomenology is the "study of human experience and the ways things present themselves to

us and through such experience" (Sokolowski, 2000, p.2). Smith (2000) defines phenomenology as the study of structures of consciousness as experienced from the first-person point of view. Consequently, phenomenology seeks to study the lived human experiences and the way things are perceived and appear to the consciousness (Smith, Flower and Larkin, 2009; Tuffour, 2017). In other words, phenomenology holds that humans observe and experience events and situations, which is the lived experienced, as they exist in the social world (Eberle, 2014). Every individual develops consciousness through lived experiences, constructing their reality based on personal perceptions and interactions within the social world. Consequently, there is no single, universal reality.

Healthcare workers (HCWs) were disproportionately affected by the COVID-19 pandemic and, as a result, they were designated a high-priority group for vaccination by the Government of Eswatini, aligning with global health initiatives. Vaccines have demonstrated high efficacy in clinical trials, leading to their approval for clinical use (Baden, 2021; Polack, 2020). However, despite the proven effectives of vaccines in general; and against a background of serious mistrust of the COVID -19 vaccines in particular, vaccine uptake among HCWs varied (George et al., 2023). This contrast between clinical success and real-world acceptance underscores the importance of understanding contextual and behavourial dynamics within healthcare settings. Despite this, the perceptions and experiences of HCWs regarding the COVID-19 vaccine within healthcare settings in Eswatini remain unexplored.

Phenomenology is both a philosophical tradition and a qualitative research methodology, each serving distinct purposes within academic inquiry (Williams, 2021; Gill, 2020). As a philosophy, it seeks to analyze the structures of consciousness and experience, whereas as a research approach, it provides a framework for exploring human lived experiences within empirical studies (Van Manen, 2017). Before discussing phenomenology's value as a research approach for this study, it is necessary to explain the differences phenomenology as a philosophy and phenomenology as a research approach.

Phenomenology as a Philosophy

The philosophical foundations of phenomenology were established by Edmund Husserl (1913), who argued that knowledge should focus on human experience as directly encountered. He introduced the concept of epoché, or bracketing, which involves suspending preconceived beliefs to examine phenomena as they present themselves. Husserl's work laid the groundwork

for transcendental phenomenology, emphasising pure subjective consciousness as the basis for knowledge (Moran, 2000).

Following Husserl, Martin Heidegger (1927) expanded phenomenology into the realm of existential inquiry, emphasising the lived experience of individuals within their socio-historical contexts. His concept of Dasein, or "being-in-the-world," shifted the focus from purely descriptive analysis to interpretive inquiry, laying the foundation for hermeneutic phenomenology (van Manen, 1990).

Other influential thinkers in phenomenology include Maurice Merleau-Ponty (1945), who examined embodiment and perception, and Jean-Paul Sartre (1943), who explored human freedom and consciousness within existential phenomenology. Merleau-Ponty's emphasis on embodied perception (1945) enriches this study's attention to the contextual dimensions of healthcare workers' experiences while Sartre's existential focus on freedom and meaning making (1943) complements the interpretivist phenomenological analysis adopted in this study by highlighting how participants construct and navigate their realities. Together, their insights inform both the individual and collective narratives explored through focus group discussions and interviews.

Phenomenology as a Research Design

In qualitative research, phenomenology serves as an empirical methodology for studying the lived experiences of individuals (Eberle, 2014). It is particularly prevalent in disciplines such as psychology, education, healthcare, and sociology, where researchers seek first-person accounts of subjective phenomena. In this research, phenomenology as a research approach is preferred for its ability to aid a deep, nuanced understanding of healthcare workers' perceptions and experiences of the COVID-19 vaccine in Eswatini. Phenomenology is uniquely suited for exploring subjective experiences, making it ideal for capturing the complexities of vaccine acceptance, uncertainty, and decision-making among professionals in the healthcare sector (Neubauer, Witkop and Varpio, 2019). Thus, I adopted a phenomenological approach within qualitative research to examine healthcare workers' perceptions and experiences of the COVID-19 vaccine in Eswatini. Phenomenology, as a research methodology, seeks to describe the shared meaning of lived experiences among individuals regarding a particular concept or phenomenon (Moustakas, 1994). Such phenomena may include emotions like anxiety, exclusion, anger, or grief. By employing a phenomenological framework, this research

provided in-depth insights into HCWs' subjective experiences, contributing to a nuanced understanding of vaccine reception and hesitancy within the healthcare sector.

Ultimately, the primary distinction between phenomenology as a philosophy and as a research approach lies in their respective objectives. While philosophical phenomenology is abstract and theoretical, aiming to understand the structures of consciousness and existence; research phenomenology applies phenomenological principles to empirical investigations, focusing on how individuals experience specific phenomena (Williams, 2021).

Categorisation of Phenomenological Research

Phenomenological research can be broadly categorized into:

1. Descriptive Phenomenology – Rooted in Husserl's ideas, this approach prioritizes bracketing researcher biases and systematically analyzing experiences (Giorgi, 2009).
2. Interpretive (Hermeneutic) Phenomenology – Influenced by Heidegger, this approach emphasizes the contextual and meaning-making aspects of human experience (Smith et al., 2009).

This study patterns itself along hermeneutic phenomenology based on the philosophy of Heidegger, which is "oriented toward lived experience (phenomenology) and interpreting the "texts" of life" (Creswell and Poth, 2016, p.126). According to the hermeneutic perspective, social reality is seen as socially constructed, rather than being rooted in objective fact (Gray, 2013; van Manen, 1990). Hence, hermeneutics argues that interpretation should be given greater significance than explanation and description. Social reality is too complex to be understood through the process of observation. Thus, it was important for me to interpret data in order to achieve deeper levels of knowledge and self-understanding.

Researcher positionality and reflexivity

Positionality refers to the recognition that a researcher's identity, background, and experiences influence the research process, including data collection, analysis, and interpretation (Bourke, 2014; Corlett and Mavin, 2018; Gurr et al., 2024). In qualitative research, particularly within interpretivist–constructivist and critical paradigms, the researcher is not a neutral observer but an active participant in the co-construction of knowledge. This study acknowledges that my positionality; my social identity, professional background, cultural affiliations, and personal experiences inevitably shape the research process, from the formulation of questions to the interpretation of data (Holmes, 2020; Savin-Baden and Major, 2013). Therefore,

acknowledging positionality enhances transparency and strengthens methodological rigor (Holmes, 2020).

However, some scholars have challenged the binary framing of insider–outsider status, arguing instead for a more fluid and context-sensitive understanding of researcher identity (Tomaselli, Dyll-Myklebust and van Grootheest, 2016). In his work with indigenous communities in Southern Africa, Tomaselli (2007) emphasises that researchers often occupy a negotiated space, where insider and outsider roles shift depending on relational dynamics, cultural proximity, and institutional positioning.

This perspective aligns with the view that positionality is not fixed, but rather shaped by ongoing interaction and reflexive engagement. In this study, I acknowledge that my role as a researcher was not static; at times, I shared cultural commonalities with participants, fostering trust and openness, while in other moments, my academic status and methodological stance positioned me as an outsider. Drawing on Tomaselli's insights, I approached this research as a dialogic and ethically reflexive process, remaining attentive to how my presence influenced data generation, interpretation, and representation.

Accordingly, as a researcher engaging with healthcare workers in Eswatini, I draw on Tomaselli's (2007) notion of a negotiated space, where the researcher's identity shifts in response to relational dynamics, cultural proximity, and institutional positioning. For example, as a citizen of the Kingdom of Eswatini, I share cultural experiences with the participants in this study. This fostered rapport, while differences in institutional role and educational background – my role as an academic affiliated with the University of Eswatini; my academic background in Journalism and Mass Communication, and my postgraduate studies in health communication - potentially introduced distance. These dynamics influenced how participants responded, what they chose to disclose, and how I interpreted their narratives (Kennedy et al., 2024; Hellawell, 2006).

To navigate these complexities, I engaged in reflexive practice throughout the research journey. Scholars emphasise that researchers must critically reflect on their backgrounds to understand how their perspectives shape knowledge production (Gurr et al., 2024; Shai, 2020; Tomaselli, Dyll-Myklebust and van Grootheest, 2016). As such, reflexivity becomes a key component of qualitative research. Reflexivity involves critically examining how my assumptions, values, and positional power affected the research process and outcomes (Denzin and Lincoln, 2018; Brown, 2023). In this specific study, this involved:

- Maintaining a reflexive journal to document evolving thoughts, emotional responses, and ethical tensions.
- Reflecting on how my presence influenced group dynamics during focus group discussions.
- Acknowledging moments of interpretive bias and actively seeking alternative readings of the data.

Therefore, reflexivity involves continuous self-examination of biases and assumptions throughout the research process (Gurr et al., 2024). I must acknowledge that while my background in health communication provided analytical insights, it also posed limitations in fully grasping the lived experiences of healthcare professionals. Acknowledging these limitations strengthens the integrity of the study and allows for a more nuanced interpretation of findings (Levitt et al., 2021; Drisko, 1997).

Accessing the sites

Access to credible and comprehensive research materials is essential for scholarly inquiry. The effective use of research sources enables scholars to engage with authoritative sources, facilitating rigorous analysis and contributing to the advancement of knowledge within their respective fields (Tracy, 2024). This section details the steps I undertook to access my participants, emphasising the preparatory considerations necessary before the commencement of this research.

Gatekeeping

In qualitative research, gatekeepers play a pivotal role in facilitating or restricting access to participants, settings, and information (Clark, 2011). Gatekeeping refers to the actions of individuals or institutions who hold the authority to permit or deny entry into research contexts (Ahern, 2014; Rankin, 2016). In this study, which explores healthcare workers' perceptions of COVID-19 vaccines in Eswatini, gatekeeping emerged as a critical consideration, both logistically and ethically.

Formal and Informal Gatekeepers

Access to healthcare institutions and professionals required negotiation with formal gatekeepers, such as ethics committees, hospital administrators, and departmental heads. These individuals were responsible for granting official permission to conduct research within their facilities and among their staff. In addition, informal gatekeepers, such as senior nurses

designated as Matrons, played a subtler but equally influential role in shaping participant engagement and trust (Wanat, 2008).

Recognising the layered nature of gatekeeping, the study adopted a strategic and respectful approach to access, including:

- Early engagement with institutional stakeholders to explain the study's purpose and ethical safeguards. I first consulted formal gatekeepers beginning with the Centre for Culture, Media, and Society (CCMS) and the School of Human Sciences in the University of KwaZulu-Natal to ensure compliance with the university's Code of Conduct for research. Following this process, I applied and received ethical clearance through the University of KwaZulu-Natal Humanities and Social Science Research Ethics Committee under ethical clearance number (HSSREC/00004072/2022).
- Sensitivity to organisational hierarchies and cultural norms that influence decision-making: Prior to engagement, efforts were made to identify key decision-makers within each organization, including formal authorities.
    - I first wrote to the Principal Secretary (PS) in the Ministry of Health to explain my study and the kind of access I would need to hospitals and healthcare workers. When no one contacted me in response to my written request, I followed up with a visit to the Ministry's offices where I was informed that over and above permission from the Ministry of Health, I would need to apply for ethical clearance from the Eswatini Health and Human Research Review Board (EHHRRB).
    - Once I had received permission from the Ministry of Health, I applied to the EHHRRB and received ethical clearance under protocol reference number FWA00026661/IRB 00011253. It is important to note that in 2022, the ERRHHB had been recently commissioned by the Government of Eswatini to oversee research activities in the country. Because the institution was still being set up, a number of systems were not in place at the time of my application. Consequently, I was only asked to complete research ethics training much later in the research process, as part of periodical updates to the Board about my study's progress. Consequently, I completed *Module 1 (2023) - Introduction to Research Ethics*, an online course through the Training and Resources in

Research Ethics Evaluation **(**TRREE) training programme in research ethics evaluation.

- Once these permissions were granted, I was able to approach the administrative staff in hospitals for selection of participants. Administrative staff can be considered as informal gatekeepers and served as intermediaries who assisted in navigating the hospital settings and recruiting participants.

- Transparent communication regarding participant rights, confidentiality, and data use: I clearly outlined participants' right to decline or withdraw from the study at any point without penalty. I explained that their participation was entirely voluntary. I also explained that I would use pseudonyms to protect their privacy and anonymize my data. I further detailed my process for obtaining informed consent and language use during data collection.

Recruitment and Selection

This study purposively selected nurses employed at the Hlatikulu Government Hospital, Mbabane Government Hospital and the Raleigh Fitkin Memorial Hospitals who experienced the second wave of COVID-19 in Eswatini, a period marked by clinical uncertainty, high occupational risk, and the absence of biomedical interventions such as vaccines. These participants represent a distinct population whose perceptions, coping strategies, and health communication practices were shaped in the context of profound vulnerability and rapid social change. Their lived experiences are particularly instructive in understanding how meaning is constructed and communicated in high-stakes health settings.

The selection of this cohort aligns closely with the Health Belief Model (HBM), which conceptualises health behaviour as influenced by individuals' perceptions of perceived susceptibility, severity, benefits and barriers; cues to action and self-efficacy. Second-wave nurses operated under heightened exposure to risk and directly observed the health impact of the virus on patients and colleagues, shaping their perceptions of vulnerability and disease severity (Ngobeni, 2025; Goff et al., 2022; Puci, 2022). Although vaccines were unavailable during the initial wave, healthcare workers developed anticipatory attitudes and beliefs that later influenced vaccine acceptance and uptake (Mokoena and Singh, 2024; Slivesteri et al., 2023; Leach et al., 2022). Additionally, first-hand clinical experiences; such as treating critically ill patients or navigating resource constraints, acted as powerful internal cues that affected later decisions regarding vaccination (Slivesteri et al., 2023). Finally, their professional

autonomy and evolving confidence in managing COVID-related challenges contributed to their perceived capacity to act upon health threats effectively (Fisher et al., 2023, Mokoena and Singh, 2024. Thus, by selecting nurses from this phase of the pandemic, the study captures baseline health beliefs and evolving behavioural motivations that informed vaccine perceptions and practices.

Moreover, the selected participants provided rich insight into the dynamics described by Campinha-Bacote's (2002) Model of Cultural Competence, which includes five interrelated constructs: cultural awareness, knowledge, skill, encounters, and desire. Notably, first-wave nurses may have developed heightened sensitivity to their own cultural assumptions and biases, particularly in relation to patient fears and vaccine resistance (Goldenberg, 2021). Additionally, early exposure to diverse community responses to COVID-19 may have prompted nurses to seek context-specific understanding of health behaviours, misinformation, and traditional practices (Haffizulla, 2025). If this was the case, these nurses may have adapted care and communication strategies to align with both institutional protocols and community expectations, often working within pluralistic health systems (Kessy et al, 2025). This suggests that their frontline roles may have facilitated direct and sustained engagement with patients and families, fostering experiential learning and reflexive practice. Thus, the unique moral and professional demands of the second wave may have cultivated a proactive orientation toward culturally sensitive care and public health advocacy.

This justifies the focus on this group, allowing me to explore how cultural competence is shaped not just by formal training, but by experiential learning during a crisis. These nurses' insights illuminate how lived experience informs vaccine-related dialogue, professional identity, and culturally responsive practice. Understanding nurses' perceived role in COVID-19 prevention is essential for assessing how healthcare workers contributed to mitigating the spread of the virus. Their influence extends beyond direct patient interactions to broader institutional and community health strategies. However, while their contributions are significant, doubts and anxieties about the COVID-19 vaccine among HCWs, misinformation, and resource limitations may have affected the effectiveness of their advocacy efforts in Eswatini. Therefore, providing a platform for engagement on their perceptions and experiences was crucial for optimising healthcare workers' role in enhancing public confidence in COVID-19 prevention measures (Chang, Simon and Dong, 2012).

Inclusion Criteria

Establishing clear inclusion criteria was fundamental to ensuring the methodological rigor and validity of this study. Establishing an inclusion criterion suggests that the researcher must have an exclusion criterion. Inclusion criteria define the characteristics that participants must possess to be eligible for participation, thereby enhancing the reliability and generalisability of the findings (Etikan et al., 2015). They specify essential characteristics of the target population needed to answer the research question, such as demographics, clinical conditions, and geographic location (Patino and Ferreira, 2018; Etikan et al., 2015). By carefully selecting participants based on the relevant professional and experiential attributes of nurses, this study aims to capture meaningful insights into the perceptions and experiences of healthcare workers regarding COVID-19 vaccination in Eswatini. The inclusion criteria are designed to align with the study's objectives, ensuring that the selected participants provide data that is both representative and analytically robust.

Key informants were drawn from nurses who were working at the Hlatikulu Government Hospital, Mbabane Government Hospital and the Raleigh Fitkin Memorial Hospitals between March – August 2020. Participants were expected to be willing to participate, and be able to communicate in either SiSwati or English or both languages. Because the study was conceptualised during the pandemic in 2021, it was important to consider issues related to Internet access in the event of further lockdowns. Therefore, key informants were expected to have access to the Internet and own a gadget that allowed for a connection to the ZOOM platform in the case of restrictions due to COVID-19.

Exclusion criteria are useful to filter out participants who may interfere with study results, including those likely to miss follow-ups, or provide inaccurate data (Patino and Ferreira, 2018). In this research, healthcare workers who were not working as nurses during the designated period were excluded from participating. Additionally, nurses who may have been working during this period, but were not employed by the specific hospitals selected for this study, were not included.

The inclusion and exclusion criteria were as follows:

Table 3 shows the inclusion and exclusion criteria for participants in this study.

Inclusion Criteria	Exclusion Criteria
1. Be a nurse at the Mbabane Government Hospital, Hlatikulu Government Hospital and Raleigh Fitkin Memorial Hospital between March –August 2020.	1. A nurse who was not employed by these hospitals in the period under review.
2. Must have access to the Internet and have a gadget that allows connection to Zoom in the case of restrictions	2. Unwillingness to participate and
3. Must be willing to participate	3. Unwilling to participate
4. Be able to respond to questions	4. Has no access to the internet or the Zoom platform

Sampling

Understanding the purpose of research must be a decisive factor in selecting a qualitative sample (Byrne, 2001). A researcher has many sampling choices available that may stem from theory, method, or simple practicalities, such as time and money (Denny and Weckesser, 2018). A sample, therefore, is chosen purposefully, and many sampling strategies can be used. Purposive sampling is a type of non-probability sampling, which is most useful when one needs to explore a certain aspect of life with knowledgeable experts within a particular field (Etikan, Musa and Alkassim, 2016). The selection of these participants should reflect and represent the homogeneity that exists among the participants' sample pools (Robinson, 2014).

For phenomenological studies, the number of recommended research participants is between five and 25 (Sloan and Bowe, 2014; Ellis, 2016; Creswell, 2013). This serves as a guideline to help a researcher estimate how many participants they will need, but ultimately, the required number of participants should depend on when saturation is reached. While phenomenology traditionally emphasises individual accounts to uncover the essence of experience, recent scholarship supports the integration of focus groups within phenomenological frameworks, provided that methodological congruence is maintained (Bradbury-Jones et al., 2009). For this study, I conducted two focus group discussions with a total of 16 healthcare (HCWs) who are

nurses by profession. One focus group was held at Hlatikulu Government Hospital and the other focus group was held at the Raleigh Fitkin Memorial Hospital. Conference rooms were availed at each of the hospitals by the hospital administrators. I also conducted four semi-structured interviews with nurses at Mbabane Government Hospital.

Recruitment

Hlatikulu Government Hospital was selected as the initial research site following unforeseen challenges in data collection at both Raleigh Fitkin Memorial Hospital and Mbabane Government Hospital. At the time, nursing staff at these facilities were actively engaged in protest actions, which significantly disrupted hospital operations and rendered the environment unsuitable for conducting interviews and focus group discussions. Consequently, data collection at these two hospitals was deferred to the following year, 2023. Upon resumption, I was able to conduct the planned focus groups and interviews although there were still challenges with participant recruitment. Matrons serve as Head of the Nursing Cadres in hospitals in Eswatini and as such, they were my point of entry at the hospitals.

Each focus group discussion comprised eight nurses from each hospital. Because I had no direct knowledge of healthcare workers, I approached the matron at the Hlatikulu Government Hospital, who is in charge of nursing staff in the hospital and sought his assistance in recruiting suitable participants for this study. Therefore, the matron was useful in purposively selecting relevant participants for this study. To guide the matron in his selection, I provided him with a screener (*Annex 1*) that was based on the inclusion and exclusion criteria It is worth noting that the nurses worked in different departments during the COVID-19 pandemic as such, each brought unique experiences influenced by their duty stations. At the Raleigh Fitkin Memorial and Mbabane Government Hospitals, I used a different approach due to challenges accessing Matrons. Therefore, instead of relying on the matrons at these two hospitals, I engaged a research assistant who is also a nurse by profession, but was not employed at these two hospitals. Her background made her an ideal collaborator, as she possessed both insider knowledge and research experience, having worked at a global research institution located in Eswatini.

She played a key role in recruiting relevant participants through her professional networks, despite the prevailing instability in the healthcare institutions. Furthermore, she actively participated in the focus group discussion at Raleigh Fitkin Memorial Hospital and assisted with the interviews conducted at Mbabane Government Hospital. I opted for this approach

because while I had received permission to proceed with data collection, the matrons were often unavailable to assist with this and I was concerned that my ethical approvals would expire before I could conclude data collection. I then decided to introduce my assistant to the matrons so they would know why she was there and give her space to recruit participants. I provided the assistant with the same screener used for participant recruitment at my first research site, which she used to recruit participants.

The table below shows demographics of the participants of this study.

Table 4 illustrates participant distribution by hospital, age, group, gender and department

Hospital Site	Age Group	Gender	No. of Participants	Departments
Hlatikhulu Govt Hospital	20–30	Female	1	TB Clinic, Screening
		Male	2	Surgical
	31–40	Female	2	Female Surgical, Male Medical
		Male	1	Male Medical
	41–50	Female	1	Casualty, Male Surgical
		Male	1	Male Surgical
Raleigh Fitkin Memorial Hospital	20–30	Female	1	Female Medical
		Male	1	Screening
	31–40	Female	2	Casualty, Male Medical
		Male	1	Male Medical
	41–50	Female	1	Female Medical
		Male	2	Screening
Mbabane Govt Hospital	20–30	Female	1	TB Clinic

Hospital Site	Age Group	Gender	No. of Participants	Departments
		Male	1	Casualty
	31–40	Female	1	Surgical
		Male	1	Male Medical
	41–50	Female	0	
		Male	0	

**Table generated using AI on Canva.*

Data collection

Data was collected through two focus group discussions and four semi-structured interviews between October 2022 and May 2023. Data at Hlatikulu Government hospital was collected on October 27, 2022 while at the Raleigh Fitkin Memorial Hospital, data was collected on February 20, 2023. Data collection through interviews commenced in May 29 and concluded on May 31, 2023 at the Mbabane Government Hospital.

The decision to use two focus groups was guided by the need to capture collective narratives within distinct institutional contexts. Focus groups are particularly effective in eliciting shared meanings and generating dynamic discussions that may reveal inter-subjective dimensions of experience (Almutrafi, 2019; Palmer et al., 2010). Each group comprised eight participants, a size deemed appropriate for ensuring diversity of perspectives while maintaining manageability is discussion (Gundumogula, 2020).

In contrast, the four individual semi-structured interviews conducted at Mbabane Government Hospital were designed to illicit deeper, more nuanced accounts of personal experience. Semi-structured interviews are well-suited to phenomenological inquiry as they allow participants to reflect on their lived experiences while enabling the researcher to probe emergent themes (Naz et al., 2022; Magaldi and Berler, 2018). The choice of interviews at Mbabane Government Hospital was strategic: as a tertiary hospital, its operational environment differs significantly from the regional hospitals, with heavier patient loads and more complex institutional structures. These conditions made collective sessions less feasible and heightened the value of

individual interviews for capturing personal perspectives that might be constrained in a group setting.

Combining focus groups and interviews across the three hospitals enriched the dataset and strengthened its validity through triangulation. This multi-site, multi-method design aligns with interpretive phenomenology's emphasis on contextual variation and the co-construction of meaning (Sholokhova, 2022; van Manen, 2017). It also acknowledges the heterogeneity of healthcare settings in Eswatini, ensuring that the study captured both collective narratives and individual reflections. By deliberately varying methods across sites, the research was able to balance breadth with depth, producing a more comprehensive account of nurses' perceptions and experiences of COVID-19 vaccination. Therefore, rather than a limitation, this variation enhanced the study's ability to interrogate both institutional and personal dimensions of vaccine communication. By situating focus groups within regional hospitals and individual interviews within a tertiary hospital, the design captured the interplay between collective narratives and individual reflections, thereby producing a richer and more contextually grounded account of nurses' experiences during the COVID-19 pandemic.

Upon arrival at Hlatikulu Government Hospital, the matron escorted both myself and the participants to a designated conference room. After facilitating brief introductions, he departed, leaving the group to proceed with the focus group discussion. Recognising an initial sense of tension within the room, I took deliberate steps to foster a more comfortable and inclusive environment. I began by providing a personal introduction in SiSwati—the local language—which served to establish rapport and cultural alignment. I then articulated my interest in the subject matter and outlined the rationale behind exploring participants' perceptions and experiences concerning COVID-19 vaccination.

Following this introductory engagement, I presented the informed consent forms (*Annex 2*) and explained the purpose and significance of this process. Informed consent is a foundational component of ethical research, designed to uphold participants' autonomy and ensure their voluntary and knowledgeable participation (Islam, 2025). I clarified that involvement in the study was entirely voluntary and that participants retained the right to withdraw from the discussion at any point, without fear of repercussion. This ethical obligation, rooted in the principle of respect for persons, necessitates that researchers clearly communicate the objectives of the study, along with the associated procedures, risks, and benefits prior to data collection (Ferreira and Serpa, 2018). I followed the same processes at the Raleigh Fitkin

Memorial Hospital and Mbabane Government Hospital, ensuring that research participants were comfortable to engage with me. My research assistant was tasked with distributing the necessary forms while I explained expectations.

Subsequently, I distributed a study population form (*Annex 3*) designed to collect demographic information from participants. To address potential sensitivities around vaccination status, the form provided response options of "Yes," "No," or "Rather Not Say," allowing participants to disclose this information at their discretion. In order to safeguard participant confidentiality, no personally identifiable information—including names—was collected. This anonymity-focused approach was integral to preserving participants' privacy and reinforcing the study's commitment to ethical research practice.

Focus group discussions and interviews were guided by the semi-structured interview guide (*Annex 4*) that I had developed to initiate dialogue and ensure coverage of key themes. However, the use of these guides remained flexible; I deliberately avoided rigid adherence to the questions, allowing participants the space to articulate their views freely and without pressure. This approach helped create a more open and responsive research environment, reducing time-related stress and enabling richer data collection. Consequently, each focus group session was completed within the allocated timeframe of 50 to 60 minutes at both hospitals, while individual interviews adhered to the planned 45-minute duration.

Focus Group Discussions

To collect qualitative data, I conducted two focus group discussions comprising 16 nurses from Hlatikulu Government Hospital and Raleigh Fitkin Memorial Hospital. Each focus group comprised eight nurses. The literature offers various definitions of focus groups. Morgan (1996) defines focus groups as a research technique that collects data through group interaction on a topic determined by the researcher. Krueger (1994) defines focus groups as carefully planned discussions designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment. Kitzinger (1994) emphasises the social aspect of focus groups, arguing that they allow participants to challenge and build upon each other's perspectives, making them particularly useful for exploring collective experiences. However, whatever the definition, certain features—such as organised discussion (Kitzinger, 1994), collective activity (Powell et al., 1996), social events (Goss and Leinbach, 1996), and interaction (Kitzinger, 1994)—underscore the unique contributions of focus groups to social research. The primary purpose of focus group inquiry is to elicit respondents' attitudes, feelings, beliefs, experiences,

and reactions in a manner that would be difficult to achieve through other qualitative methods, such as observation, one-on-one interviews, or questionnaire surveys (Gibbs, 1997).

According to Stewart and Shamdasani (2010), interaction is a fundamental characteristic of focus groups, as it reveals participants' perspectives, the language they use in discussing particular issues, and their values and beliefs regarding specific situations. Interaction also allows participants to question one another, fostering opportunities for re-evaluation and deeper reflection on their personal experiences (Gibbs, 1997). The goal of the two focus groups was to generate critical perspectives that would uncover contextual and cultural factors specific to healthcare workers in Eswatini. To facilitate these discussions, I developed a focus group guide (*Appendix 5*). The semi-structured interviews complemented the focus groups by capturing subjective interpretations and personal perceptions, providing further depth to the inquiry (Roberts, 2020).

Advantages of focus groups

Focus groups are considered to be rich qualitative data. They allow participants to express their thoughts, experiences, and emotions in a dynamic setting, leading to in-depth insights that may not emerge in individual interviews (Morgan, 1996; Susanto et al., 2024). The collective discussion in focus groups fosters idea generation, enabling participants to build on each other's perspectives (Gibbs, 1997). This was particularly useful in exploring shared concerns among healthcare workers regarding vaccine hesitancy. Focus groups are effective for exploring new or complex topics, such as healthcare workers' perceptions of COVID-19 vaccines, where little prior research may exist, particularly in the context of Eswatini. Compared to individual interviews, focus groups allow researchers to gather data from multiple participants simultaneously, making them time- and cost-effective (Kitzinger, 1994). Additionally, participants often provide contextual information about their experiences, helping researchers understand external influences such as workplace policies, media narratives, and institutional trust (Stewart and Shamdasani, 2010).

Limitations of Focus Groups

While focus groups generate nuanced insights through collective dialogue, they also present methodological limitations. Dominant voices may suppress diverse views, and social desirability bias can lead to conformity in responses (Morgan, 1996; Kitzinger, 1994). This may lead to sensitive topics going unexplored due to the lack of privacy and group dynamics risk overshadowing individual authenticity (Dehalwar and Sharma, 2024). To mitigate these

limitations, complementary individual interviews, skilled facilitation and thoughtful question design are recommended (Ennis and Chen, 2012; Acocella, 2012). Therefore, my decision to conduct individual interviews within Mbabane Government Hospital functioned as a strategic approach to mitigate the methodological limitations associated with focus group discussions.

Despite the logistical demands associated with organising focus groups; including participant recruitment, scheduling, and venue co-ordination as well as the analytical complexity of managing large volumes of qualitative data, these challenges were proactively addressed in this study. I drew on the best practices outlined by Morgan (1996) and Kitzinger (1994) to undertake meticulous planning to ensure smooth implementation. Recruitment was facilitated through institutional support at each hospital site and scheduling was aligned with participants' availability to minimize disruption. To manage the data complexity, all focus group sessions were audio-recorded and transcribed verbatim, followed by systematic coding using interpretative phenomenological analysis. This approach ensured analytical rigor while maintaining transparency and traceability in the data interpretation process.

Tensions between IPA and Focus Groups

There has been some controversy regarding the use of IPA in focus groups. Criticism has largely focused on the challenge of isolating idiographic accounts, as they are deeply embedded within the collective experience of a focus group setting (Palmer et al., 2010), where the dominant group narrative often overshadows individual perspectives (Tomkins and Eatough, 2010). Additionally, the presence of multiple layers of hermeneutic interpretation further complicates the analysis, as the researcher seeks to understand participants' meaning-making while they, in turn, attempt to interpret each other's perspectives within the group context (Tomkins and Eatough, 2010). Nevertheless, studies that have applied IPA to focus groups exist (Blake et al., 2007; Dunne and Quayle, 2001; Flowers et al., 2001).

Some researchers have adapted IPA for use in focus groups to address philosophical and theoretical tensions associated with its application (Palmer et al., 2010; Tomkins and Eatough, 2010). However, critiques of such studies highlight a lack of transparency regarding the modifications made to IPA, as well as the neglect of the inherent dynamics within focus groups (Tomkins and Eatough, 2010). Other IPA studies employing focus groups (Githaiga, 2016; Makin, 2012; Phillips et al., 2016) demonstrate that these challenges persist, and the aforementioned criticisms remain relevant. To overcome these tensions, I adopted the step-by-step guide used by Love et al., 2020 in their study using IPA with focus groups of drug-using

offenders, demonstrating how individual experiences of drug use, relapse, and recovery were captured while accounting for group interactions. These steps are discussed in greater detail in Chapter 5, where I present the data.

Semi-Structured Interviews

Semi-structured interviews offered several advantages in examining nurses' perceptions and experiences of the COVID-19 vaccine in Eswatini and their influence on patient-provider communication. Defined as interviews conducted with the purpose of obtaining descriptions of the interviewee's life world to interpret the meaning of the described phenomena (Kvale and Brinkmann, 2015), semi-structured interviews have become the most widely used qualitative method in the human and social sciences. Their value lies in their ability to harness the knowledge-generating potential of discussions by allowing flexibility in exploring angles deemed important by the interviewee (Creswell and Poth, 2016).

One of the primary benefits of this approach is its adaptability in questioning (Parkhouse and Ormerod, 2018). Researchers can use predefined questions while allowing for follow-up inquiries that probe unexpected but relevant insights (Roberts, 2020). For the current research, this flexibility facilitated a deeper understanding of nurses' experiences by eliciting open-ended responses that captured attitudes, concerns, and motivations regarding the COVID-19 vaccines. Additionally, semi-structured interviews provided an avenue for exploring contextual factors; such as sociocultural and institutional influences, that shape nurses' perspectives on immunization and inform their communication practices with patients (Adedokun and Idowu-Collins, 2024).

Moreover, the conversational nature of semi-structured interviews fostered an environment that encouraged honesty and reflection. Nurses could express personal viewpoints freely, enabling them to articulate challenges and concerns about the vaccines without constraint. This method was particularly valuable in assessing how nurses communicated vaccine information to patients, addressed hesitancy, and tailored their messaging based on their own experiences. By capturing the human element—including emotions, frustrations, and positive interactions—semi-structured interviews enrich qualitative data with authentic, in-depth insights.

Given the study's multi-site approach, semi-structured interviews also provided deeper, personal insights into nurses' perceptions and experiences, complementing the collective dynamics observed in the FGDs thus enriching the analysis with individual perspectives on institutional practices and patient–provider communication. . Ultimately, this method provided

a rigorous framework for generating nuanced data, contributing to a comprehensive understanding of vaccine-related attitudes among healthcare professionals in the selected hospitals.

Prior to conducting the interviews, I developed an interview schedule comprising open-ended, non-directive questions. Rather than constraining the dialogue, the schedule served as a navigational tool, facilitating engagement with participants while preserving the fluidity of conversation and encouraging free expression. The adaptability of this framework allowed for dynamic adjustments to the questions in response to participants' answers, occasionally steering the discussion in unforeseen yet insightful directions. Throughout the data collection phase, it became evident that deviating from the predetermined schedule to explore emerging ideas in greater depth led to a more nuanced and comprehensive understanding of the nurses' social world. Consequently, by the final interview, participants were afforded substantial autonomy in shaping the discussion, enabling them to highlight issues of personal significance.

Language, recording and transcription

The focus group discussions and the semi-structured interviews were conducted in both English and SiSwati. This was expected as the Kingdom of Eswatini is a dual –language country and both English and SiSwati are official languages in the country. Having the participants engage in SiSwati, which is their mother tongue, further fostered a sense of comfort and trust, making them more willing to share their thoughts and experiences openly. Speaking in SiSwati also allowed them to express complex emotions, cultural nuances, and deeply held beliefs that may not have translated accurately into English.

Additionally, indigenous languages often contain concepts and perspectives that are unique to the community, helping researchers gain deeper insights into participants' lived experiences (Blodgett et al., 2011). Therefore, the use of SiSwati in this research also minimized misunderstandings and ensured that responses were more authentic, reducing the risk of misinterpretation due to linguistic barriers. Nurses were also able to refer to a lot of the traditional medicine by their indigenous names, which are in SiSwati, which kept the discussions at a non-technical level, allowing me an opportunity to understand the nuances of prescriptions and doses.

Interviews were recorded by means of an audio recorder to ensure that the information was captured accurately. The interviews were transcribed and the SiSwati dialogue was translated into English. Although I am well acquainted with both languages, I engaged my research

assistant for transcription and translation, especially for the focus group discussion at the Raleigh Fitkin Memorial Hospital and the interviews at the Mbabane Government Hospital. Because she was present at all these interviews, she had working knowledge of the context of the discussions.

Data analysis

Qualitative research offers a variety of analytical approaches for data interpretation. For this study, I adopted Interpretative Phenomenological Analysis (IPA), a contemporary qualitative method that has gained widespread use across multiple academic disciplines (Miller, Chan and Farmer, 2018).

Interpretative Phenomenological Analysis

My method of analysis for this study is Interpretative Phenomenological Analysis (IPA). IPA, initially developed by psychologist Jonathan Smith (1996), is a qualitative research approach rooted in phenomenology and hermeneutics. It is designed to explore how individuals make sense of significant life experiences, particularly within domains such as health, identity, and cognition (Smith, Flowers and Larkin, 2014). Although IPA originated in psychology, its application has expanded across disciplines, including health communication, nursing, and public health (Eatough and Smith, 2008; Larkin and Thompson, 2011), demonstrating its methodological versatility and relevance to this study.

This research employed IPA to examine Eswatini nurses' perceptions of COVID-19 vaccines, recognizing that these perceptions are shaped by personal experiences, professional obligations, institutional protocols, and sociocultural contexts (Mokoena and Singh, 2024; Zhang et al., 2011). IPA's theoretical underpinnings—phenomenological sensitivity and hermeneutic interpretation—align with the interpretive aims of health communication research, which focuses not solely on the transmission of health messages but on the construction of meaning through interpersonal interaction and emotional engagement (Zoller and Dutta, 2009).

IPA's idiographic emphasis further supports the study's analytical depth by prioritizing detailed individual accounts before extrapolating broader thematic patterns (Larkin, Shaw and Flowers, 2019). This approach enabled a nuanced analysis of variation in nurses' perspectives across healthcare settings while preserving the specificity and authenticity of participant narratives. Such insight is particularly valuable for informing vaccine-related communication strategies at both institutional and policy levels.

Moreover, this study integrates IPA with selected principles from critical theory and interpretivism, facilitating a dual focus on lived experience and structural context. This integrated framework supported a comprehensive examination of how nurses not only interpreted their vaccine experiences but also navigated institutional power relations, public health discourses, and professional identity formation (Alase, 2017). Chapter 5 provides a more in-depth discussion of my application of IPA in analysing data.

Research integrity

Research integrity is fundamental to ensuring rigor, ethical responsibility, and credibility in qualitative inquiry. The evaluation of qualitative research has long been the subject of scholarly debate, reflecting the diverse epistemological and methodological foundations that underpin qualitative inquiry. Unlike quantitative research, which is often assessed using standardized criteria such as validity, reliability, and generalizability, qualitative research resists uniform evaluation due to its interpretive, context-dependent nature (Bryman, 1984; Yadav, 2022). Scholars have proposed various frameworks to address this complexity, ranging from Lincoln and Guba's criteria of trustworthiness—credibility, transferability, dependability, and confirmability—to more contemporary models emphasising reflexivity, coherence, and ethical sensitivity (Cho and Trent, 2014; Ballinger, 2006).

These debates are further complicated by differing views on the role of paradigms, with some researchers advocating for paradigm-specific criteria while others call for more flexible, context-responsive approaches (Chafe, 2024). As such, evaluating qualitative research requires a nuanced understanding of its philosophical underpinnings and methodological diversity, making it essential for researchers to justify their evaluative stance within the context of their chosen paradigm. According to Tracy (2010), qualitative research must prioritize sincerity, transparency, and ethical commitment to produce trustworthy findings. It is particularly crucial when investigating healthcare workers' perceptions of COVID-19 vaccines in Eswatini, as it ensures that findings accurately represent participants' experiences while upholding ethical standards. In this study, I adopt the framework proposed by (Tracy, 2010) to evaluate this research for research integrity.

Tracy (2010) proposes eight criteria, which she addresses as follows:

1. ***Worthy Topic***

The research should be relevant, timely, significant, and interesting. My study addresses a highly pertinent and socially significant issue: the perceptions and lived experiences of

healthcare workers regarding COVID-19 vaccination. Given Eswatini's public health context and global vaccine hesitancy debates, the topic is both timely and impactful

2. ***Rich Rigor***

According to Tracy (2010), this entails a solid foundation of appropriate theoretical constructs, sufficient data, and carefully applied methods. The use of phenomenology is particularly appropriate for exploring nuanced personal experiences and perceptions—key concerns when investigating vaccine hesitancy and cultural competency. It enables you to uncover healthcare workers' lived realities in depth. Moreover, the theoretical grounding of my study includes the Health Belief Model (HBM), which offers a solid conceptual structure for investigating individual decision-making processes, specifically around perceived susceptibility, severity, benefits, and barriers to COVID-19 vaccination. Thus, guided my interview protocol, thematic coding, and interpretation. Additionally, I adopted Campinha-Bacote's Cultural Competency Model (2002), which adds a critical sociocultural layer, emphasising the importance of cultural awareness, skill, knowledge, and encounters; particularly relevant in a diverse healthcare context like Eswatini. Applying this model deepened understanding of interpersonal and systemic influences on vaccine attitudes.

Furthermore, purposeful selection of participants across demographics and healthcare settings ensures diversity and richness in experiential accounts. This supports analytic depth and improves thematic saturation. Finally, I ensured transparency in data practices though detailed reporting of how data were collected, transcribed, and analysed—including reflexive journaling and iterative coding procedures, which work together to enhance procedural clarity.

3. ***Sincerity***

Tracy (2010) argues that researchers must show transparency and self-reflexivity, acknowledging their positionality and biases. My positionality as a researcher situated within Eswatini is clearly reflected through:

- Reflexivity: I acknowledge my assumptions about vaccines and the local healthcare systems.
- Transparency: I have clarified the decision-making processes in data collection, transcription, and analysis.

4. Credibility

According to Tracy (2010), findings must be plausible and trustworthy, supported by thick description, triangulation, and member reflections. In this study, credibility is assured through vivid participant narratives that convey emotional, cultural, and ethical nuances. Triangulation was implemented through the choice to supplement focus group discussions with semi-structured interviews to gain nuanced understanding of participants' perceptions and experiences.

5. Resonance

This criterion is addressed by crafting evocative representations that allow readers; especially those outside Eswatini, to empathize with local vaccine-related concerns. Additionally, the study aims to facilitate cross-cultural reflection on global vaccination campaigns and how they affect communicative practices in the local context. Tracy (2010) views resonance as the work's ability to affect readers emotionally or intellectually and foster empathy or understanding.

6. Significant Contribution

Tracy (2010) argues that research must add insight to the field, advances theory, improve practice, or raise social awareness. My research has practical relevance. It may inform vaccine policy and communication strategies in resource-constrained contexts. Additionally, it offer theoretical insight by advancing an understanding of phenomenology in pandemic studies and vaccine perception research.

7. Ethics

Tracy (2010) advocates for research that is conducted with care and integrity, ensuring both procedural and relational ethics are considered. I complied with this criterion by securing informed consent, confidentiality, and ethical clearance from appropriate bodies before data collection could proceed. Moreover, building trust and minimizing power imbalances during fieldwork was important to me, especially given the sensitive nature of COVID-related discourse.

8. Meaningful Coherence

Finally, Tracy (2010) argues that the study's purpose, methods, and findings must align in a way that makes sense and supports the claims. My study's coherence derives from clear

alignment among my research aims (understanding lived experiences), methodology (phenomenology), and data presentation (interpretative phenomenological analysis). Additionally, I have ensured a logical flow and integration of philosophical underpinnings with practical implementation.

Ethical considerations

Given the interactive and often exploratory nature of qualitative research, obtaining informed consent requires continuous engagement with participants to ensure they fully comprehend the study's objectives and implications (Houghton et al, 2010). Key considerations include informed consent, where participants are fully aware of the study's purpose and any potential risks (Beauchamp and Childress, 2019).

Before the commencement of focus group discussions and interviews, participants were required to complete consent forms, which were provided in both English and SiSwati to ensure accessibility. The study's objectives were clearly explained, and participants were encouraged to seek clarification by asking questions prior to signing the forms.

To uphold ethical standards, confidentiality and anonymity were prioritized, fostering openness in discussions of the nurses' perceptions and experiences of COVID-19 vaccines in Eswatini (Israel and Hay, 2006). Pseudonyms were assigned during data analysis and the study population form included a "Rather Not Say," option for vaccination status. Although the forms were anonymous, these safeguards helped participants feel protected from the outset. Neutrality and transparency throughout the research process helped ensure fair representation of participants' views and avoid potential bias (Macdonald and Birdi, 2020). While confidentiality was emphasised, the nature of focus groups inherently limits the researcher's ability to ensure that all participants maintain it. This limitation was clearly stated in the informed consent form, and participants provided consent with this understanding.

Institutional ethical guidelines, including those from the University of KwaZulu-Natal and Eswatini's national research ethics frameworks, provide foundational principles for maintaining integrity in health research. Thus, the study was approved and registered under reference number HSSREC/00004072/22 by the Humanities and Social Sciences Research Ethics Committee at the University of KwaZulu-Natal. However, since this study was conducted in the Kingdom of Eswatini, I was required to obtain additional ethical clearance through the Eswatini Health and Human Research Review Board in accordance with legislative requirements for research conducted in the country. Ethical approval was granted under

protocol number FWA00026661/IRB 00011253. Securing these clearances enabled me to formally approach hospital administrators with requests to collect data.

Data Storage

Interview recordings and transcripts are securely stored on a personal computer and backed up in a password-protected cloud folder, ensuring restricted access. The collected data was utilized exclusively for this study and was safeguarded in accordance with university guidelines. In compliance with institutional requirements, the data would be securely retained for five years and subsequently disposed of following established protocols.

Conclusion

This chapter has established a methodological framework for investigating healthcare workers' perceptions and experiences regarding COVID-19 vaccines in Eswatini. The study adopts a qualitative methodology rooted in hermeneutic phenomenology to explore how nurses in Eswatini perceived COVID-19 vaccines and how these perceptions shaped their patient communication. The inquiry was anchored within an interpretivist-constructivist paradigm that recognises the multiplicity and contextual nature of reality, and further enriched through a critical theoretical lens attentive to global health inequities. By drawing on the Health Belief Model and Campinha-Bacote's Cultural Competence Model, this research provides both a behavioural and culturally responsive framework for understanding health discourses among frontline workers.

The philosophical stance guiding this study emphasised layered interpretation. This includes participants' first-order sense making to second-order researcher analysis, culminating in structural critique informed by aspects of Critical Theory. This nuanced hermeneutic approach acknowledged both personal experience and broader socio-political structures. Ontologically, the study embraced the view that reality is shaped by human perception and cultural context, while its epistemology favoured co-constructed knowledge, privileging reflection and dialogue over empirical generalisation.

A phenomenological design; drawing from Heideggerian principles and the broader cannon of phenomenological philosophers, enabled a rich exploration of lived experience, capturing the complexity of nurses' affective and cognitive engagement with vaccine-related decisions. My reflexive positionality further strengthened the study's trustworthiness, with thoughtful consideration given to insider-outsider dynamics and the influence of shared cultural heritage

and professional distance. Reflexivity was embedded through journaling, bias management and ethical mindfulness.

Access to the sites and ethical clearance procedures were observed, with approvals being obtained from local and university ethics committees. The sampling strategy applied purposive techniques to identify nurses directly involved during the pandemic's initial surge, across three strategically selected hospitals representing both urban and rural contexts. Inclusion criteria were refined to ensure relevance, diversity, and logistical feasibility. Data collection combined semi-structured individual interviews and focus group discussions conducted in both English and Siswati. This bilingual engagement strategy facilitated a culturally congruent space for participants to express nuanced reflections. The integration of Interpretative Phenomenological Analysis (IPA) allowed me to delve into individual narratives and aggregate thematic meanings with careful attention given to reconciling IPA's ideolograhic ethos with the broader dynamics of group conversation.

Throughout the study, research integrity was upheld through engagement with Tracy's (2010) "big-tent" criteria. The study demonstrated worthy topical relevance, methodological and analytical rigor, reflexive sincerity and ethically grounded practices. The use of pseudonyms, informed consent procedures in English and participants' native language, and secure data handling further ensured compliance with international ethical standards.

In summary, the methodology presented in this chapter reflects a contextualised, ethically sound and theoretically rich approach to understanding health communication during a global health emergency. By capturing the voices of nurses at a critical juncture, the study contributes meaningfully to scholarship on culturally sensitive public health engagement, foregrounding the human dimensions of medical discourse in times of crisis.

CHAPTER FIVE

DATA ANALYSIS

Introduction

This chapter presents a comprehensive analysis of qualitative data gathered to explore perceptions and experiences of healthcare workers regarding COVID-19 vaccines in Eswatini; namely, the Hlatikulu Government Hospital, Raleigh Fitkin Memorial Hospital and the Mbabane Government Hospital. Data analysis is a critical component of qualitative research, serving as a bridge between raw data and meaningful interpretation (Merriam, 2009). Data analysis refers to the systematic process of examining, organizing, transforming to extract meaning insights, identify patterns and support decision –making or theoretical development (Creswell and Poth, 2018). In qualitative research, data analysis is often iterative and interpretive, involving continuous engagement with the data to uncover themes and construct meaning (Savenye and Robinson, 2004).

In this chapter, I outline the structured approach used to analyse data from two focus groups and four individual interviews. Guided by Interpretative Phenomenological Analysis (IPA), I offer a detailed interpretative account of how healthcare workers, contextualised as nurses in this study, made sense of COVID-19 vaccination within their social and cultural environments. The analytical process followed the core principles of IPA for data sourced from individual interviews, including iterative reading of transcripts, detailed annotation and identification of themes. Additionally, principles of IPA were applied to the focus groups' data, with modifications introduced to address the methodological tensions that may arise when using IPA in group settings. The analysis is guided by four research questions:

1. How do nurses at Raleigh Fitkin Memorial, Hlatikulu, and Mbabane Government Hospitals experience and interpret COVID-19 vaccination within the context of trauma, stigma, and resilience?
2. In what ways have nurses concerns and scepticisms regarding COVID-19 vaccines been shaped by cultural identity, professional responsibility, and systemic fragility?
3. In what ways do nurses perceive and enact their role as mediators of trust in promoting COVID-19 prevention across clinical and community settings?
4. In what ways do nurses perceive and enact their role as mediators of trust in promoting COVID-19 prevention across clinical and community settings?

Data analysis method

The method of analysis adopted for this study is Interpretative Phenomenological Analysis (IPA). IPA is a qualitative research methodology aimed at exploring how individuals make sense of their lived experiences within specific social, cultural and institutional contexts (Smith and Osborn, 2008). Rooted in phenomenology, hermeneutics and ideography, IPA emphasizes the subjective meaning-making and acknowledges the researcher's interpretative role in analyzing these experiences (Smith et al, 2009). By employing IPA, the study seeks to illuminate the personal and contextual interpretations healthcare workers in Eswatini constructed in relation to COVID- 19 vaccination discourse; particularly within a healthcare system shaped by socio-political and cultural considerations.

Interpretative Phenomenological Analysis (IPA) traces its roots to psychology and health research, offering a systematic yet flexible framework for capturing how people experience and ascribe meaning to significant life phenomena (Smith et al., 2009). Its theoretical foundations rest on phenomenology, which seeks to describe phenomena as they appear to consciousness, and hermeneutics, which attends to the interpretive process (Kafle, 2011; Moran, 2002). Key to IPA is the iterative movement from detailed, line-by-line analysis toward the abstraction of emergent themes, ensuring that interpretations remain grounded in the original data (Smith and Fieldsend, 2021; Riegler, 2019).

Building on IPA's core steps, Love et al (2020) proposed a series of adaptations for analyzing focus-group transcripts that preserve the method's ideographic commitment while incorporating group dynamic dimensions. The procedural refinements by Love et al (2020) include mapping conversational sequences, noting interactional cues such as agreement or dissent, and developing themes that reflect both individual contributions and collective sense-making. This adaptation ensures that themes capture not only what is said but how participant interactions shape emerging interactions (Love et al., 2020).

This study, situated within an Interpretivist-Constructivist paradigm enriched by Critical Theory, adopts the deliberate use of two complementary analytical frameworks, each tailored to a different data source, which privileges participants' subjective meaning-making while remaining alert to power relations shaping vaccine discourse. As stated in earlier sections of this research and chapter, Interpretative Phenomenological Analysis (IPA) was first applied to the four individual interviews to capture each nurse's singular lived experience of COVID-19 vaccination in this specific study. Second, the adaptation of IPA proposed by Love et al (2020)

was employed for the two focus groups, introducing procedures such as interactional noting, which attends specifically to group dynamics and collective meaning-making.

Reflexivity in Interpretative Phenomenological Analysis

Reflexivity in qualitative research refers to the systematic, continuous process by which researchers critically examine how their own values, experiences, assumptions and social positions shape every stage of a study (Olmos-Vega et al., 2022; Finlay, 2002). Rather than striving for an impossible objectivity, reflexivity acknowledges that researchers inevitably influence and are influenced by the research context and participants (Tomaselli et al., 2016). This involves transparent self-scrutiny of one's epistemological stance, methodological choices and interactions with participants, ensuring that interpretations remain grounded in data while accounting for personal and cultural lenses (Olmos-Vega et al., 2022; Haynes, 2012; Mruck and Breuer, 2003). Consistent with this viewpoint, my epistemological stance is informed by the Interpretivist-Constructivist orientation with elements of Critical Theory. This epistemological stance influenced both the selection of qualitative methods and my approach to data analysis.

Based on this stance, I believe that knowledge is socially co-constructed, relational and context-dependent, while also recognizing the impact of systemic structures and power dynamics on the production and circulation of meaning (Denzin and Lincoln, 2018). This placed me in the centre of the research process as researchers who adopt this stance often serve as the primary instrument of data collection and interpretation (Dodgson, 2019).

Engaging in reflexivity enhances the credibility and trustworthiness of qualitative findings by making the researcher's influence visible and subject to critical appraisal (Johnson and Duberley, 2003). Literature suggests that common reflexive practices include keeping a reflective journal or analytic memos, conducting peer debriefings, and performing member checks (McGrath, 2021; Greene, 2014; Lietz and Zayas, 2010). The methods all serve to generate an audit trail and evolving insights (Heaton, 2004).

My preferred method involved keeping a reflexive journal, which I used to document my thoughts and observations during the processes of data collection and analysis. By foregrounding, rather than concealing their positionality, researchers can more responsibly interpret participants' accounts and provide readers with necessary context to evaluate the study's rigor and relevance (Denzin and Lincoln, 2018).

Reflecting this theoretical stance, Hermeneutic phenomenology, unlike Husserl's descriptive approach, does not seek to suspend all preconceptions through epoche or bracketing. Instead, it acknowledges that a researcher's background, language and prior understandings are inseparable from interpretation (Laverty, 2003; Heidegger, 1962). In keeping with this view, methodologists like van Manen (1990) emphasise reflexivity over bracketing, urging researchers to document their preconceptions in a reflective journal and to deliberately engage with their own positionality throughout the analysis. Other scholars similarly critique strict bracketing, suggesting that openness and sensitivity to emerging meanings depend on a dynamic, rather than suspended researcher stance (Dahlberg et al., 2008). Consequently, in this chapter, I critically reflect on my positionality and its influence on key aspects of this study, particularly the data analysis process. To avoid superficial self-reflection, the discussion focuses on specific elements of reflexivity; namely, personal, interpersonal and contextual dimensions, which directly shaped research decisions and analytical procedures (Holmes, 2020; Berger, 2015).

Personal reflexivity

In qualitative research, particularly within an Interpretivist-Constructivist orientation with elements of Critical Theory, the researcher is not a neutral observer but an active participant in the co-construction of meaning (Holmes, 2020; Bourke, 2014). In this study, I acknowledge that my positionality is shaped by my cultural identity, professional background and academic training and these inevitably influenced the process of data interpretation and thematic construction.

As a citizen of the Kingdom of Eswatini and a scholar trained in health communication, I occupied a fluid space between insider and outsider, navigating relational dynamics that shaped both participant engagement and analytical insight (Tomaselli, Dyll-Myklebust and van Grootheest, 2016). These relational dynamics, including trust, familiarity, power asymmetries and mutual identification, can influence how openly participants share their experiences, what they choose to disclose and how they frame their narratives (Arnold et al., 2022; Goldstein, 2017). In a context where racial homogeneity is the norm, given that the majority of the population identify as Black and ethnically Swazi, race did not emerge as a salient factor in my interactions with participants. As such, my shared racial identity with the nurses I interviewed facilitated a sense of familiarity and reduced the potential for a racialised power dynamics within the research encounter (Mapedzahama et al., 2012).

However, race did surface as a meaningful theme in the narratives of some participants particularly in relation to patient-provider communication. Nurses described instances where racial differences between themselves and non-Swazi patients influenced perceptions of authority, trust and cultural competence. This aspect is covered in greater detail in Chapter Six where I discuss the findings of this research. However, these reflections underscore the fact that while race was not a barrier between myself and my participants, it remained a relevant axis of power and identity within the broader healthcare setting (Pinderhughes, 1989).

My identity as a woman played a more immediate role in shaping the research process. Gendered norms within Swazi society and healthcare spaces influenced the interpersonal dynamics with the two focus group discussions as these were composed of both male and female nurses. In many African contexts, including Eswatini, gendered norms shape communication styles, expressions of authority and perceptions of credibility (Tamale, 2020; Mama, 2001). Consequently, my presence may have simultaneously facilitated openness and introduced constraints. On one hand, being female fostered a sense of relational safety, especially among female participants. Discussions around care, emotional labour and vaccine-related fears were often expressed with vulnerability and my gender may have signaled empathy and shared understanding.

On the other hand, my gender influenced how male participants engaged with the discussion. In some cases male nurses moderated their language, avoided emotionally charged topics or asserted professional authority more strongly in response to gender dynamics (Mama, 2001). This could reflect broader societal expectations around masculinity and leadership, which sometimes position women as less authoritative in professional discourse (Tamale, 2004). I remained reflexively aware of these dynamics, noting moments where gendered interactions may have shaped the flow or depth of conversation.

Importantly, these observations do not suggest a fixed or deterministic influence of gender, but rather a relational and context-dependent interplay (Oyěwùmí, 1997). My role as facilitator required ongoing sensitivity to these dynamics, including the use of inclusive language, balanced turn-taking and non-verbal cues to ensure equitable participation. This reflexive stance was essential in navigating the subtle power relations embedded in group dialogue and in interpreting the data with cultural and gender nuance (Tomaselli et al., 2016; Couture et al., 2012).

In individual interviews, my identity as a female researcher influenced the nature of participant engagement in more intimate and nuanced ways than in focus group settings. Researchers have

emphasised that qualitative interviewing is not a neutral exchange but a relational encounter shaped by power, identity and emotional labour (Thwaites, 2017; Mama, 2011). Just like in the focus group settings, my gender facilitated a sense of shared experience, especially when discussing emotional responses to the pandemic, caregiving burdens, and vaccine-related fears. With male participants, the dynamic was more complex. In some cases, my gender encouraged openness, especially in discussions around ethical dilemmas or emotional strain, topics that are often stigmatized within masculinised professional cultures (Martínez-Morato, 2021; Gray, 2010). In other instances, male participants adopted a more formal or guarded tone, possibly influenced by societal expectations around masculinity and authority in healthcare settings (Tamale, 2022). These shifts in tone and disclosure were noted in my reflexive journal and considered during data interpretation.

Finally, it is important to acknowledge that language and class also played subtle but significant roles in shaping my positionality. While I am fluent in Siswati and English, and conducted interviews in participants' preferred language, Siswati, my professional and educational background may have positioned me as part of an elite class. This dynamic required careful attention to power dynamics, particularly ensuring that participants felt their voices were valued and not overshadowed by academic authority. One of the ways I considered this was to give participants an option to respond to questions in either English or Siswati. I noticed that the majority of participants demonstrated a clear preference for Siswati in both focus groups and individual interviews. This linguistic choice reflected not only comfort and fluency but also the cultural embeddedness of health-related discourses in the local language (Zayts-Spence and Bridges, 2023). Participants often shifted into Siswati when expressing emotionally charged experiences, culturally nuanced beliefs, or context-specific terminology related to COVID-19 and vaccination. This aligns with research emphasising the importance of conducting interviews in participants' preferred language to facilitate authenticity, depth and cultural resonance (Squires, 2009; Temple and Young, 2004).

As a researcher, my fluency in both languages enabled me to engage responsively and interpret meaning with cultural sensitivity. However, I remained reflexively aware of the challenges inherent in translating idiomatic expressions and culturally embedded concepts into English for analysis, wherever such cases arose. Where necessary, I retained original Siswati phrases in the transcripts and provided contextual translations to preserve meaning and nuance. This positionality, situated within a shared cultural and linguistic context, allowed for a degree of

insider access, while also requiring ongoing reflexivity about the intersections of gender, race, language and professional knowledge in shaping knowledge production (Dwyer and Buckle, 2022).

Data analysis and application

In this study, Interpretive Phenomenological Analysis (IPA), a qualitative approach that seeks to explore and interpret the lived experiences of individuals within specific contexts, was adopted as a method of analysis. Specifically, IPA was selected to explore how healthcare workers in three hospitals in Eswatini made sense of COVID-19 vaccination as well as the impact on patient-provider communication. To accommodate the dynamics of focus group data, the analysis also draws on the adaptation of IPA for group settings as proposed by Love et al (2020). Focus group data was analysed first given that data from individual interviews was used mainly for triangulation purposes. Finally, to analyse the four interviews conducted at Mbabane Government Hospital, I followed the six step IPA process as outlined by Smith et al (2009).

Focus group data were collected on October 27, 2022, at Hlatikulu Government Hospital, while data collection commenced and was concluded on February 20, 2023, at the Raleigh Fitkin Memorial Hospital. While the sequential nature of data collection and data analysis across the three research sites was initially a logistical consideration due to the challenges outlined in Chapter Four, it proved to be a valuable methodological strength. This approach, consistent with the principles of sequential research design and progressive focusing in qualitative research, allowed for a deeper and more rigorous analysis of the data (Roller and Lavrakas, 2015; Simons, Lathlean and Squire, 2008). By completing the analysis of data from Hlatikulu Government Hospital, prior to proceeding to the other sites, I was able to clarify my understanding of key themes, and in turn, ensure the depth and relevance of subsequent data collection efforts.

Despite these advantages, this sequential approach was not without potential limitations. One of my main concerns was the potential for confirmation bias. Confirmation bias is a significant concern in research as it can subconsciously influence a researcher to seek out and interpret evidence that supports their existing beliefs while ignoring contradicting information (Motz and Wright, 2021; Koslowski, 2012). This selective process can threaten the validity of a study by potentially leading to distorted findings and unreliable conclusions (Schumm, 2021). However, by actively engaging in self-reflexivity and seeking out contradictory evidence,

researchers can mitigate this bias and uphold the rigour and trustworthiness of their work (Smith et al., 2009).

The interpretation of themes was guided by the Health Belief Model and Campinha-Bacote's Cultural Competence Framework, which provided a dual lens for understanding how participants' health related decisions were shaped by both individual perceptions of risk and broader cultural dynamics. A more detailed theoretical integration is presented in Chapter Six.

Steps Undertaken for IPA in Focus Group Discussions

As discussed in Chapter Four, a key consideration in the research design was the use of focus groups, which presents a methodological challenge to Interpretative Phenomenological Analysis (IPA)'s on individual, "discrete cases" (Smith et al., 2009 p. 51). To address this, this study followed an adapted framework for applying IPA to focus groups, as proposed by Love et al (2020). This adaptation allowed for a rigorous, systematic analysis that honours the ideographic commitment to each participant's unique experience while also interpreting the relational and collective sense-making that occurs within a group setting. The subsequent steps detail how this adapted approach was implemented in the analysis of the focus group.

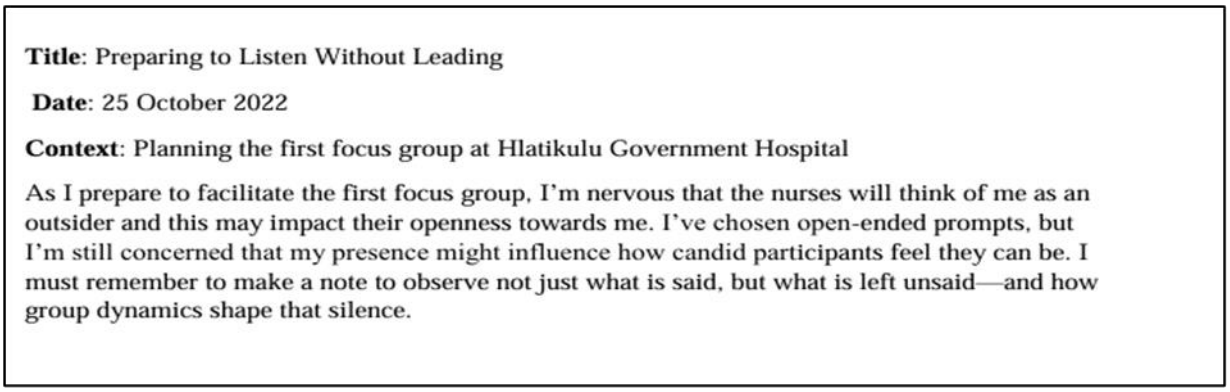
Step 1: Designing the Focus Groups with IPA Principles

Interpretative Phenomenological Analysis (IPA) is rooted in exploring how individuals make sense of their lived experiences (Smith et al., 2009). In adapting IPA for focus group discussions, Love et al (2020) emphasise the importance of purposeful sampling to ensure that participants share a relevant experiential context. Additionally;

> "The group must be constructed to allow for both individual expression and relational dynamics" (Love et al., 2020, p.4)

To this end, I purposively selected nurses who were working in the selected hospitals during the second wave of the COVID-19 pandemic in Eswatini, before COVID-19 vaccines became available. Additionally, I kept the two focus groups small, each with 8 participants, to allow each participant to contribute meaningfully, thus preserving the ideographic focus. At this point, I was already making entries into my reflexive journal. I used the reflexive journal continually to record my thoughts and document the analysis choices I was making at each step of the process.

Figure 5.1 My first entry in my reflexive journal.



Title: Preparing to Listen Without Leading

Date: 25 October 2022

Context: Planning the first focus group at Hlatikulu Government Hospital

As I prepare to facilitate the first focus group, I'm nervous that the nurses will think of me as an outsider and this may impact their openness towards me. I've chosen open-ended prompts, but I'm still concerned that my presence might influence how candid participants feel they can be. I must remember to make a note to observe not just what is said, but what is left unsaid—and how group dynamics shape that silence.

Step 2: Facilitating the Group Discussion

The facilitator plays a crucial role in balancing the natural flow of group interaction with the need to elicit rich personal narratives (Ennis and Chen, 2012). According to Love et al. (2020, p.6),

> "Facilitators must be attuned to the emergence of shared meaning while remaining sensitive to individual accounts".

Consequently, open-ended questions were used to prompt reflection while I, in my role as facilitator, monitored the discussion to ensure quieter voices were heard and dominant ones did not overshadow others.

Step 3: Transcription and Initial Engagement

When transcribing, it is essential to capture not only the verbatim dialogue but also the relational context in which the discussion occurred (Love et al., 2020). Therefore, transcripts must be verbatim and include non-verbal cues such as laughter, pauses and emotional inflexions (Landone, 2022). Transcribing one's own data is a critical practice in qualitative research, offering analytical and ethical advantages that contribute to the rigour and depth of the study (Lim, 2025). When researchers transcribe their own interviews or focus group recordings, they engage deeply with raw data, and this fosters understanding and nuances in speech, tone, pauses and emotional cues (Müller et al., 2005).

Consequently, I first transcribed the transcripts verbatim. In the case of this study, I retained original Siswati phrases in the transcripts and provided contextual translations to preserve meaning and nuance where relevant.

Figure 5:0:1 an excerpt of verbatim transcribed and translated into English.

Particpant B: Okay like nje besikucala lokutsi manje ke sekutwafuna sifake tifonyo, bekungajwayeleki. Sometimes besisikhohlwa, sometimes ube forced kusifaka noma utsandza noma ungatsandza. Kwaba nguletintfo leto nje, kwasitfusa sonkhe [translation: ***It was the first time that we would need to be constantly wearing masks, it was difficult to get used to. Sometimes we would forget, sometimes you would be forced to wear it, whether you wanted to or not. It was all those things and it scared us***]

Interviewer: Would this be emsebentini or even ekhaya?[translation: ***would this be only at work or also at home?***]

Parctipant C: Like besisiyisaba le Covid so botsi ngisho usekhaya usijikijekele vele sifonyo [translation: ***We were really afraid of COVID, so even if you were at home, you would wear the mask***]

From there, I annotated the transcripts with notes on group dynamics such as agreement, disagreement or shifts in tone to add depth to the analysis.

Figure 5:2 Notes showing an annotation of observations made on the use of language and group dynamics, such as agreement on the transcription of focus group discussions at Hlatikulu Government Hospital

***note:** use of we- indicates agreement regardless of who is speaking: suggests a shared experience of use of masks as prevention in the early days of COVID-19.*

Participant A refers to "they" to reference instructions to wear masks to protect against COVID- remember, instructions came from the Ministry of Health [Government] with guidance from WHO. Already evidence of them vs us- an indication of being left of planning and comms?

Despite the group setting, IPA's commitment to idiography requires that each participant's contributions be analysed independently. Therefore, the researcher engages in a double hermeneutic process, which involves interpreting how participants make sense of their experiences and how the researcher makes sense of those interpretations (Smith et al., 2009). Love et al., (2020, p.8) concur with this view and state:

"Each participant's narrative is treated as a distinct experiential account".

Figure 5:3 an excerpt of my reflexive journal entries illustrating individual level analysis.

Reflexive Journal Entry: Individual-Level Analysis

Date: 20 November 2022

Context: Focus group at Hlatikulu Government Hospital

Title: Tracing the Turning Point in Perception

Today I focused on one participant's narrative: *"Even then, we started getting seriously afraid when people started dying like flies… we did have the idea that they are being ridiculous and we won't wear masks… but then when we realized that people were dying in numbers, that's when we saw that it's serious."*

I isolated this contribution from the group discussion to honour IPA's idiographic commitment. Her words reflect a dramatic shift, from dismissiveness to fear, and I found myself interpreting this as a moment of collective awakening. But I had to pause. Was I reading this as a societal turning point because it aligns with my own memory of the pandemic's early days?

The phrase "dying like flies" is emotionally charged, even when stated in the local language, Siswati. It evokes panic, helplessness, and a loss of control. I noted how she used repetition—"that's when we realized… that's when we saw…" to emphasize the gravity of the moment.

In the double hermeneutic, I'm interpreting how she made sense of her experience, but I'm also aware that my own emotional response to this quote may shape its thematic weight. I'll revisit this when I have data the other research sites to ensure I'm not over interpreting or projecting.

This entry reminds me that even within a group, each participant's voice carries a distinct emotional arc, and it's my responsibility to trace it with care (***important to note this as I proceed***).

Step 5: Group - level analysis

After individual-level analysis, it is important for the researcher to undertake group-level analysis. At this level, I was able to develop themes through a process of interpretative analysis, informed by the research questions and conceptual orientation. This is in keeping with the view that themes do not simply emerge from the data but are actively constructed by the researcher through a reflexive and theoretically informed process (Morriss, 2024; Braun and Clarke, 2022; Byrne, 2022).

Thus, formulating and constructing thematic patterns includes identifying shared meanings, points of divergence and how group dynamics may have shaped the expression of the experience (Palmer et al., 2025). Therefore, group-level analysis "allows for the identification of collective sense-making processes" (Love et al., 2020, p. 9).

Figure 5:4 Reflexive Journal Entry -FDG Hlatikulu Government Hospital (30 Nov. 2022)

Reflexive Journal Entry: Group-Level Analysis Date:

30 November 2022

Focus Group: Hlatikulu Government Hospital

Theme: Constructing the Theme of Trauma & Emotional Strain

In analysing the transcript from the focus group at Hlatikulu Government Hospital, I was struck by how participants made sense of the shift to mandatory mask-wearing. One participant stated:

"It was the first time that we would need to be constantly wearing masks, it was difficult to get used to. Sometimes we would forget, sometimes you would be forced to wear it, whether you wanted to or not. It was all those things and it scared us."

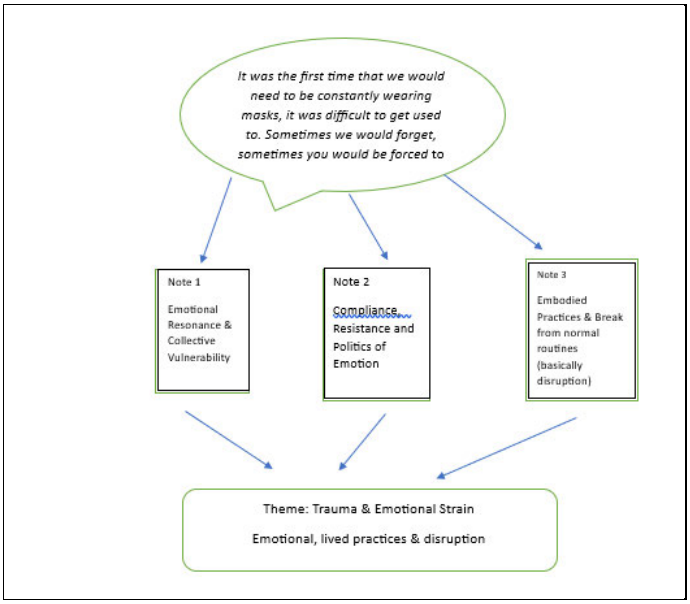
This quote resonated with others in the group **[seen through collective nods from all participants]**, who viewed masks not only as protective gear but also as symbols of fear, control, and disruption. The theme "Trauma & Emotional Strain" emerged to describe how physical practices like mask-wearing became emotionally charged and socially regulated. **There was a noticeable divergence in responses**. Some participants expressed resistance to the mandate, while others described compliance under pressure. The phrase "it scared us" was echoed by multiple voices, suggesting a shared emotional response that transcended individual experience. Group dynamics appeared to amplify this fear, reinforcing the idea that mask-wearing was not merely a behavioural adjustment but a deeply affective and symbolic shift.

I need to remain critically reflexive, recognising how my own interpretations are influenced by the emotional tone of the group and the broader context of the pandemic. ***Note for Later: Theme of Trauma & Emotional Strain" captures the intersection of policy, emotion, and social regulation, and reflects the complexity of public health communication in times of crisis.**

This reflexive journal entry is presented as evidence of the analytic process. It demonstrates how raw participant data from the focus group was interpreted through reflexive engagement, highlighting the emergence of the theme *Trauma and Emotional Strain.* By documenting both the participant quote and my reflection, the entry shows how meaning was constructed, how emotional responses were identified, and how group dynamics were considered. Including the journal entry in this way allows examiners to trace the analytic pathway from data to interpretation, reinforcing the transparency and rigour of the thematic analysis.

From this reflexive journal entry, the analysis progressed through the development of concise analytic memos. These memos captured distinct dimensions of the data; shared emotional resonance, the tension between compliance and resistance, and the physical disruption of everyday practices. Together, they provided the scaffolding for the theme *Trauma and Emotional Strain*. The following diagram visually maps this analytic pathway, showing how the journal entry informed the memos and how these strands converged into the final theme as illustrated below.

Figure 5:5 an example of analytic pathways from journal entry to theme development



Trauma was not imposed as a predetermined category but identified as a critical dimension through both the framing of the research questions and the lived accounts of participants. The guiding questions explicitly foregrounded trauma, stigma, and resilience as concepts central to understanding nurses' experiences, which directed the analytic lens toward these phenomena. At the same time, trauma emerged organically in the data, as participants narrated the psychological strain of working under conditions of uncertainty, loss, and heightened risk. This dual positioning, both anticipated in the inquiry and revealed in the narratives, ensured that trauma was treated not as an abstract construct but as a lived reality articulated by nurses themselves. In line with interpretative phenomenological analysis, the theme was therefore co-constructed through the interplay of researcher sensitivity and participant meaning-making, reinforcing its salience within the study.

Having established trauma, stigma, and resilience as themes that were both anticipated and emergent, the analysis proceeded to Step 6, where connections across cases were explored to deepen understanding of how these experiences were situated within broader institutional and cultural contexts.

Step 6: Developing Superordinate Themes

Themes are developed by integrating both individual and group-level insights. Superordinate themes reflect both personal and shared experiences, and are supported by illustrative quotes that demonstrate the richness of the data. This is important in IPA because "themes must

honour the complexity of individual and collective meaning-making processes" (Love et al., 2020, p.10).

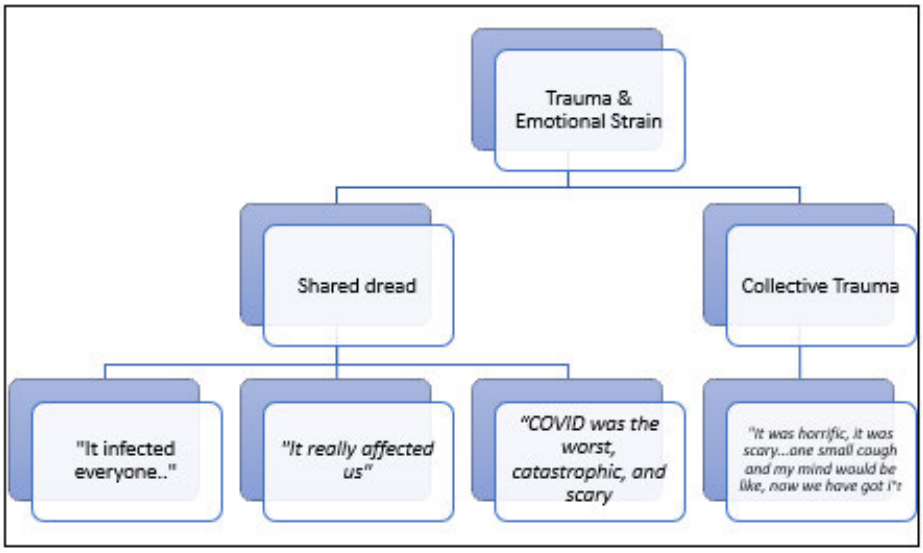
To demonstrate the analytic process underpinning the development of superordinate themes, the following table traces how individual and group-level insights were integrated into higher-order constructs. In line with IPA's emphasis on honouring both personal meaning-making and collective dynamics (Love et al., 2020), each theme is supported by illustrative quotes, analytic commentary, and evidence of convergence and divergence across sites. This structure makes visible the pathway from raw data to interpretation, showing how nurses' accounts of trauma, stigma, neglect, scepticism, cultural beliefs, communication gaps, and resilience were synthesised into the eight overarching themes presented in Chapter Six.

Table 5 Development of Superordinate themes from individual and group level insights.

Theme	Illustrative Quote(s)	Individual Insight	Group Insight	Interpretative Commentary
Trauma & Emotional Strain	"It was horrific, it was scary…one small cough and my mind would be like, now we have got it." (Nurse 2, MGH)	Personal anxiety and fear of infection	Shared dread amplified in collective discussions	Shows trauma as both internalised individually and reinforced collectively, forming a superordinate theme of emotional strain.
Stigma, Separation & Social Disruption	"I felt I was so stigmatised, discriminated, rejected and separated." (Nurse 3, RFM FGD)	Experience of rejection and isolation	Group recognition of stigma as cultural and institutional	Demonstrates stigma as convergent across sites but divergent in framing (social, institutional, cultural).
Institutional Neglect & Lack of Support	"We were used like rags…once your house is clean, you leave the rag outside." (Nurse 2, RFM FGD)	Feelings of exploitation and undervaluation	Collective frustration at lack of resources and recognition	Highlights neglect as systemic, undermining confidence and intensifying ethical dilemmas.
Professional Identity & Ethical Dilemmas	"For patients, I acted professional…I always made sure that I advise them well." (Nurse 1, MGH Interview)	Upholding duty despite uncertainty	Shared negotiation of ethical dilemmas in care	Shows resilience through professionalism, sacrifice, and dual caregiver/community identity.
Vaccine Efficacy & Scepticism	"It was never about cultural beliefs per se but…a solution comes in a space of less than a year." (Nurse 2, MGH Interview)	Biomedical scepticism about rushed development	Collective doubts reinforced by cultural remedies and myths	Demonstrates scepticism as negotiation between biomedical knowledge, cultural identity, and personal observation.
Cultural Context & Health Beliefs	"I feel like what worked was the steaming, and lemihlonyane. What we prescribed [vaccination] was not working." (Nurse 7, RFM FGD)	Reliance on traditional remedies	Shared cultural framings shaping vaccine uptake	Shows cultural identity as inseparable from health decisions, producing tensions with biomedical care.
Communication & Information Gaps	"It wasn't easy…as professional workers it was difficult to communicate with a client that they should get vaccinated because there was missing information." (Nurse 2, MGH Interview)	Uncertainty in advising patients	Group frustration with misinformation and fragmented training	Highlights communication failures as barriers to advocacy and trust.
Resilience & Dedication	"Nobody would voluntarily expose themselves to this stuff. We dedicated ourselves…we worked	Personal sacrifice and endurance	Collective solidarity and teamwork	Shows resilience as ethical and communal practice, sustaining healthcare delivery under strain.

To complement the analytic table, the following diagram visually maps the development of superordinate themes. It shows how individual accounts (e.g., fear of infection, reliance on remedies) were amplified or negotiated in group settings (e.g., shared dread, collective trauma), and how these insights converged into the eight overarching themes presented in Chapter 6. This dual presentation of text and visual evidence demonstrates the transparency and rigour of the analytic process.

Figure 5:6 Building Superordinate themes in IPA



This diagram illustrates how individual insights at the base were integrated into group-level dynamics and progressively built upward into superordinate themes. The upward orientation reflects the analytic process of moving from raw data to higher-order constructs. The diagram is oriented to reflect the process of building up from raw data into higher-order constructs. Individual insights form the foundation at the base, representing nurses' lived experiences captured in interviews and focus groups. These insights were then amplified or negotiated in group settings, producing collective framings that occupy the middle layer. Finally, these strands were synthesised into superordinate themes at the top, illustrating the culmination of the analytic process. The upward orientation underscores the interpretative progression in IPA, where meaning is constructed step by step, moving from particular accounts toward shared and integrated themes.

Having demonstrated how individual and group-level insights were integrated into superordinate themes, it is equally important to acknowledge the researcher's role in shaping this analytic process. IPA emphasises that meaning-making is co-constructed, and therefore transparency requires not only presenting participants' voices but also critically reflecting on how facilitation, interpretation, and positionality influenced the analysis. To ensure credibility, I maintained a reflexive journal that documented analytic decisions and moments of influence. The following section presents key reflections from this audit trail, illustrating how reflexivity

was embedded throughout the study to uphold interpretative integrity and honour the complexity of participants' accounts.

Step 7: Reflexivity and Transparency

Researchers must reflect on their own role in the research process, including how their facilitation and interpretation may have influenced the data (Jamieson et al., 2023; Dwyer and Buckle, 2022; Finlay, 2002). I was able to maintain an audit trail of analytic decisions by keeping a reflexive journal with the aim of enhancing transparency and credibility. This practice aligns with calls for transparency in qualitative research, where the researcher's positionality must be critically examined (Greene, 2014; Finlay, 2002).

To make reflexivity visible rather than abstract, I documented specific moments where my own role as researcher shaped the data collection and analysis process. These reflections were recorded in a reflexive journal and later organised into an audit trail. Table 6.2 presents selected examples, highlighting how my facilitation, assumptions, and positionality influenced meaning-making, and how deliberate strategies were employed to address these influences. By presenting these moments explicitly, the table demonstrates that reflexivity was embedded throughout the study, strengthening transparency and interpretative integrity.

While the table provides a structured overview of key reflexive moments and the strategies used to address them, excerpts from the reflexive journal offer a more textured account of how these reflections unfolded in practice. Presenting selected entries after the table allows the reader to see not only the analytic decisions but also the immediacy of my thought process. These excerpts illustrate the lived dimension of reflexivity, showing how positionality and interpretation were actively monitored and documented throughout the study.

Table 6 Key moments of reflexivity during data collection and analysis

Moment/Context	Researcher Reflection	Potential Impact on Data/Analysis	Strategy to Address It
Focus group at HGH (discussion on trauma)	I noticed I was steering the conversation toward trauma because of my own sensitivity to loss.	Risk of over-emphasising trauma and overlooking other themes such as resilience.	Re-read transcripts with attention to resilience; checked against memos to balance emphasis.
Interview at MGH (stigma narratives)	I realised my questions framed stigma as primarily social, which may have shaped participant responses.	Could narrow the framing of stigma to social aspects, missing institutional or cultural dimensions.	Compared across sites; triangulated with RFM and HGH data to broaden interpretation.
Analysis of cultural remedies (umhlonyane, steaming)	My personal scepticism toward traditional remedies made me initially dismiss these accounts.	Risk of undervaluing cultural framings and privileging biomedical perspectives.	Documented reflexive note; deliberately coded cultural remedies alongside biomedical scepticism to honour complexity.
Writing memos on institutional neglect	I felt frustration at accounts of neglect, which resonated with my own experiences of systemic weakness.	Could amplify negative institutional framings and overshadow nurses' resilience.	Used peer debriefing to check analytic balance; ensured resilience was coded as a counterpoint theme.

To complement the structured overview provided in Table 6.2 above, the following excerpts from my reflexive journal capture the immediacy of my thought process during data collection and analysis. These entries illustrate how reflexivity was lived in practice, revealing moments where my positionality shaped interpretation and how deliberate strategies were employed to uphold transparency and credibility.

Figure 5:7 selected journal entries showing moments of reflexivity during analysis

Reflexive Journal Entry: Group-Level Analysis Date:

Date: March 24, 2023

Focus Group: RFM

Theme: Institutional Neglect

Triggering account:

"We were not getting any support the point that we worked in the COVID wards, when the senior nurses [Sisters] fetch the reports…they just wait outside and maybe communicate that please put the books outside for me and I'll come. So, I just feel like we haven't been taken care of."

As I am doing the analysis of data towards this theme, I am shocked and frustrated at nurses' accounts of neglect. These resonate with my own experiences of systemic weakness even though I am in Education. We were also been given perfunctory training and told to return to work [university lecturer]. Despite being vaccinated, I remember being worried that I could contract COVID from students. I had to buy my own masks and sanitizers. UNESWA didn't show care for us as well.

NOTE TO SELF: I must be careful that this doesn't amplify negative framings in my analysis. To counter this, I will seek peer debriefing [Nolwazi helped collect data, she will be useful for this]. I feel that this was very unfair, but also recognise collective resilience. I must code resilience as a counterpoint theme.

Reflexive Journal Entry: Group-Level Analysis Date:

Date: April 2, 2023

Focus Group: RFM

Theme: Cultural Remedies

Interviwer: Okay, thank you Nurse 3. During COVID what did we believe to be working that we can promote, or that brought a speedy recovery.

Random participant: Steaming.

Nurse 4: I saw the Castle Milk Stout beer working.

Others: Yes, Castle Milk Stout (Laughing).

Nurse 4: They did not come to the hospital at all, even some that I know of. I am not sure on how true it is that COVID caused blood clots, given that alcohol thins blood, I think it helped them. Since if you were to be stebbed while drunk you bleed faster rather than… (inaudible on what he said next because they all started mumbling and talking together).

Participant: Stout was used all over, and those that took it survived.

Participant: Nemhlonyane/

When participants spoke about alcohol, steaming and umhlonyane, I initially dismissed these accounts as anecdotal. Especially because the Nurses at Hlatikulu were dismissive about it [using it themselves]- they did concede that patients use them and that they don't stand in the way of patients taking alternative medicine. In fact, they alluded to all of us in the group being "EmaSwati"; which draws on our cultural identity and understand.

I notice that at RFM, nurses were more open and treated the session as a counselling session. I do think they were more honest than nurses at MGH and HGH. **I wonder if it has to do with RFM not being a Government Hospital at all**

Together, the reflexivity table and journal excerpts demonstrate that researcher influence was not ignored but actively interrogated throughout the study. By documenting moments of positionality and responding with deliberate strategies, I was able to maintain an audit trail that strengthened transparency and credibility. This reflexive practice ensured that the interpretative process remained balanced, honouring both the complexity of participants' meaning-making and the methodological integrity of IPA. In doing so, reflexivity became not only a safeguard against bias but also a vital resource for deepening the analysis, laying a strong foundation for the discussion of findings that follows.

Having outlined the role of reflexivity and demonstrated how transparency was embedded throughout the analytic process, it is now important to turn to the practical steps that guided the application of IPA in the individual interviews. This section details the systematic procedures undertaken to ensure that participants' lived experiences were explored in depth, while maintaining methodological rigour and interpretative sensitivity. By presenting these steps explicitly, the analysis is situated within the established framework of IPA, showing how the study moved from data collection to the development of meaningful themes.

Steps undertaken for IPA in individual interviews

As stated in the previous chapter and earlier sections of this chapter, I adopted the six-step process for Interpretative Phenomenological Analysis (IPA) proposed by Smith et al (2009)

and systematically applied these to each of the four individual interviews conducted at the Mbabane Government Hospital.

While Smith, Flowers and Larkin's (2009) six-step IPA framework offers a structured approach to exploring lived experiences, its psychological orientation has been critiqued for privileging individual cognition over the socio-cultural context (Monaro et al, 2022). Scholars have argued that this version of IPA, though methodologically rigorous, may under-represent the relational, historical and ideological dimensions of meaning-making, which is central to interpretive and hermeneutic inquiry (Sharma, 2025; Langdridge, 2007; Finlay, 2002).

In response to these critiques, I adopted a critically reflexive adaptation of IPA to individual interviews by integrating insights from hermeneutic phenomenology and critical theory to deepen interpretive engagement. Specifically in the analytical process, I drew on Finlay's (2002) emphasis on reflexivity as a methodological imperative whereby my positionality, cultural identity and methodological stance were continuously interrogated throughout the interpretive process. Additionally, Dahlberg et al. (2008) shaped the approach by advocating for openness and sensitivity to emerging meanings, rather than a rigid bracketing of preconceptions.

This allowed for a dynamic interplay between the participants' narrative and my interpretive lens, in keeping with the hermeneutic circle (Moran, 2002). In addition, the analysis was situated within a critical framework that attends to power relations, institutional discourses and cultural embeddness, elements that are often overlooked in traditional psychological interpretations of IPA. By incorporating these adaptations, this study preserves IPA's idiographic commitment while expanding its interpretive depth to account for the complex and contextually situated experiences of healthcare workers in Eswatini. Two interviews were conducted on May 29, 2023 due to the availability of the two nurses on this day. One interview was conducted on May 30, 2023 and the final interview was conducted on May 31, 2023. Each interview was 45 minutes long. Each of the interviews was transcribed verbatim before the commencement of data analysis.

From there, the six-step process went as follows:

Step 1: Reading and Re-reading

After transcription and translation of each of the audio recordings of the individual interviews, the initial phase involved repeated engagement with each transcript to facilitate immersion in

the participants' narrative world. Immersion sets the stage for initial noting, where the researcher begins to annotate the transcript with descriptive, linguistic and conceptual comments (Monaro et al, 2022). This iterative process allowed for a holistic understanding of the various accounts before I attempted any analytical abstraction (Smith et al, 2009). Early readings focused on grasping the emotional tone and narrative flow, while subsequent readings focused on subtle linguistic cues, pauses and emphasis that signaled deeper meaning (Eatough and Smith, 2017).

Step 2: Initial Noting

This step entailed a detailed annotation of the transcripts, capturing three layers of insight: descriptive, linguistic, and conceptual. Descriptive notes focused on the content of what was said, linguistic notes focused on the participants' choice of words, metaphors and syntax, while conceptual notes reflected my interpretive engagement with the data (Smith and Osborn, 2015; 2008). To demonstrate the analytic process in this step, I have included worked examples from the transcripts. These tables and excerpts illustrate how I made descriptive, linguistic and conceptual notes on selected passages of participant data. The purpose of these examples is not to present the entire dataset, but to show transparently how I constructed meaning through layered annotation. By juxtaposing the raw transcript excerpts with my notes, the tables make visible the interpretative steps that underpin the later clustering of emergent themes into superordinate categories.

In addition to the tables, I have included images of the translated annotated transcripts. These provide further evidence of rigor of the process showing how notes were captured and how the hermeneutic circle was enacted through iterative engagement with both parts of the text and the whole. Together, the tables and excerpts serve as methodological exemplars, allowing the reader to see how the analytic framework was applied consistently across all interviews.

Consequently, I made notes within the text, taking care to capture descriptive comments (what was said), linguistic observations (how it was said), and conceptual reflections (why it might have been said and my thoughts on this). These notes (captured in red text in the excerpt below) served as the foundation for deeper interpretative work, allowing me to engage with the participants' meaning-making process.

This process was informed by the hermeneutic circle, wherein understanding is developed through a dynamic interplay between parts of the text and the whole (Kafle, 2011; Moran, 2002). My positionality, as both outsider and insider, was reflexively acknowledged during this

stage, ensuring that interpretations were critically examined and contextually grounded (Holmes, 2020; Berger, 2015).

Table 7 shows an example of Initial Noting (Nurse 4: Male Surgical Ward, MGH Transcript

Transcript Excerpt	**Descriptive Notes (what was said)**	**Linguistic Notes (how it was said)**	**Conceptual Notes (why / interpretive engagement)**
"The pandemic… it opened our eyes on how our health system is weak or needs to be upgraded."	Participant describes pandemic as "eye-opening." Identifies systemic weakness and lack of preparedness.	Metaphor: "opened our eyes" conveys revelation. Repetition of "weak" and "needs" emphasises fragility and urgency. Syntax is flowing, suggesting emotional intensity.	Pandemic framed as catalyst for awareness, not just health crisis. Reflects professional identity as witness to systemic gaps. Raises question: does "eye-opening" imply hope for reform or despair at fragility?
"It was scary, very scary… people were dying left and right." (Female Surgical Ward)	Participant emphasises fear and mortality. Observes frequent deaths among patients and colleagues.	Repetition: "scary, very scary" intensifies emotional tone. Colloquial phrase "left and right" conveys overwhelming frequency.	Fear grounded in lived experience of witnessing death. Language conveys trauma and exhaustion. Raises question: how does repeated exposure to death shape resilience or burnout?

Table 8 another example of Initial Noting (Nurse 3: Gynae Department MGH Transcript)

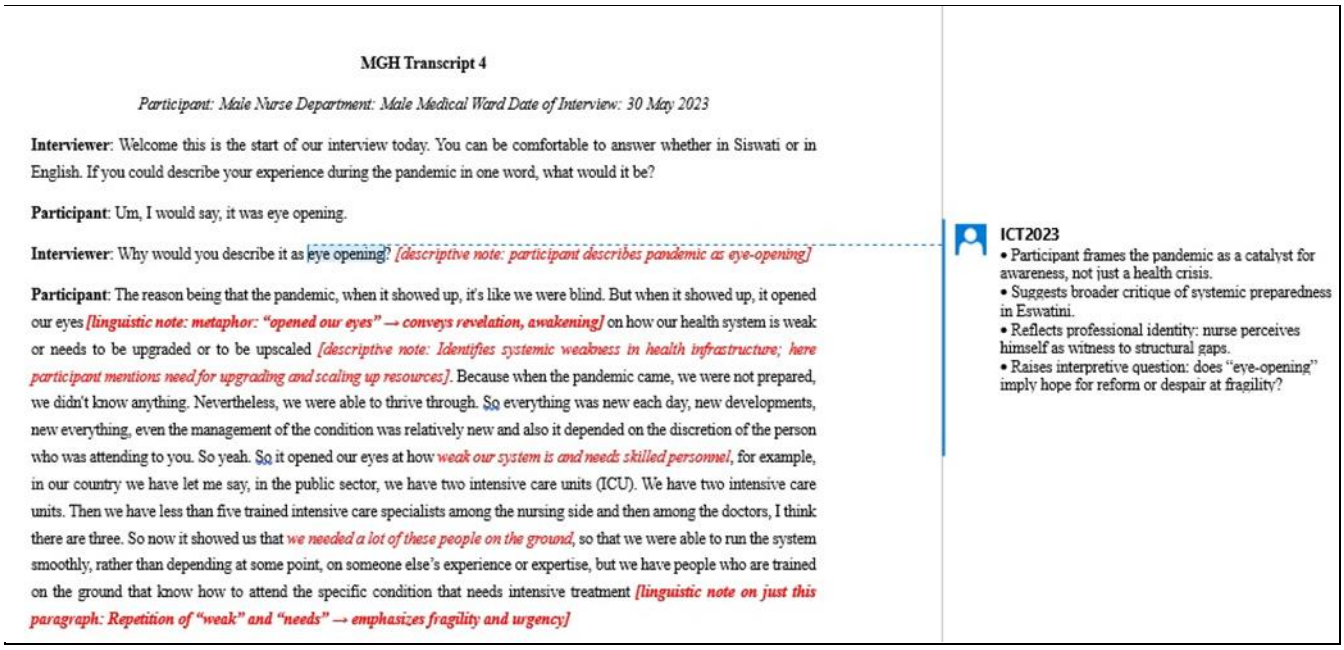
Transcript Excerpt	**Descriptive Notes (what was said)**	**Linguistic Notes (how it was said)**	**Conceptual Notes (why / interpretive engagement)**
"It was scary, very scary… people were dying left and right."	Participant emphasises fear and mortality. Observes frequent deaths among patients and colleagues.	Repetition: "scary, very scary" intensifies emotional tone. Colloquial phrase "left and right" conveys overwhelming frequency.	Fear grounded in lived experience of witnessing death. Language conveys trauma and emotional exhaustion. Raises interpretive question: how does repeated exposure to death shape resilience or burnout?

While the tables provide a structured overview of how descriptive, linguistic, and conceptual notes were layered onto selected passages, the transcript excerpts offer a closer view of this process in action. By presenting the annotated transcripts themselves, the reader can see how observations were captured directly within the text, making visible the iterative engagement

between parts and whole that characterises the hermeneutic circle. These excerpts therefore complement the tables by illustrating the immediacy of the analytic work, showing how meaning was constructed through detailed annotation and reflexive interpretation.

The following transcript excerpts, annotated with descriptive, linguistic, and conceptual notes, provide a close-up view of how meaning was constructed through layered engagement with the data. By embedding reflections directly within the text, these examples make visible the iterative process of interpretation and demonstrate how the hermeneutic circle was enacted in practice.

Figure 5:8 excerpts of two of the four interviews conducted at Mbabane Government Hospital



MGH Transcript 4

Participant: Male Nurse Department: Male Medical Ward Date of Interview: 30 May 2023

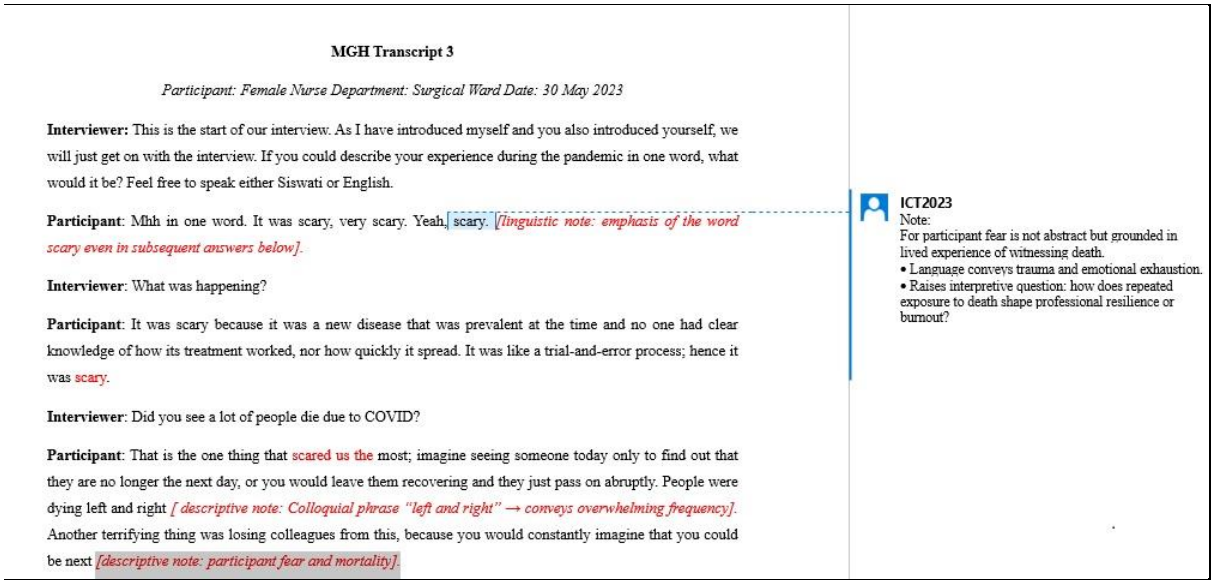
Interviewer: Welcome this is the start of our interview today. You can be comfortable to answer whether in Siswati or in English. If you could describe your experience during the pandemic in one word, what would it be?

Participant: Um, I would say, it was eye opening.

Interviewer: Why would you describe it as eye opening? *[descriptive note: participant describes pandemic as eye-opening]*

Participant: The reason being that the pandemic, when it showed up, it's like we were blind. But when it showed up, it opened our eyes ***[linguistic note: metaphor: "opened our eyes" → conveys revelation, awakening]*** on how our health system is weak or needs to be upgraded or to be upscaled *[descriptive note: Identifies systemic weakness in health infrastructure; here participant mentions need for upgrading and scaling up resources]*. Because when the pandemic came, we were not prepared, we didn't know anything. Nevertheless, we were able to thrive through. So everything was new each day, new developments, new everything, even the management of the condition was relatively new and also it depended on the discretion of the person who was attending to you. So yeah. So it opened our eyes at how *weak our system is and needs skilled personnel*, for example, in our country we have let me say, in the public sector, we have two intensive care units (ICU). We have two intensive care units. Then we have less than five trained intensive care specialists among the nursing side and then among the doctors, I think there are three. So now it showed us that *we needed a lot of these people on the ground*, so that we were able to run the system smoothly, rather than depending at some point, on someone else's experience or expertise, but we have people who are trained on the ground that know how to attend the specific condition that needs intensive treatment ***[linguistic note on just this paragraph: Repetition of "weak" and "needs" → emphasizes fragility and urgency]***

ICT2023
- Participant frames the pandemic as a catalyst for awareness, not just a health crisis.
- Suggests broader critique of systemic preparedness in Eswatini.
- Reflects professional identity: nurse perceives himself as witness to structural gaps.
- Raises interpretive question: does "eye-opening" imply hope for reform or despair at fragility?



MGH Transcript 3

Participant: Female Nurse Department: Surgical Ward Date: 30 May 2023

Interviewer: This is the start of our interview. As I have introduced myself and you also introduced yourself, we will just get on with the interview. If you could describe your experience during the pandemic in one word, what would it be? Feel free to speak either Siswati or English.

Participant: Mhh in one word. It was scary, very scary. Yeah, scary. *[linguistic note: emphasis of the word scary even in subsequent answers below].*

Interviewer: What was happening?

Participant: It was scary because it was a new disease that was prevalent at the time and no one had clear knowledge of how its treatment worked, nor how quickly it spread. It was like a trial-and-error process; hence it was scary.

Interviewer: Did you see a lot of people die due to COVID?

Participant: That is the one thing that scared us the most; imagine seeing someone today only to find out that they are no longer the next day, or you would leave them recovering and they just pass on abruptly. People were dying left and right *[descriptive note: Colloquial phrase "left and right" → conveys overwhelming frequency].* Another terrifying thing was losing colleagues from this, because you would constantly imagine that you could be next *[descriptive note: participant fear and mortality].*

ICT2023
Note:
For participant fear is not abstract but grounded in lived experience of witnessing death.
- Language conveys trauma and emotional exhaustion.
- Raises interpretive question: how does repeated exposure to death shape professional resilience or burnout?

The red text in the transcript represents my initial analytic notes, captured during Step 2 of IPA: initial noting. These annotations reflect three layers of engagement with the data. First, descriptive notes identify what was said; for example, the phrase "*left and right*" was flagged as a colloquial expression conveying the overwhelming frequency of death. Second, linguistic notes attend to how things were said; such as the repeated emphasis on the word "*scary*," which signals emotional intensity and sets the tone for the narrative. Third, conceptual notes reflect my interpretative engagement with the data, where I began to ask deeper questions about meaning; such as how repeated exposure to death might shape professional resilience or contribute to burnout. These notes were not merely observational but formed the foundation for later theme development, allowing me to move from surface content to deeper psychological and contextual insights.

Step 3: Developing Themes

From the annotated transcripts, I constructed themes that outlined significant experiential elements within each transcript. These themes were grounded in the participants' own words but abstracted to reflect broader socio-cultural meanings (Smith et al., 2009). Following the initial annotation of all the transcripts, I constructed themes to capture significant experiential elements within each participant's account.

This process was guided by close engagement with the data and informed by the conceptual lenses of the Health Belief Model and Campinha-Bacote's Cultural Competence Framework. Rather than relying on software or automated coding, I developed themes manually through a reflective and iterative process. Key phrases, patterns, and emotional tones were identified and

interpreted in light of the participants' socio-cultural contexts. Each interview was treated as a discrete case; however, for purposes of illustrating my process, I have sourced quotes from each case to illustrate theme development.

To illustrate this process, the following examples present transcript excerpts alongside descriptive, linguistic and conceptual notes. They also show how these informed the development of emergent themes.

These tables, together with images of my annotated transcripts, provide transparency and demonstrate the analytic chain of evidence underpinning theme construction.

Table 5.5 shows the development of themes (Nurse 3: Female Surgical Ward)

Table 9 development of themes MGH Trancript

Transcript Excerpt	Notes (Descriptive, Linguistic, Conceptual)	Emergent Theme
"It was scary, very scary… people were dying left and right."	**Descriptive:** Participant emphasizes fear and mortality, observing frequent deaths. **Linguistic:** Repetition "scary, very scary" intensifies tone; colloquial "left and right" conveys overwhelming frequency **Conceptual:** Fear grounded in lived experience of witnessing death; language conveys trauma and exhaustion; raises question of resilience vs. burnout.	**Trauma and Emotional Strain**
"I remembered my oath… so I volunteered at the isolation center."	**Descriptive:** Participant recalls professional commitment, volunteering despite risk. **Linguistic:** Invocation of "oath" signals solemn duty; verb "volunteered" highlights agency. **Conceptual:** Professional identity anchors resilience; moral obligation overrides fear; illustrates ethical responsibility.	**Resilience and Dedication**
"I was hesitant… but because I needed to travel, I took the vaccine."	**Descriptive:** Participant admits reluctance; decision influenced by external requirement (travel). **Linguistic:** Pause marker "…" conveys hesitation; contrast between "hesitant" and "I took" highlights tension; declarative syntax underscores pragmatic compliance. **Conceptual:** Vaccine uptake framed as pragmatic rather than trust-based; compliance driven by necessity, not conviction; raises	**Vaccine Efficacy and Scepticism**

	question of external pressures shaping health decisions.	

Table 10 Development of Themes MGH Transcript

Transcript Excerpt	Notes (Descriptive, Linguistic, Conceptual)	Emergent Theme
"The pandemic… it opened our eyes on how our health system is weak or needs to be upgraded."	**Descriptive:** Participant describes pandemic as "eye-opening," highlighting systemic weakness and lack of preparedness. **Linguistic:** Metaphor "opened our eyes" conveys revelation; repetition of "weak" and "needs" emphasizes fragility and urgency; flowing syntax suggests emotional intensity. **Conceptual:** Pandemic framed as catalyst for awareness, not just a health crisis. Reflects professional identity as witness to systemic gaps. Raises interpretive question: does "eye-opening" imply hope for reform or despair at fragility?	**Institutional Neglect and Lack of Support**
"Why do we have a vaccine so quick? Yet HIV has been in existence for 40 years… but we don't have a vaccine for HIV."	**Descriptive:** Participant questions speed of COVID-19 vaccine development; compares to HIV vaccine absence. **Linguistic:** Rhetorical question "Why…?" conveys doubt; contrastive "yet HIV…" highlights perceived inconsistency; repetition of "vaccine" underscores fixation on legitimacy. **Conceptual:** Scepticism rooted in perceived mismatch between scientific timelines; reflects broader distrust in institutional processes. Raises interpretive question: does rapid development undermine trust even when scientifically justified?	**Vaccine Efficacy and Scepticism**
"We were given adverse reaction forms to fill… but no one would collect them."	**Descriptive:** Participant describes reporting system for vaccine side effects; notes lack of follow-up. **Linguistic:** Passive construction "no one would collect them" conveys neglect; ellipsis (…) suggests frustration or resignation. **Conceptual:** Highlights systemic weakness in monitoring; reflects perception of institutional indifference, reinforcing hesitancy. Raises interpretive question: how does lack of feedback loop erode trust in health system?	**Institutional Neglect and Lack of Support**

Having demonstrated how descriptive, linguistic, and conceptual notes were layered onto the transcripts, the next step was to move from these detailed annotations toward the clustering of emergent themes. To illustrate this analytic progression, I draw on the constructs of the Health

Belief Model as an example framework. By mapping participants' accounts onto dimensions such as perceived susceptibility, perceived severity, perceived benefits, and perceived barriers, the table below shows how raw data and initial notes were transformed into higher-order themes. This process highlights the interpretative movement from individual meaning-making to conceptual categories, making visible how theoretical constructs were used to organise and deepen the analysis.

This table illustrates how participant quotes were interpreted through the lens of the Health Belief Model, specifically focusing on perceived susceptibility and perceived barriers. Initial interpretations reflect the analytic movement from raw data to conceptual insight, while the developed themes demonstrate how theoretical constructs were used to organise meaning and support theme development. The table exemplifies how individual experiences were systematically clustered into higher-order categories, contributing to the broader analytic framework of the study.

Table 11 Mapping Participant Narratives onto Health Belief Model Constructs

HBM Construct	Participant Quote	Initial Interpretation	Developed theme
Perceived susceptibility	"I was definitely at risk because they put me in the COVID ward" (Nurse 2 - Mbabane Gov)	Acknowledgement of direct exposure and institutional assignment as a source of vulnerability.	Institutional Neglect & Lack of Support
	"I worked in the COVID wards from wave 1 to wave 5, and this had a negative bearing on me. I was working awkward hours and spending too much time at work" (Nurse 1-Mbabane Government Hospital)	Perceived vulnerability due to inadequate PPE and improvisation under pressure	Institutional Neglect & Lack of Support
Perceived Barriers	"Did you see how fast those vaccines came out? I want to be sure about them. So I waited to take the vaccine" Nurse 4, Mbabane Government Hospital	Concerns over rapid development and perceived lack of testing	Professional Identity & Ethical Dilemmas
	"With those first vaccines, we saw a lot of people die. Someone would come and get the vaccine and next thing they are gasping for air or hear that they have died. For some time, it seemed as if it was the vaccines themselves killing people. This made me put it off as much as possible. I was grateful that we were not forced to get the vaccine" Nurse 2, Hlatikulu Government Hospital	Fear stemming from anecdotal reports of adverse outcomes	Professional Identity & Ethical Dilemmas
	"You know what, I didn't get vaccinated because I trusted the vaccines. I got vaccinated because I had been allocated to the COVID ward and I was terrified to die. I thought, let me get vaccinated in case I get COVID" Nurse 2, HGH	Fear of death and occupational exposure served as a powerful internal motivation	Vaccine Efficacy & Scepticism

	It was different for me. I was working at the COVID ward and I got sick. I had contracted COVID and was very very sick. When I recovered, they brought me back to the COVID ward and so, because I had already suffered from COVID, I got vaccinated…" Nurse 5, RFM	Personal experience of severe illness prompted vaccination, despite lingering doubts and side effects.	Vaccine Efficacy & Scepticism
Self-Efficacy	"…But even now, I don't know if it was worth it because I have serious side effects. I can nolonger breathe well and I worry that in a few months I will need to get on oxygen. I'm afraid to take tests, I'm just not ok…" Nurse B, Mbabane Government Hospital	Low confidence in managing post-vaccine health complications; emotional distress undermining perceived control	Cultural Context & Health Beliefs
Perceived Severity	"No one would have voluntarily exposed themselves to this thing, but we were working with people who were infected, even people we knew and saw many of them die, but we had no equipment. But we worked in those conditions" Nurse 3- RFM	Commitment despite doubts, solidarity	Resilience & Dedication
	"In the first wave, there came a time where even the gear we were using to protect ourselves ran out. Do you remember cloth masks? We would end up washing these to ensure we could keep working. Disposable masks at this point were nolonger being supplied." Nurse C- Mbabane Government Hospital	Commitment despite doubts, solidarity	Resilience & Dedication

By organising participant narratives through the constructs of the Health Belief Model, this table demonstrates how theoretical framing supported the clustering of developed themes. The movement from initial interpretation to developed themes reflects the analytic process of abstraction, where individual experiences were grouped into higher-order categories. These conceptual clusters laid the groundwork for identifying superordinate themes across interviews, allowing for a deeper understanding of how health beliefs shaped participants' responses to risk, institutional support, and vaccine decision-making.

Building on the thematic development illustrated through the Health Belief Model, the next analytic stage involved searching for connections across themes. This process required moving beyond individual constructs to examine how themes intersected, overlapped, and sometimes contradicted one another. By mapping these interrelationships, I was able to identify hierarchies and broader categories that captured the complexity of participants' experiences. To deepen interpretation, the analysis was situated within both the Health Belief Model and Campinha-Bacote's Cultural Competence framework, allowing theoretical insights to inform the clustering of themes.

The integration of the Health Belief Model with Campinha-Bacote's Cultural Competence framework in the table reflects the dual dimensions of nurses' meaning-making during the pandemic. While the HBM provided a behavioural lens to interpret perceptions of susceptibility, severity, benefits, barriers, cues to action, and self-efficacy, it did not fully

capture the cultural and relational contexts that shaped these perceptions. Campinha-Bacote's framework complemented this by foregrounding cultural awareness, knowledge, skill, encounters, and desire, thereby situating nurses' experiences within their broader social and cultural realities. Presenting the two frameworks together demonstrates how behavioural and cultural constructs intersected in practice, offering a richer and more nuanced interpretation of the superordinate themes.

Table 12 Superordinate Themes Emerging Across HBM and Campinha-Bacote Model Constructs

Superordinate Theme	HBM Construct(s)	Campinha-Bacote Construct(s)	Illustrative Quote(s)	Interpretative Commentary
Trauma & Emotional Strain	Susceptibility / Severity	Cultural Encounters	*"Imagine seeing someone today only to find out they are no longer the next day."* (Nurse 3, MGH)	Trauma framed through risk perception and repeated cultural encounters with death; communal grieving disrupted.
Stigma, Separation & Social Disruption	Perceived Barriers	Cultural Awareness / Cultural Knowledge	*"At home, I stopped my elders from vaccinating…others developed sugar diabetes due to it."* (Nurse 3, HGH)	Stigma shaped by cultural narratives; nurses reflexively aware of their dual role as caregivers and community members.
Institutional Neglect & Lack of Support	Cues to Action / Self-Efficacy	Cultural Skill	*"We were used like rags…once your house is clean, you leave the rag outside."* (Nurse 2, RFM)	Neglect undermined self-efficacy; nurses improvised care without institutional support, requiring culturally sensitive skill in resource-poor settings.
Professional Identity & Ethical Dilemmas	Benefits vs Barriers	Cultural Awareness / Cultural Desire	*"We had to choose between our families and our patients, and sometimes it felt impossible."* (Nurse 3, MGH)	Ethical dilemmas reflected awareness of cultural obligations and desire to uphold professional duty despite risks.
Vaccine Efficacy & Scepticism	Perceived Barriers / Benefits	Cultural Knowledge	*"We used steaming and traditional herbs, and they worked for us."* (Nurse 7, HGH)	Scepticism grounded in cultural knowledge of remedies; biomedical and indigenous practices intersected in meaning-making.
Cultural Context & Health Beliefs	Perceived Barriers / Cues to Action	Cultural Knowledge / Cultural Encounters	*"As a Swazi you grow up knowing that as a man you go to hospital when things are bad."* (Nurse 1, MGH)	Masculinity norms and cultural encounters shaped vaccine uptake; cultural competence lens highlights need for contextual engagement.
Communication & Information Gaps	Cues to Action / Self-Efficacy	Cultural Skill / Cultural Awareness	*"There was no formal training…it would be just discussions."* (Nurse 1, MGH)	Communication failures weakened cues to action; nurses needed cultural skill to navigate misinformation and patient beliefs.
Resilience & Dedication	Self-Efficacy / Benefits	Cultural Desire / Cultural Encounters	*"Our strength was in being together, not alone."* (Nurse 5, HGH)	Resilience sustained through cultural desire for solidarity and repeated encounters with community expectations.

By combining the Health Belief Model with Campinha-Bacote's Cultural Competence framework, the table demonstrates how behavioural perceptions and cultural contexts were interpreted together, ensuring that the superordinate themes remained grounded in participants' lived experiences while also situated within broader theoretical lenses. This integration reflects IPA's emphasis on moving from detailed accounts to layered interpretation, showing how meaning was co-constructed across individual, institutional, and cultural dimensions.

Having established superordinate themes across constructs, the analysis then returned to the idiographic focus that is central to IPA. To preserve the individuality of each participant's account, every interview was treated as a discrete case. This ensured that the unique context and meaning of each narrative were honoured before any attempt was made to synthesise findings across participants. In this way, the analytic process remained faithful to IPA's commitment to depth and detail, allowing each case to stand on its own terms before moving toward broader patterns

Step 5: Moving to the Next Case

Each interview was treated as a discrete case analysed independently to preserve Interpretive Phenomenological Analysis' ideographic commitment (Pietkiewicz and Smith, 2014). Put simply, this means that I considered each interview transcript as a complete and separate unit of analysis. This allowed me to focus on one participant's narrative at a time as opposed to merging all the interview data together into a single large text. This ensured that the unique context and meaning of each participant's experience was honoured before any cross-case synthesis was attempted (Smith et al., 2009). As illustrated in Chapter Six, the presentation of themes with site-specific quotations demonstrates this idiographic focus, showing how each case was analysed in depth before connections across cases were explored.

Once the individual case analyses were completed, the next stage involved examining connections across cases. This step marked the analytic shift from idiographic detail to cross-case synthesis, where shared themes, divergent perspectives, and contextual influences were identified. By mapping convergence and divergence, the analysis highlighted how meaning was co-constructed across different institutional and cultural settings, while remaining sensitive to the distinctiveness of each participant's voice. This stage therefore deepened interpretation by situating individual experiences within collective patterns of sense-making.

This cross-case synthesis provided the foundation for addressing the study's research questions, revealing how nurses' perceptions of COVID-19 vaccination were influenced by

behavioural constructs and cultural contexts. These patterns are critically interpreted in Chapter Seven, where the findings are situated within the Health Belief Model and Campinha-Bacote's Cultural Competence framework to deepen theoretical and policy insights.

Step 6: Looking for Patterns across Cases

Once individual analyses were completed, patterns across the four cases were examined (Smith et al., 2009). This involved identifying shared themes, divergent perspectives, and contextual influences that shaped how nurses made sense of COVID-19 vaccination. The process remained sensitive to both convergence and divergence, recognizing that meaning is co-constructed and contextually situated (Denzin and Lincoln, 2018; Finlay, 2002).

Once individual analyses were completed, the next stage involved examining connections across cases. This step marked the analytic shift from idiographic detail to cross-case synthesis, where shared themes, divergent perspectives, and contextual influences were identified. By mapping convergence and divergence, the analysis highlighted how meaning was co-constructed across different institutional and cultural settings, while remaining sensitive to the distinctiveness of each participant's voice. As discussed in Chapter Seven, these cross-case patterns are critically interpreted through the Health Belief Model and Campinha-Bacote's Cultural Competence framework, situating the findings within broader theoretical and policy debates.

Together, the cross-case analysis highlighted both convergence and divergence in how nurses made sense of COVID-19 vaccination. While shared themes such as trauma, stigma, neglect, and resilience cut across sites, the framing of these experiences was deeply influenced by institutional contexts and cultural narratives. This synthesis therefore reinforced the layered nature of meaning-making, where behavioural perceptions and cultural identities intersected to produce complex understandings of vaccination.

Conclusion

This chapter has traced the analytic journey from individual transcripts to the identification of overarching themes and their organisation into superordinate categories. The process remained faithful to the idiographic commitment of Interpretative Phenomenological Analysis, ensuring that each case was examined in depth before connections were sought across participants. By moving systematically through the analytic steps, the chapter demonstrated how meaning was

constructed at multiple levels: within individual narratives, across thematic clusters, and ultimately through cross-case synthesis.

The use of the Health Belief Model provided a behavioural lens through which perceptions of susceptibility, severity, benefits, barriers, cues to action, and self-efficacy could be organised. At the same time, Campinha-Bacote's Cultural Competence framework offered a complementary perspective, foregrounding cultural awareness, knowledge, skill, encounters, and desire. Integrating these frameworks within the analytic process allowed for a more layered interpretation, situating nurses' accounts not only within behavioural constructs but also within cultural and relational contexts. This dual orientation strengthened the analysis by highlighting how behavioural perceptions were inseparable from cultural identity and institutional structures.

Critically, the analytic process revealed that themes were not discrete but interconnected. Trauma overlapped with stigma, neglect was entangled with resilience, and communication gaps intersected with cultural health beliefs. These interrelationships underscored the importance of mapping connections across themes rather than treating them as isolated categories. The analytic steps therefore moved beyond description to show how meaning was co-constructed across personal, institutional, and cultural dimensions.

CHAPTER SIX

FINDINGS

Introduction

This chapter presents the empirical findings of the study, drawn from two focus group discussions and four individual interviews with nurses at Raleigh Fitkin Memorial Hospital (RFM), Mbabane Government Hospital (MGH), and Hlatikulu Government Hospital (HGH). Guided by Interpretative Phenomenological Analysis (IPA), the analysis explores how participants made sense of their lived experiences with COVID-19 vaccination.

The findings are organised thematically across eight overarching themes, allowing for a holistic account of nurses' perceptions, concerns, and roles while attending to contextual differences in how these were expressed. Each theme is examined in depth and supported by direct quotations to preserve authenticity. The analysis highlights both convergences, where experiences were shared across sites, and divergence, where institutional and cultural contexts shaped distinct framings.

Some narratives inevitably straddle multiple themes, reflecting the complexity of nurses' experiences. Issues such as institutional neglect, cultural health beliefs, communication gaps, and resilience were not encountered in isolation but intertwined in practice. A single account might describe shortages of protective equipment while also revealing trauma or improvisation, illustrating how structural, cultural, and personal dimensions of care were deeply interconnected. This overlap strengthens the analysis by demonstrating the layered nature of nurses' perceptions and responses.

The findings are presented descriptively, with interpretation and theoretical integration reserved for Chapter Seven, the Discussion chapter. The next section presents the findings in detail, organised thematically to capture both shared and divergent experiences across sites.

Overarching Themes that Emerged Across All Transcripts

Building on the introduction, this section presents the eight overarching themes identified from the focus group discussions and interviews conducted at Raleigh Fitkin Memorial Hospital (RFM), Mbabane Government Hospital (MGH), and Hlatikulu Government Hospital (HGH). These themes capture the breadth of nurses' perceptions, experiences, concerns, and roles in relation to COVID-19 vaccination. Presenting them collectively highlights the common threads that cut across sites while also drawing attention to the contextual differences that shaped how

these experiences were expressed. Each theme is examined in detail in the sections that follow, supported by direct quotations to preserve the authenticity of participants' voices.

Table 13 illustrates an overview of overarching themes across the three research sites

Theme	Core Meaning	Cross-Site Expression
Trauma and Emotional Strain	Emotional overwhelm, fear, psychological distress	RFM: linked to stigma; MGH: fear of infection; Hlatikulu: grief and cultural disruption
Stigma, Separation and Social Disruption	Social rejection, isolation, cultural disruption	RFM: stigma in hospital; MGH: isolation from family; Hlatikulu: disrupted funerals/rituals
Institutional Neglect and Lack of Support	Lack of recognition, inadequate resources	RFM: no allowances, symbolic rewards; MGH: fragmented training; Hlatikulu: shortages of PPE
Professional Identity and Ethical Dilemmas	Balancing duty with skepticism	RFM: ethical sacrifice; MGH: professionalism in communication; Hlatikulu: dual caregiver/community identity
Vaccine Efficacy and Scepticism	Doubts about safety, efficacy, rushed development	RFM: adverse outcomes; MGH: biomedical trial scepticism; Hlatikulu: myths and remedies
Cultural Context and Health Beliefs	Traditional remedies, cultural norms shaping uptake	RFM: remedies vs biomedical care; MGH: masculinity norms; Hlatikulu: funeral disruptions
Communication and Information Gaps	Fragmented training, misinformation	RFM: patient mistrust; MGH: peer reliance; Hlatikulu: difficulty debunking myths
Resilience and Dedication	Commitment despite doubts, solidarity	RFM: sacrifice and frustration; MGH: teamwork; Hlatikulu: community solidarity

The thematic matrix above provides a comparative overview of the eight overarching themes across hospital sites, highlighting both convergence and divergence in nurses' perceptions, experiences, concerns, and roles. While the table offers a concise snapshot, the narrative sections that follow expand on these themes in greater depth. This structure ensures that the findings are not only visually summarised but also richly contextualised through direct quotations and detailed accounts, capturing the nuances of how institutional settings and cultural contexts shaped nurses' voices during the pandemic.

Having outlined the themes in summary form, the next section examines each in detail.

Theme 1: Trauma and Emotional Strain

Trauma and emotional strain were central to nurses' experiences across all sites, influencing both their professional practice and personal lives. While trauma was experienced collectively, individual accounts revealed how grief and pain were internalised in unique ways.

At MGH, nurses described the constant fear of infection and the anxiety triggered by ordinary symptoms: "*It was horrific, it was scary…one small cough and my mind would be like, now we have got it*." (Nurse 2, MGH Interview). The fear of death was emphasised with one participant saying: "*Imagine seeing someone today only to find out that they are no longer the next day…losing colleagues from this, because you would constantly imagine that you could be next*" (Nurse 3, MGH Interview). Trauma was compounded by stigma, as one nurse explained: *"As a nurse you work in a hospital yet you have friends who don't work in hospital so they would be like ei you will give us COVID…you would find yourself isolated in a way even if you didn't want to isolate yourself*." (Nurse 1, MGH Interview). Here, trauma was not only biomedical but also social, extending into personal relationships and reinforcing isolation.

At RFM, trauma was described in collective terms, with participants repeatedly framing COVID-19 as catastrophic and draining: *"COVID was the worst, catastrophic, and scary*." (Nurse 2, RFM FGD). Yet within this collective framing, divergence was evident. Nurse 6 recounted the pain of stigma and isolation: "*I felt I was so stigmatised, discriminated, rejected and separated*" (Nurse 3, RFM FGD). Nurse 4 emphasised the trauma of repeated exposure to death: "*Sometimes you would see more than 10 corpses in one day…that stuck with us, but with time, we are finding healing*" (Nurse 5, RFM FGD). Meanwhile, Nurse 6 described ongoing physical and emotional strain: "*Even today colleagues, I always say that I do not feel okay…every time it just happens, I cannot breathe properly*" (Nurse 7, RFM FGD). These accounts show how collective trauma was shared across the group but manifested differently at the individual level, producing varied expressions of pain and vulnerability.

At Hlatikulu, trauma was intensified by proximity and collective vulnerability. One participant explained: "*Because it infected everyone, and you would find that several nurses are sick from it and only two would remain in a ward, while the rest are in isolation*." (Nurse 5, HGH FGD). This illustrates how the collapse of staffing structures amplified exhaustion and dread. Trauma also extended into the domestic sphere, as nurses carried fear of contamination into their homes: "*It really affected us because some of us lived with our children, and you couldn't control the surfaces you would find yourself touching*" (Nurse 2, HGH FGD). Another nurse highlighted the difficulties of isolating in crowded living conditions: "*It would probably be*

seven of us in a two-bedroom house, so how were we supposed to practice social distancing?" (Nurse 7, MGH FGD). Trauma was also framed through cultural disruption, as the inability to perform funeral rituals severed nurses from their communities and traditions, deepening grief.

Building on these accounts, trauma was a universal experience across sites, though its framing diverged. At MGH, trauma was primarily biomedical and individual, rooted in fear of infection, exposure to death, and stigma within hospital settings. Yet it also carried a social dimension, as nurses shared in the collective grief, uncertainty, and stigma experienced by their communities. This duality highlights that trauma was not confined to the biomedical risks of frontline work but extended into the social fabric of everyday life, shaping how vaccine messages were interpreted and communicated. At RFM, it was collective yet internally varied, expressed through catastrophe, stigma, and lasting health fears. At Hlatikulu, trauma was communal and relational, shaped by proximity, domestic vulnerability, and cultural disruption. While behavioural framings such as the Health Belief Model reduce trauma to cognitive appraisal of risk, nurses' accounts in Eswatini reveal trauma as a lived reality shaped by systemic fragility and institutional neglect. This challenges dominant narratives that individualise vaccine decision-making and underscores the need to situate trauma within structural and relational contexts.

This theme shows how systemic fragility and emotional strain intersect to influence vaccine communication. Trauma undermined nurses' confidence and credibility, aligning with Gilson's (2003) argument that trust in health systems is mediated through interpersonal encounters. The accounts also reveal contested perceptions of healthcare workers: while nurses embodied resilience, stigma and fear positioned them as potential sources of danger. This tension highlights the relational nature of communication in fragile health systems, where emotional strain directly shapes the ability of nurses to advocate for vaccination. By foregrounding trauma and emotional strain as both biomedical and social, the findings extend critical health communication scholarship and underscore the need for culturally competent strategies that acknowledge emotional realities alongside technical messaging.

Theme 2: Stigma, Separation and Social Disruption

Stigma was a recurring experience across all sites, compounding trauma and restructuring nurses' social lives. While universally present, its framing differed by context.

At MGH, stigma was experienced socially, with nurses describing how their professional identity marked them as potential carriers of infection. One participant explained: "*At that point you would just isolate and this is why I say it was scarier. Even coming to work, you would end up being scared that what if what if.*" (Nurse 1, MGH Interview).

This demonstrates how stigma undermined belonging outside the workplace. Nurse 2 described the exhausting reality of isolation: "*I don't want to lie. It was isolating. Total isolation, total isolation and it was so exhausting…"* (MGH Interview). Nurse 3 emphasised the fear of infecting loved ones: "*We were even scared to go home because you would worry about infecting family in case you were asymptomatic at the time"* (MGH Interview). These accounts show how stigma at MGH was relational, extending into domestic spaces and eroding feelings of safety at home.

At RFM, stigma was described in institutional terms. Nurses recalled rejection by colleagues and supervisors, with one participant explaining: "*We were not taken care of…they just wait outside and maybe communicate that please put the books outside for me*" (Nurse 8, RFM FGD). Another recounted: "*Even when the results came that I was negative, I was made to stay home. At Pharmacy [Department], they did not want to give me drugs, they told me to stay very far*" (Nurse 6, RFM FGD). Here, stigma was embedded in workplace practices, reinforcing feelings of exclusion and neglect.

At Hlatikulu, stigma was culturally embedded. Nurses described suspicion from patients and relatives, with vaccination associated with harm. One participant explained: "*It was another world…separated from people. It was really painful"* (Nurse 1, HGH FGD). Another added: "*At home, I stopped my elders from vaccinating…others developed sugar diabetes due to it, others hypertension*" (Nurse 3, HGH FGD). These accounts show how stigma was negotiated within family and community contexts, positioning nurses as conduits of doubt.

Evidently, stigma was convergent across sites as rejection and mistrust, yet divergent in framing. At MGH it was relational and social, at RFM institutional, and at Hlatikulu cultural. Within each site, participants converged on stigma as rejection but diverged in how they narrated its impact, whether through isolation, discriminatory workplace practices, or cultural mistrust. This layered analysis demonstrates that stigma was both external and internalised, reshaping nurses' identities by positioning them simultaneously as caregivers and as perceived sources of danger. Dominant narratives often frame stigma as a barrier to individual compliance, yet in Eswatini stigma was experienced as a relational dynamic that eroded professional identity and complicated trust. Nurses' accounts show that stigma cannot be understood through behavioural deficit models alone, but must be analysed as a product of

systemic weakness and cultural positioning. Additionally, mainstream rhetoric assumes that trust can be secured through authoritative messaging and compliance. Nurses' accounts disrupt this assumption, showing that trust was mediated through relational credibility, cultural negotiation, and improvisation in fragile systems. This challenges the reduction of trust to institutional authority and highlights its relational and contextual dimensions.

This theme highlights how stigma reshaped perceptions of healthcare workers and complicated vaccine communication. Nurses were positioned simultaneously as trusted caregivers and potential sources of danger, a duality that weakened their authority and credibility. These findings resonate with Larson et al. (2014), who argue that trust in vaccination is fragile and contingent, but they extend this scholarship by showing how stigma operates across social, institutional, and cultural levels. The accounts also validate the conceptual framework's emphasis on perceptions of healthcare workers, demonstrating that stigma is not only a social phenomenon but also an institutional and cultural barrier to communication.

By foregrounding stigma as multidimensional, the findings contribute empirically to understanding nurses' lived realities in Eswatini, while theoretically extending critical health communication scholarship to encompass the layered ways stigma reshapes communicative labour. They underscore the need for culturally competent strategies that address stigma as both relational and structural, ensuring that vaccine communication engages with the social identities of frontline staff as well as the communities they serve.

Theme 3: Institutional Neglect and Lack of Support

Across all sites, nurses consistently reported inadequate institutional support, lack of recognition, and resource shortages, although the form this neglect took varied by context.

At MGH, neglect was framed through fragmented training and inadequate preparation. One nurse explained: "*There was no formal training…it would be just discussions*" (Nurse 1, MGH Interview). Another added: "*We didn't have the right equipment; we didn't have the right knowledge or specific expertise on that condition*" (Nurse 2, MGH Interview). Nurse 3 highlighted confusion caused by inconsistent information: "*At first, it was said its airborne, then alongside droplets…we did not understand most of the things. So as healthcare workers we found ourselves believing whatever was circulating on social media because there was no time to sit in a boardroom to say: this is what is happening*" (Nurse 3, MGH Interview). Nurse 4 reflected on systemic weaknesses: "*It opened our eyes on how our health system is weak or needs to be upgraded…we have less than five trained intensive care specialists among the*

nursing side and then among the doctors, I think there are three" (Nurse 4, MGH Interview). These accounts show how neglect at MGH was experienced as a failure of preparedness, undermining confidence and leaving nurses uncertain in their frontline roles.

At RFM, neglect was described in terms of exploitation and symbolic gestures. Nurses expressed frustration at being undervalued, with one participant stating: "*We were used like rags. You know you use rags to clean a dirty house, once your house is clean, you leave the rag outside*" (Nurse 2, RFM FGD). Another added: "*We only got mugs written 'COVID warriors RFM'…there was no allowance whatsoever*" (Nurse 1, RFM FGD). Others suspected corruption, noting that promised disaster funds never reached frontline staff: "*We hear that there was disaster money…we registered our account numbers, and I think six months has passed since we did that. We still do not understand why they made us do that*" (Nurse 4, RFM FGD). These accounts highlight how neglect at RFM was experienced as exploitation, with symbolic recognition replacing material support.

At Hlatikulu, neglect was framed through resource shortages. Nurses described improvising in the absence of protective equipment and support, with one participant explaining: "*Even when there are no resources, we keep improvising*" (Nurse 7, HGH FGD). This shows how neglect was experienced as material deprivation, forcing nurses to rely on creativity and solidarity to sustain care.

Following these accounts, institutional neglect was a convergent experience across sites, though its manifestations revealed the depth of systemic fragility in Eswatini's health system. At MGH, neglect appeared through fragmented training and inadequate preparation, leaving nurses uncertain and reliant on informal peer networks. At RFM, it took the form of exploitation and symbolic gestures, where frontline staff were given mugs instead of allowances, reinforcing feelings of being undervalued. At Hlatikulu, neglect was material, expressed through shortages of protective equipment and the need to improvise care. These variations show that institutional weakness was lived differently depending on context, shaping both confidence and communicative authority.

The findings resonate with Murewanhema et al. (2022), who documented similar frustrations among healthcare workers in Zimbabwe, and echo Mackintosh and Tibandebage's (2004) analysis of Tanzanian health systems, where frontline staff navigated systemic weakness while maintaining professional duty. By situating Eswatini within this broader African scholarship,

the study demonstrates that institutional neglect is a defining feature of fragile health systems, producing ethical dilemmas and undermining trust in healthcare workers.

Importantly, the accounts validate the conceptual framework's emphasis on perceptions of healthcare workers. Nurses' credibility was directly shaped by the extent to which institutions supported or abandoned them: visible neglect — through lack of training, symbolic recognition, or shortages — weakened their authority in vaccine advocacy and reinforced community scepticism. This underscores that institutional support is inseparable from communicative effectiveness, as recognition and resources are essential for nurses to persuade patients.

By foregrounding institutional neglect, the findings contribute empirically to understanding frontline realities in Eswatini, while theoretically extending critical health communication scholarship to encompass the structural dimensions of communicative labour. They highlight that vaccine communication in fragile health systems depends not only on technical training but also on material and symbolic recognition of frontline staff.

Theme 4: Professional Identity and Ethical Dilemmas

Across sites, nurses described tensions between their professional duty and personal scepticism, highlighting ethical dilemmas in patient communication and care.

At MGH, professionalism was emphasised as a way of sustaining resilience. One nurse explained: "*For patients, I acted professional…I always made sure that I advise them well*." (Nurse 1, MGH Interview). Another added: "*I make sure that I tell you about the positive aspects of vaccinating. I didn't influence patients negatively… I always made sure that I advise them well that they should get vaccinated. I told them what I had also been told, I admit I had no evidence of this, but I used to motivate them*." (Nurse 2, MGH Interview). These accounts show how nurses upheld professional responsibility even when uncertain, framing ethical practice as commitment to patient trust.

At RFM, ethical dilemmas were described in terms of sacrifice and frustration. Nurses reported continuing to care for patients despite feeling exploited or unsupported, with one participant stating: "*We were used like rags…once your house is clean, you leave the rag outside*." (Nurse 2, RFM FGD). Here, professional identity was tied to endurance, but also to resentment at institutional neglect.

At Hlatikulu, nurses highlighted the dual identity of being both caregivers and community members. One explained: "*Our strength was in being together, not alone. We were too*

separated from our families not to stand together as a team." (Nurse 5, HGH FGD). This illustrates how professional duty was inseparable from communal solidarity, with nurses navigating ethical dilemmas not only in patient care but also in their roles within families and communities.

Building on these accounts, professional identity and ethical dilemmas were central to nurses' experiences, convergent across sites as a source of resilience yet divergent in framing. At MGH, professionalism sustained credibility in patient communication, even when nurses themselves harboured doubts about vaccine efficacy. At RFM, identity was expressed through sacrifice and frustration, with nurses continuing to care for patients despite feeling exploited and undervalued. At Hlatikulu, identity was dual, as nurses navigated obligations to patients while sustaining solidarity within their families and communities. These variations show that ethical dilemmas were lived differently across sites, shaping the ways nurses enacted communicative labour.

The findings resonate with Mackintosh and Tibandebage's (2004) analysis of Tanzanian health systems, where frontline staff straddle biomedical authority and local realities, and echo Gilson's (2003) emphasis on trust as relational. Nurses' authority was contingent on their ability to embody professionalism even under conditions of neglect, demonstrating that ethical dilemmas are a defining feature of vaccine communication in fragile health systems. Importantly, the accounts validate the conceptual framework's focus on intersectionality and perceptions of healthcare workers: credibility was shaped both by professional duty and by how communities perceived nurses' ethical stance.

Theme 5: Vaccine Efficacy and Scepticism

Scepticism about vaccine efficacy and safety was widespread, though its framing varied across sites.

At MGH, scepticism was grounded in biomedical reasoning. One nurse explained: *"It was never about cultural beliefs per se but it was more of a professional aspect…we had so many pre-existing conditions which you cannot control…then there is this thing killing people in masses and the healthcare system is not prepared but a solution comes in a space of less than a year."* (Nurse 2, MGH Interview). This account shows how scepticism was tied to concerns about rushed development and lack of clarity around contraindications.

At RFM, scepticism was framed through adverse outcomes and personal remedies. One nurse recounted: *"I feel like what worked was the steaming, and lemihlonyane*[1]*. What we prescribed [vaccination] was not working."* (Nurse 7, RFM FGD). Another added: *"I saw the Castle Milk Stout beer working…even some that I know of did not come to the hospital at all."* (Nurse 2, RFM FGD). These accounts reveal how scepticism was reinforced by cultural framings and experiential observations, creating tension between professional duty and personal belief.

At Hlatikulu, scepticism was shaped by myths and traditional remedies. Nurses described patients associating vaccination with harm, while relying on steaming or herbal practices. One explained: *"Even when there are no resources, we keep improvising."* (Nurse 7, HGH FGD). This shows how scepticism was embedded in cultural practices that substituted biomedical interventions.

Broadly, scepticism was convergent across sites as doubt about safety and efficacy, yet divergent in framing. At MGH it was biomedical and professional, at RFM experiential and cultural, and at Hlatikulu rooted in myths and remedies. These accounts highlight how scepticism was not simply rejection but a negotiation between biomedical knowledge, cultural identity, and personal observation. While the findings presented here emphasise biomedical, cultural, and experiential framings, nurses also raised inconsistent communication as a broader systemic problem that shaped their perceptions of vaccine messaging. To illustrate this concern, one nurse said, "*I even prevented my elder family members from vaccinating because I did not trust it.*" (Nurse 2, MGH). Vaccine scepticism is frequently narrated in global literature as misinformation or irrationality, reflecting dominant biomedical framings. In contrast, nurses in Eswatini articulated scepticism as a rational response to systemic fragility, cultural remedies, and inconsistent communication. This highlights the limits of dominant narratives and demonstrates the importance of contextualising scepticism within lived realities.

Drawing from these accounts, scepticism about vaccine efficacy and safety was a convergent theme across sites, though its framing diverged. At MGH, scepticism was biomedical, with nurses questioning the rapid development of vaccines and the lack of clarity around contraindications. At RFM, it was experiential, shaped by perceived adverse outcomes and reinforced by reliance on remedies such as steaming or umhlonyane. At Hlatikulu, scepticism

[1] Umhlonyane, also known as African Wormwood (Artemisia afra), is a highly aromatic perennial herb native to South Africa. It is known for its medicinal properties and is used to treat a variety of ailments, including respiratory issues, gastrointestinal complaints, and infections. **Source:** https://pza.sanbi.org/artemisia-afra

was cultural, embedded in myths and traditional practices that substituted biomedical interventions. These variations show that scepticism was not a simple rejection of vaccination but a negotiated stance shaped by multiple epistemologies.

These sceptical beliefs did not remain abstract but directly influenced how nurses communicated with patients. One participant explained: *"Honestly speaking, I never encouraged anyone to take the vaccine…my response would be a no…Just guided the person to the right direction so that the person could decide on their own."* (Nurse 1, MGH). A similar uncertainty was echoed by another nurse at RFM, who said, "*People would ask us if steaming was better than the vaccine, and we did not know how to answer,*" (Nurse 4, RFM Hospital). This shows how scepticism translated into cautious, non-directive communication, where nurses refrained from actively promoting vaccination and instead deferred decision-making to patients. These examples demonstrate that nurses' beliefs were not abstract but actively influenced how they communicated with patients and colleagues.

The findings resonate with Larson et al. (2014), who argue that vaccine confidence is fragile and contingent, and extend this scholarship by showing how scepticism operates differently across professional, experiential, and cultural domains. They also echo De Schacht et al. (2025), who documented how Mozambican healthcare workers balanced biomedical directives with community remedies, reinforcing the idea that frontline staff must navigate competing logics of health. By situating Eswatini within this broader African scholarship, the study demonstrates that scepticism is relational, shaped by both institutional weakness and cultural identity.

Importantly, the accounts validate the conceptual framework's emphasis on cultural competence and perceptions of healthcare workers. Nurses' credibility was conditioned by how they communicated scepticism: when framed professionally, it reinforced trust; when expressed through remedies or myths, it risked undermining authority. This underscores that vaccine communication requires more than technical messaging, demanding engagement with cultural frameworks and acknowledgement of frontline scepticism as part of the communicative process.

Theme 6: Cultural Context and Health Beliefs

Cultural framings intersected with biomedical scepticism, shaping vaccine uptake in complex ways.

At RFM, nurses described how patients and colleagues debated whether traditional remedies or biomedical interventions were more effective. One explained: *"I feel like what worked was the steaming, and lemihlonyane. What we prescribed [vaccination] was not working."* (Nurse 7, RFM FGD). Another added: *"Those that were drinking a lot were not getting sick. Even now those that drink never catch flu. We laughed about it, joking that people should drink alcohol so that they do not get infected, because there might be a science to it."* (Nurse 8, RFM FGD). These accounts show how cultural identity and everyday practices shaped health beliefs, often challenging biomedical prescriptions.

At MGH, cultural perceptions were less dominant but still present. Masculinity norms influenced vaccine uptake, with men reluctant to vaccinate due to perceptions of weakness. One nurse explained: *"As a Swazi you grow up knowing that as a man you go to hospital when things are bad…yet now you needed to be vaccinated when you are still very much well."* (Nurse 1, MGH Interview). This illustrates how cultural norms around masculinity conflicted with biomedical expectations.

At Hlatikulu, cultural disruption was framed through funerals and rituals. Nurses described how the inability to perform funeral practices was deeply traumatic, severing them from communities and traditions. One explained: *"It was another world…separated from people. It was really painful."* (Nurse 1, HGH FGD). Here, cultural practices were central to how nurses understood both health and disruption.

Therefore, viewed collectively, cultural context was convergent across sites as a factor shaping health beliefs, yet divergent in emphasis. At RFM it was remedies versus biomedical care, at MGH masculinity norms, and at Hlatikulu funeral disruptions. These accounts highlight how cultural identity was inseparable from health decisions, producing tensions between professional duty and community narratives.

Extending from these accounts, cultural framings were inseparable from vaccine uptake, shaping how nurses and communities negotiated biomedical prescriptions. At RFM, remedies such as steaming, umhlonyane, and even alcohol consumption were positioned as alternatives to vaccination, reflecting everyday practices that challenged biomedical authority. At MGH, masculinity norms influenced uptake, with men reluctant to vaccinate because it was perceived as a sign of weakness, a clash between cultural identity and biomedical expectations. At Hlatikulu, cultural disruption was most visible in the inability to perform funeral rituals, which severed nurses from their communities and traditions, deepening grief and mistrust. These variations show that cultural identity was central to vaccine communication, producing tensions between professional duty and community narratives.

Nurses explained that cultural and religious beliefs created communicative dilemmas. One participant noted: "*That was the toughest predicament. It was difficult to force that patient, especially if it was religion based…The challenge there was with social media because there were a lot of stories that came up with patients. It was difficult but we tried to encourage them to rely on information or sources that have accurate information, from the right sources such as WHO*." (Nurse 7, RFM). At Hlatikulu, one nurse stated: "*People would ask us if steaming was better than the vaccine, and honestly, we did not know how to answer*." (Nurse 5, Hlatikulu). This illustrates how indigenous knowledge and religious framing complicated communication, which resulted in nurses redirecting patients to sources such as the World Health Organisation and others endorsed by the Ministry of Health, even when they did not necessarily believe those sources themselves.

These accounts highlight how fragmented communication left nurses uncertain, weakening their authority in patient interactions. Nurses' credibility was conditioned by how they communicated scepticism: when framed professionally, it reinforced trust; when expressed through remedies or myths, it risked undermining authority. Communication was therefore relational, requiring constant negotiation of credibility under systemic fragility and cultural complexity.

The findings resonate with Airhihenbuwa's (1995) call for culturally grounded health strategies, which emphasise that health communication must engage with cultural logics rather than attempt to override them. They also echo De Schacht et al. (2025), who documented how Mozambican healthcare workers navigated cultural remedies alongside biomedical directives, reinforcing the idea that frontline staff must balance competing epistemologies. By situating Eswatini within this broader African scholarship, the study demonstrates that cultural competence is a critical determinant of vaccine uptake, shaping both trust and scepticism.

Importantly, the accounts validate the conceptual framework's emphasis on cultural competence and perceptions of healthcare workers. Nurses were positioned as translators between biomedical knowledge and cultural identity, tasked with making vaccination resonate within community frameworks. When cultural competence was absent, communication faltered; when nurses engaged cultural logics, credibility was strengthened. This underscores that vaccine communication is not simply about information transfer but about relational negotiation across cultural boundaries.

Theme 7: Communication and Information Gaps

Communication emerged as a critical challenge during the pandemic, undermining nurses' confidence in the vaccines and complicating their ability to advocate for patients.

At MGH, participants emphasised the absence of structured training and the difficulty of advising patients when information was incomplete. One nurse explained: *"There was no formal training…it would be just discussions."* (Nurse 1, MGH Interview). Another added: *"It wasn't easy…as professional workers it was difficult to communicate with a client that they should get vaccinated because there was missing information."* (Nurse 2, MGH Interview). These accounts highlight how fragmented communication left nurses uncertain, weakening their authority in patient interactions.

Nurse 3, who had access to workshops and research, did not feel the same gaps but noted challenges caused by health beliefs and unregulated information on social media: *"That was the toughest predicament. It was difficult to force that patient, especially if it was religion based…The challenge there was with social media because there were a lot of stories that came up with patients. It was difficult but we tried to encourage them to rely on information or sources that have accurate information, from the right sources such as World Health Organization (WHO)."* (MGH Interview). This shows how misinformation complicated communication even when training was available, forcing nurses to counter competing narratives.

For Nurse 4, limited information and perceptions of side effects undermined confidence: *"Locally, we didn't have any information, but going through the internet, reading health information from WHO…I still don't believe this drug. And then what made it worse is the complications from the patients so I was like they didn't tell us about this."* (MGH Interview). This scepticism translated into cautious communication: *"Honestly speaking, I never encouraged anyone to take the vaccine…my response would be a no, the statements have been issued by the government, or the Ministry of Health so you follow those rules…So it's not like I was encouraging to say go take the vaccine or don't take the vaccine. Just guided the person to the right direction so that the person could decide on their own."* (MGH Interview).

Collectively, communication gaps were convergent across sites as barriers to advocacy, though their framing diverged. At MGH, they were experienced through fragmented training and inconsistent guidance, leaving nurses uncertain and reliant on peer networks or social media. At RFM, failures were compounded by institutional neglect, where symbolic recognition

replaced meaningful engagement, leaving nurses frustrated and unsupported. At Hlatikulu, misinformation circulated widely through community channels, making it difficult for nurses to debunk myths and sustain credibility. These variations show that communication gaps were not simply technical failures but relational disruptions that weakened trust between nurses, institutions, and communities.

The findings resonate with Wasserman and Madrid-Morales (2021), who documented how digital misinformation in Africa amplified confusion and eroded confidence in official health messaging, and echo Larson et al. (2014), who emphasised that vaccine confidence depends on transparent and consistent communication. By situating Eswatini within this broader African scholarship, the study demonstrates that communication gaps are a defining feature of fragile health systems, where institutional weakness and digital misinformation converge to undermine frontline authority.

Importantly, the accounts validate the conceptual framework's emphasis on perceptions of healthcare workers and communication as relational practice. Nurses' credibility was directly shaped by the quality of information they received: when communication was fragmented, their authority was weakened; when they improvised strategies to counter misinformation, they enacted resilience and relational competence. This underscores that vaccine communication is not simply about transmitting biomedical facts but about sustaining trust through consistent, culturally competent, and relationally grounded messaging.

By highlighting communication and information gaps, the findings contribute empirically to understanding nurses' lived realities in Eswatini, while theoretically extending critical health communication scholarship to encompass the relational and digital dimensions of communicative labour. They show that effective vaccine communication in fragile health systems requires not only accurate information but also institutional support and strategies to counter misinformation, positioning nurses as central mediators of trust in the digital age.

Theme 8: Resilience and Dedication

Despite trauma, stigma, and neglect, nurses consistently emphasised resilience and commitment to care.

At MGH, resilience was expressed through professionalism and patient communication. One nurse explained: *"For patients, I acted professional…I always made sure that I advise them well."* (Nurse 1, MGH Interview). Another added: *"I make sure that I tell you about the positive aspects of vaccinating…I admit I had no evidence of this, but I used to motivate them."* (Nurse

2, MGH Interview). Nurse 3 stressed: *"However, though the case may be, we still gave information and advocated for the vaccine and educated them on its importance."* (MGH FDG). These accounts show how resilience was enacted as ethical responsibility, sustaining patient trust despite uncertainty.

At RFM, resilience was framed through sacrifice and frustration. Nurses described continuing to care for patients despite exploitation, with one participant stating: *"We were used like rags."* (Nurse 2, RFM FGD). Another stated: *"Nobody would voluntarily expose themselves to this stuff. We dedicated ourselves…we worked with commitment because we needed to."* (RFM FGD). Dedication was expressed as endurance, even when institutional support was absent.

At Hlatikulu, resilience was framed through community solidarity. One nurse explained: *"Our strength was in being together, not alone. We were too separated from our families not to stand together as a team."* (Nurse 5, HGH FGD). Another added: *"Even when we were afraid and tired, we kept going because our community depended on us."* (Nurse 2, HGH FGD). These accounts highlight how resilience was sustained through collective strength and improvisation in the face of shortages.

Emerging from these accounts, resilience and dedication were convergent across sites as defining features of nurses' experiences, though framed differently. At MGH, resilience was expressed through professionalism and patient communication, with nurses emphasising their duty to advise and motivate despite uncertainty. At RFM, it was framed through sacrifice, as nurses continued to care for patients even when they felt exploited and undervalued. At Hlatikulu, resilience was communal, sustained through solidarity and collective strength in the face of shortages and cultural disruption. These variations show that resilience was not simply coping but an active form of communicative labour, sustaining healthcare delivery under extreme conditions.

The findings resonate with Gilson's (2003) emphasis on trust as relational, showing that resilience was enacted through professional credibility and communal solidarity. They also echo Murewanhema et al. (2022), who documented how frontline staff in Zimbabwe sustained care through improvisation and dedication despite systemic neglect. By situating Eswatini within this broader African scholarship, the study demonstrates that resilience is a defining feature of fragile health systems, where frontline staff compensate for institutional weakness through ethical commitment and collective strength.

Importantly, the accounts validate the conceptual framework's focus on perceptions of healthcare workers and intersectionality. Nurses' resilience was shaped by how they were perceived: professionalism reinforced credibility, sacrifice exposed vulnerability, and solidarity strengthened communal trust. This underscores that resilience is inseparable from communicative effectiveness, as it directly influenced how nurses were able to advocate for vaccination and sustain patient trust.

FINDINGS IN RELATION TO RESEARCH QUESTIONS

RQ1: :How do nurses at Raleigh Fitkin Memorial, Hlatikulu, and Mbabane Government Hospitals experience and interpret COVID 19 vaccination within the context of trauma, stigma, and resilience?

Nurses' experiences and perceptions of vaccine communication were shaped by trauma, stigma, and professional identity, converging across sites yet diverging in framing. Their accounts reveal how emotional strain, ethical dilemmas, and resilience were interpreted in ways that directly influenced communicative practice.

Trauma and stigma (Themes 1 and 2): At Mbabane Government Hospital, nurses perceived vaccination through the lens of biomedical fear and relational stigma, interpreting themselves as vulnerable to infection while simultaneously distrusted by patients and communities. At Raleigh Fitkin Memorial, trauma was experienced collectively and perceived as catastrophic, reinforcing a sense of institutional fragility and shared vulnerability. At Hlatikulu, trauma was understood communally, linked to cultural disruption, and perceived as undermining traditional forms of solidarity. These perceptions and experiences eroded confidence and credibility, showing that vaccine communication was inseparable from emotional strain and social positioning.

Professional identity and ethical dilemmas (Theme 4): Nurses perceived their professional role as both a source of authority and a site of tension. Experiences of sacrifice, neglect, and dual caregiver roles were interpreted as ethical dilemmas, where credibility had to be negotiated under conditions of uncertainty. Their perceptions of duty were often in conflict with scepticism, highlighting that communication was not only technical but also deeply

ethical, requiring nurses to position themselves as mediators of trust while sustaining resilience through professionalism.

Resilience and dedication (Theme 8): Despite systemic fragility, nurses perceived resilience as both a professional obligation and a communal necessity. Experiences of sacrifice and solidarity were interpreted as strategies to sustain vaccine advocacy even when institutional support was limited. These perceptions reinforced the idea that resilience was enacted not only through individual adaptation but also through collective commitment to patients and communities, underscoring the relational dimension of vaccine communication.

Together, these findings demonstrate that vaccine communication was lived and perceived as a relational and ethical practice, shaped by trauma, stigma, and resilience. Nurses' authority rested not only on biomedical knowledge but also on how they interpreted and embodied professionalism, negotiating contested perceptions within families, communities, and institutions. Their accounts reveal that communication was inseparable from emotional strain and ethical responsibility, and that credibility depended on the ability to balance technical expertise with cultural sensitivity and communal trust.

RQ2: In what ways have nurses concerns and scepticisms regarding COVID 19 vaccines, been shaped by cultural identity, professional responsibility, and systemic fragility?

Nurses' concerns and scepticisms regarding COVID-19 vaccines were shaped by cultural identity, professional responsibility, and systemic fragility. These influences converged across sites yet were expressed differently, revealing how institutional neglect, communicative gaps, stigma, and ethical dilemmas undermined confidence and credibility while forcing nurses to reinterpret their roles.

Institutional neglect (Theme 3): Nurses described fragmented training, symbolic recognition, and shortages of protective equipment as signs of systemic fragility. These experiences were perceived as institutional neglect, leaving them undervalued and uncertain about their authority. The lack of consistent support weakened their credibility and reinforced community scepticism, showing how systemic failures translated directly into communicative challenges.

Communication and information gaps (Theme 7): Fragmented training, misinformation, and inconsistent guidance were interpreted as relational disruptions rather than merely technical failures. Nurses perceived these gaps as undermining trust, forcing them to rely on peer networks or improvise strategies to counter myths. Their scepticism was shaped not only

by the absence of reliable information but also by the perception that institutional communication failed to acknowledge cultural realities and frontline needs.

Stigma and separation (Theme 2): Nurses were positioned simultaneously as caregivers and potential sources of danger. This dual perception weakened their authority and complicated advocacy, as they had to negotiate credibility in contexts where they were both trusted and feared. Stigma was experienced relationally, eroding professional identity and reinforcing scepticism about vaccines within communities.

Ethical dilemmas (Theme 4): Nurses perceived their professional responsibility as entangled with cultural obligations and systemic neglect. Experiences of sacrifice and scepticism were interpreted as ethical dilemmas, requiring improvisation to maintain trust. Their authority depended not only on biomedical knowledge but also on their ability to embody professionalism and navigate contested perceptions within families, communities, and institutions.

Together, these findings show that nurses' concerns and scepticisms were not simply individual doubts but reflections of systemic fragility, cultural positioning, and ethical responsibility. Their accounts reveal that vaccine communication was inseparable from institutional credibility and relational trust, underscoring the need for health communication strategies that recognise both structural inequities and the cultural identities of frontline workers.

RQ3: In what ways do nurses perceive and enact their role as mediators of trust in promoting COVID 19 prevention across clinical and community settings?

Nurses perceived and enacted their role as mediators of trust in ways that were shaped by systemic fragility, institutional neglect, and contested cultural expectations. Their accounts reveal that trust was not a given but had to be actively negotiated across clinical and community settings, where authority was continually tested by shortages, misinformation, stigma, and ethical dilemmas.

Institutional neglect (Theme 3): Nurses described fragmented training, symbolic recognition, and shortages of protective equipment as signs of systemic weakness. These experiences were perceived as institutional neglect, leaving them undervalued and uncertain about their

authority. The absence of consistent support weakened their credibility and reinforced community scepticism, showing that mediation of trust depended on institutional reliability as much as individual effort.

Communication and information gaps (Theme 7): Inconsistent guidance and misinformation were interpreted as relational disruptions rather than technical failures. Nurses perceived these gaps as undermining trust, forcing them to rely on peer networks or improvise strategies to counter myths. Their role as mediators of trust was therefore enacted through improvisation and relational engagement, highlighting the fragility of institutional communication in culturally complex settings.

Stigma and separation (Theme 2): Nurses were positioned simultaneously as caregivers and potential sources of danger. This dual perception weakened their authority and complicated advocacy, as they had to negotiate credibility in contexts where they were both trusted and feared. Stigma was experienced relationally, eroding professional identity and making the enactment of trust a contested process.

Ethical dilemmas (Theme 4): Nurses perceived their professional responsibility as entangled with cultural obligations and systemic neglect. Experiences of sacrifice and scepticism were interpreted as ethical dilemmas, requiring improvisation to maintain trust. Their authority depended not only on biomedical knowledge but also on their ability to embody professionalism and navigate contested perceptions within families, communities, and institutions.

Together, these findings demonstrate that nurses' mediation of trust was not limited to resource provision or technical communication. It was lived and perceived as a relational and ethical practice, requiring constant negotiation of credibility under conditions of systemic fragility and cultural complexity. Their accounts underscore that effective vaccine advocacy depended on the ability to balance professional responsibility with cultural identity, situating trust at the intersection of institutional weakness and communal resilience.

RQ4: In what ways did cultural context and health beliefs influence vaccine communication?

Cultural identity was central to vaccine uptake, producing tensions between biomedical prescriptions and community narratives.

- **Cultural remedies and practices (Theme 6):** At RFM, steaming, *umhlonyane*, and alcohol were positioned as alternatives to vaccination; at MGH, masculinity norms discouraged uptake; at Hlatikulu, disrupted funeral rituals deepened mistrust. These show that cultural identity was inseparable from vaccine communication.
- **Scepticism (Theme 5):** Nurses' scepticism was biomedical, experiential, or cultural, reflecting multiple epistemologies. Credibility depended on how scepticism was communicated: professionally framed scepticism reinforced trust, while reliance on remedies or myths risked undermining authority.
- **Resilience and solidarity (Theme 8):** Cultural disruption also shaped resilience, with nurses at Hlatikulu sustaining communal strength despite shortages and mistrust.

These findings validate the conceptual framework's emphasis on cultural competence and perceptions of healthcare workers. Nurses were positioned as translators between biomedical knowledge and cultural identity, tasked with making vaccination resonate within community frameworks. Vaccine communication was therefore not simply about information transfer but about relational negotiation across cultural boundaries.

Therefore, across all three research questions, the findings demonstrate that vaccine communication in Eswatini was influenced by systemic fragility, contested perceptions, and cultural identity. Nurses' authority depended on their ability to embody professionalism, navigate trauma and stigma, and translate biomedical knowledge into culturally resonant frameworks. Institutional neglect and communication gaps undermined credibility, while resilience and dedication sustained advocacy despite systemic weakness.

Empirically, the study contributes to understanding frontline realities in Eswatini; theoretically, it extends critical health communication scholarship by foregrounding trauma, stigma, institutional neglect, cultural competence, and resilience as dimensions of communicative labour in fragile health systems.

Conclusion

This chapter has presented the findings of the study, organised into eight themes that illuminate how nurses in Eswatini experienced vaccine communication during COVID-19. Taken together, these themes reveal that communication was not a neutral or technical process but a

deeply relational, ethical, and cultural practice, shaped by systemic fragility and contested perceptions of healthcare workers.

Across sites, nurses' experiences converged around trauma, stigma, institutional neglect, scepticism, cultural identity, communication gaps, and resilience, yet each theme was framed differently depending on context. At MGH, communication was mediated through professionalism and biomedical reasoning; at RFM, it was shaped by sacrifice, frustration, and reliance on remedies; at Hlatikulu, it was embedded in communal solidarity and cultural disruption. These divergences underscore that vaccine communication in fragile health systems cannot be understood in isolation from the social, institutional, and cultural environments in which it is enacted.

The findings validate the study's conceptual framework, particularly its emphasis on intersectionality, cultural competence, and perceptions of healthcare workers. Nurses' credibility was consistently contingent on how they were perceived: professionalism reinforced trust, stigma weakened authority, scepticism complicated advocacy, and resilience sustained credibility despite systemic neglect. Communication was therefore relational, requiring nurses to negotiate between biomedical directives, cultural logics, and community expectations.

Empirically, the chapter contributes to understanding frontline realities in Eswatini, showing that vaccine communication was lived as a form of communicative labour under conditions of trauma, neglect, and cultural contestation. Thematically, it demonstrates that nurses were not passive recipients of policy but active mediators of trust, tasked with translating biomedical knowledge into culturally resonant frameworks while sustaining resilience in the face of systemic weakness.

Theoretically, the findings extend critical health communication scholarship by foregrounding the moral, cultural, and relational dimensions of vaccine communication in fragile health systems. They show that communication is inseparable from systemic fragility, cultural identity, and frontline resilience, and that effective strategies must engage with these realities rather than attempt to override them.

In sum, this chapter has shown that vaccine communication in Eswatini was shaped by trauma, stigma, institutional neglect, scepticism, cultural identity, communication gaps, and resilience. Nurses' authority depended on their ability to embody professionalism, navigate contested

perceptions, and sustain trust across relational and cultural boundaries. These insights provide the foundation for the next chapter, which will discuss the implications of these findings for theory, policy, and practice, situating Eswatini's experience within broader debates on health communication and fragile health systems.

CHAPTER SEVEN

DISCUSSION OF FINDINGS

Introduction

This chapter provides a critical discussion of the findings presented in Chapter Six. It interprets the eight overarching themes in relation to the study's research questions, conceptual framework, and existing literature. The discussion moves beyond description to examine how nurses' perceptions and experiences of COVID-19 vaccination were shaped by cultural norms, professional responsibilities, and systemic influences. Anchored in an interpretivist–constructivist paradigm and complemented by a critical lens, the analysis foregrounds meaning-making as co-constructed through professional identity, cultural context, and institutional fragility. The phenomenological orientation and use of Interpretative Phenomenological Analysis (IPA) allowed the study to capture the depth of nurses' lived realities, while focus group dynamics, as outlined by Love et al. (2020), provided insight into collective negotiation of meaning.

The discussion is interpreted through two conceptual frameworks: the Health Belief Model (HBM), which explains perceptions of susceptibility, severity, benefits, barriers, self-efficacy, and cues to action (Rosenstock, 1974; Champion and Skinner, 2008); and Campinha-Bacote's model of cultural competence, which highlights awareness, knowledge, skills, encounters, and cultural desire in healthcare delivery (Campinha-Bacote, 2002). Together, these frameworks provide a lens to understand how nurses navigated trauma, stigma, scepticism, institutional neglect, and cultural identity while sustaining resilience and dedication. The chapter is organised around the three research questions.

Paradigmatic anchoring and methodological reflexivity

The interpretivist–constructivist paradigm shaped the analysis by emphasising that nurses' accounts were not objective reports but socially constructed meanings, produced through their dual roles as professionals and community members. Experiences of trauma, stigma, and scepticism were understood as narratives that reflected both individual perception and collective identity. The critical paradigm added a structural dimension, highlighting how

systemic neglect, inequities, and institutional cultures shaped these meanings and constrained nurses' authority.

Phenomenology provided the philosophical grounding for exploring lived experience, while IPA offered a systematic method for interpreting how nurses made sense of their realities. The use of focus groups, guided by Love et al. (2020), allowed participants to co-construct meaning in dialogue, revealing how collective narratives of resilience, frustration, and cultural obligation emerged. Reflexivity was central: the researcher acknowledged that interpretation was shaped by the paradigmatic stance and by the relational dynamics of the research process itself.

RQ1: How do nurses at Raleigh Fitkin Memorial, Hlatikulu, and Mbabane Government Hospitals experience and interpret COVID 19 vaccination within the context of trauma, stigma, and resilience?

The findings revealed that nurses' experiences of vaccine communication were deeply shaped by trauma, stigma, professional identity, and resilience. These experiences were not uniform but varied across sites, reflecting how communication was co-constructed through biomedical reasoning, cultural identity, and systemic fragility. Parker (2009) demonstrates how stigma and behavioural dynamics are deeply intertwined with communication strategies, echoing the nurses' accounts of contested messaging in Eswatini.

Trauma and Emotional Strain

Trauma was pervasive, though its framing differed across sites. At Mbabane Government Hospital, trauma was articulated in biomedical terms, with participants describing constant fear of infection and abrupt loss of colleagues. One nurse explained: *"It was horrific, it was scary…one small cough and my mind would be like, now we have got it."* This illustrates how ordinary bodily sensations became triggers for anxiety, reinforcing perceptions of susceptibility and severity. Within the Health Belief Model (HBM), these accounts reflect heightened risk perception, but the model reduces trauma to cognitive appraisal. . The Eswatini case shows trauma as more than individual cognition; it was a lived reality shaped by daily exposure and professional identity. Yet even within this individual cognition, there was variance and diversity of responses across hospitals. This challenges scholarship that places HBM within a purely individualised lens of behaviour change, and demonstrates that when

paired with interpretative phenomenological analysis and cultural competence, HBM can yield richer insight. Nurses' accounts reveal that trauma was not uniform but mediated by institutional context, cultural identity, and relational positioning, underscoring the need to situate cognitive models within lived realities. In this way, the analysis extends HBM beyond its conventional boundaries, showing how perceptions of risk were entangled with stigma, resilience, and systemic fragility, and how nurses' meaning-making practices illuminate the relational dimensions of vaccine communication.

At Hlatikulu Government Hospital, trauma was framed communally, with participants emphasising collective vulnerability and cultural disruption. One participant reflected: *"It was another world…separated from people. It was really painful."* Here trauma was co-constructed within cultural frameworks that value communal grieving and solidarity. Campinha-Bacote's model of cultural competence helps interpret this, emphasising how cultural encounters and practices shape emotional responses. Yet the model presumes cultural practices can be integrated into care, while in Eswatini restrictions prevented rituals, intensifying grief. Literature on vicarious trauma (Castelli et al., 2020) confirms that repeated exposure to death can lead to long-term consequences, but the Eswatini case extends this by showing how systemic neglect and cultural disruption amplified trauma.

At RFM, trauma was described in collective terms, with participants repeatedly framing COVID-19 as catastrophic and draining. One nurse explained: "*COVID was the worst, catastrophic, and scary.*" Others emphasised stigma and isolation, saying: "*I felt I was so stigmatised, discriminated, rejected and separated*." Trauma also stemmed from repeated exposure to death, as one participant recalled: "*Sometimes you would see more than 10 corpses in one day…that stuck with us, but with time, we are finding healing*." Another described ongoing physical and emotional strain: "*Even today colleagues, I always say that I do not feel okay…every time it just happens, I cannot breathe properly*". Thus, trauma was universal but framed differently: biomedical and individual at Mbabane, communal and cultural at Hlatikulu. These accounts demonstrate that trauma was not absent at RFM but manifested in both collective and individual ways. Nurses spoke of catastrophic experiences, stigma, and repeated exposure to death, which left lasting emotional and physical scars. This complements the findings from MGH and Hlatikulu, showing that trauma was a shared reality across all three sites, though expressed differently in each context. This layered experience challenges health communication strategies that rely solely on biomedical framings of risk. HBM captures

susceptibility and severity but fails to address cultural dimensions, while Campinha-Bacote's framework fills this gap but assumes supportive structures that were absent in fragile systems.

Stigma, Separation, and Social Disruption

Stigma was also a recurring experience, though its framing varied across sites. At Mbabane, stigma was relational, expressed through rejection by friends and family who feared contamination. One nurse explained: *"As a nurse you work in a hospital yet you have friends who don't work in hospital so they would be like ei you will give us COVID…you would find yourself isolated in a way even if you didn't want to isolate yourself."* This account illustrates how stigma was socially constructed through relationships and meanings attached to professional identity. HBM interprets stigma as a perceived barrier to preventive action, but it treats barriers as individual obstacles. In reality, stigma was relational and cultural, reshaping nurses' social belonging.

At Raleigh Fitkin Memorial, stigma was institutional, embedded in workplace practices that excluded nurses. One participant recounted: *"Even when the results came that I was negative, I was made to stay home. At pharmacy, they did not want to give me drugs, they told me to stay very far."* This shows how stigma was embedded in institutional cultures that framed nurses as risks rather than professionals. The critical paradigm is particularly important here, highlighting how hierarchical structures and systemic neglect perpetuated exclusion. Literature confirms that healthcare workers globally experienced stigma during COVID-19 (Bhanot et al., 2021; Ramaci et al., 2020), but the Eswatini case demonstrates how stigma was institutional as well as relational.

At Hlatikulu, stigma was culturally embedded. Nurses described suspicion from patients and relatives, with vaccination associated with harm. One participant explained: *"At home, I stopped my elders from vaccinating…others developed sugar diabetes due to it, others hypertension."* These accounts show how stigma was negotiated within family and community contexts, positioning nurses as conduits of doubt rather than advocates of biomedical prevention. Campinha-Bacote's framework helps interpret this, emphasising the importance of cultural awareness and encounters in shaping communication. Literature on vaccine hesitancy in African contexts similarly highlights how cultural narratives and mistrust of biomedical interventions shape perceptions (Mutombo et al., 2022; Adebisi et al., 2021).

Stigma was convergent across sites as rejection and mistrust, yet divergent in framing: relational at Mbabane, institutional at RFM, and cultural at Hlatikulu. This layered experience challenges simplistic definitions of stigma as individual prejudice. HBM helps explain stigma as a barrier, but its narrow framing overlooks institutional and cultural dimensions. Campinha-Bacote's framework highlights cultural competence, but competence was undermined by systemic neglect. Together, the paradigms provide a richer interpretation: stigma was not only a social phenomenon but also a product of institutional cultures and structural vulnerabilities.

Professional Identity and Ethical Dilemmas

Professional identity was deeply tested during the pandemic, as nurses navigated ethical dilemmas between duty to patients and responsibility to family and community. At Mbabane, nurses described the tension of continuing to work despite fear of infecting loved ones. One participant explained: *"We had to choose between our families and our patients, and sometimes it felt impossible."* This illustrates how identity was co-constructed through dual roles as caregivers and community members. HBM interprets this as a conflict between perceived benefits (protecting patients) and perceived barriers (risking family safety), but it cannot capture the moral weight of these dilemmas.

At Hlatikulu, professional identity was framed through cultural responsibility. Nurses described how their role as trusted community agents intensified ethical dilemmas, as they were expected to promote vaccination while also respecting cultural practices. One participant explained: *"We were supposed to encourage people to vaccinate, but at home they believed in herbs and steaming."* Campinha-Bacote's framework helps interpret this, emphasising how cultural awareness and encounters shaped nurses' dilemmas. Yet the model risks idealising this mediation, ignoring the ethical burden when institutions provide no support. Literature on cultural competence in healthcare (Betancourt et al., 2002) confirms these tensions, but the Eswatini case shows how fragile systems intensified them.

At RFM, professional identity was framed through sacrifice and frustration. Nurses described feeling exploited, with their dedication taken for granted. One participant explained: *"We were used like rags…once your house is clean, you leave the rag outside."* This metaphor illustrates how identity was co-constructed through narratives of disposability. The critical paradigm highlights how systemic neglect and hierarchical structures perpetuated exploitation, reducing

professional identity to symbolic recognition. Literature confirms that healthcare workers often felt undervalued during COVID-19 (Sultana et al., 2020), but the Eswatini case extends this by showing how exploitation was embedded in institutional cultures.

Professional identity was convergent across sites as tensions between duty and vulnerability, yet divergent in framing: biomedical risk at Mbabane, cultural responsibility at Hlatikulu, and institutional exploitation at RFM. This challenges simplistic definitions of identity as stable or uniform. Instead, identity was co-constructed through professional duty, cultural mediation, and systemic neglect.

Resilience and Dedication

Despite trauma, stigma, and neglect, nurses consistently demonstrated resilience and dedication. At Mbabane, resilience was expressed through professionalism and sacrifice. One participant explained: *"Even when there are no resources, we keep improvising."* This reflects self-efficacy in HBM terms, but the model treats efficacy as individual belief. In Eswatini, resilience was communal and structural, showing HBM's individualistic bias.

At Hlatikulu, resilience was framed communally, with nurses emphasising solidarity and collective improvisation. Participants described supporting one another emotionally and practically, sharing resources and coping strategies. Campinha-Bacote's framework helps interpret this, highlighting how cultural desire and encounters foster resilience through solidarity. Literature on resilience in African contexts (Munyewende et al., 2014) supports this, but the Eswatini case shows resilience as necessitated by systemic neglect.

At RFM, resilience was expressed through sacrifice and frustration. Nurses described working long hours with limited recognition, yet continuing to serve patients. The critical paradigm highlights how systemic exploitation framed resilience as necessity rather than choice, with nurses compelled to compensate for institutional neglect. Literature confirms that resilience during COVID-19 was often sustained through personal sacrifice but warns that this can lead to burnout if not supported by institutions (Sultana et al., 2020).

Resilience was convergent across sites as continued dedication, yet divergent in framing: professionalism at Mbabane, solidarity at Hlatikulu, and sacrifice at RFM. This challenges

simplistic definitions of resilience as individual coping. Instead, resilience was co-constructed through professional identity, cultural solidarity, and systemic exploitation.

RQ2: In what ways have nurses concerns and scepticisms regarding COVID 19 vaccines, been shaped by cultural identity, professional responsibility, and systemic fragility?

The findings revealed that nurses faced systemic, institutional, and communicative challenges in advocating for vaccination. These challenges were not simply logistical but reflected deeper issues of neglect, exploitation, and contested communication, all of which undermined nurses' credibility and constrained their ability to act as trusted mediators of vaccine information.

Institutional Neglect and Lack of Support

Institutional neglect was convergent across sites but divergent in form. At Mbabane Government Hospital, neglect was expressed through fragmented training and inadequate preparation. Nurses reported confusion about vaccine protocols and transmission risks, which undermined their confidence in communicating with patients. One participant explained: *"We were not sure what to tell patients, because the information kept changing."* From an interpretivist–constructivist paradigm, these accounts are understood as co-constructed meanings shaped by uncertainty and incomplete information. Within the HBM, this reflects reduced self-efficacy and heightened perceived barriers. Yet the model assumes barriers can be overcome with rational action, overlooking how systemic fragility and poor institutional support made advocacy impossible.

At Raleigh Fitkin Memorial, neglect was experienced symbolically. Nurses described being given token gestures such as mugs instead of meaningful recognition or support. One participant explained: *"We were used like rags…once your house is clean, you leave the rag outside."* This metaphor conveys disposability and exploitation, suggesting that institutional culture reduced professional sacrifice to symbolic recognition. The critical paradigm is particularly important here, highlighting how hierarchical structures and systemic neglect perpetuated exploitation. Campinha-Bacote's framework emphasises cultural skill and encounters, but competence presumes supportive structures. In Eswatini, neglect meant nurses lacked resources and recognition to enact cultural competence. Literature on healthcare worker morale during COVID-19 confirms that lack of recognition contributes to burnout and

disengagement (Sultana et al., 2020), but the Eswatini case extends this by showing neglect as symbolic and structural, not only material.

At Hlatikulu Government Hospital, neglect was material, expressed through shortages of resources and equipment. Nurses described improvising with limited supplies, emphasising resilience but also frustration. One participant explained: *"Even when there are no gloves, we keep working."* From an interpretivist lens, these accounts reflect co-constructed meanings of resilience and improvisation within a context of scarcity. Campinha-Bacote's framework helps interpret this, highlighting how institutional neglect intersects with cultural expectations of care. In Eswatini, where nurses are both professionals and community members, resource shortages not only hindered clinical practice but also undermined their cultural role as trusted caregivers. From a critical paradigm, these shortages reflect structural inequities in healthcare funding and preparedness, consistent with broader African literature documenting systemic weaknesses in pandemic response (Chersich et al., 2020).

Institutional neglect was therefore convergent across sites but divergent in form: fragmented training at Mbabane, symbolic exploitation at RFM, and material shortages at Hlatikulu. This layered experience challenges assumptions in the literature that resource provision alone is sufficient. Neglect was experienced as a lack of trust, recognition, and support, not only as absence of equipment.

Communication and Information Gaps

Communication gaps consistently undermined nurses' confidence and ability to advocate for patients. At Mbabane, fragmented training and inconsistent information created confusion about vaccine protocols and transmission risks. One participant explained: *"We were not sure what to tell patients, because the information kept changing."* Within the HBM, this reflects weakened cues to action and reduced self-efficacy. Yet the model assumes cues are clear and consistent, oversimplifying communication as a linear process. In Eswatini, cues were contradictory or absent, showing that communication was contested and relational.

At Hlatikulu, communication gaps were compounded by cultural narratives that challenged biomedical messaging. Nurses described how patients and relatives relied on community stories and traditional remedies, which often conflicted with official information. One participant explained: *"People would ask us if steaming was better than the vaccine, and we*

did not know how to answer." Campinha-Bacote's framework helps interpret this, emphasising the importance of cultural knowledge and encounters in shaping effective communication. Yet the model does not fully account for digital misinformation or institutional neglect, which left nurses unsupported. Literature on health communication in African contexts highlights the need for culturally sensitive strategies that engage with indigenous practices rather than dismiss them (Dutta, 2021; Adebisi et al., 2021).

Communication gaps were convergent across sites as uncertainty and confusion, yet divergent in framing: biomedical fragmentation at Mbabane and cultural contestation at Hlatikulu. This layered experience challenges dominant health communication strategies that assume information dissemination is sufficient.

Ethical Dilemmas Revisited

Challenges were compounded by ethical dilemmas, where nurses had to reconcile professional duty with cultural obligations and systemic neglect. At Mbabane, nurses described the tension of continuing to work despite fear of infecting loved ones. At Hlatikulu, nurses were expected to promote vaccination while respecting cultural practices such as steaming and herbal remedies. At RFM, nurses felt exploited, with their dedication taken for granted. These dilemmas illustrate conflicts between perceived benefits and barriers in HBM terms, but the model cannot capture the moral distress of systemic neglect. Campinha-Bacote's framework highlights the cultural awareness and skill required to navigate conflicting expectations, but competence was undermined by lack of institutional support. Literature confirms that healthcare workers globally faced similar dilemmas (Morley et al., 2020), but the Eswatini case shows how fragile systems intensified them.

RQ3: In what ways do nurses perceive and enact their role as mediators of trust in promoting COVID 19 prevention across clinical and community settings?

The findings demonstrate that nurses' mediation of trust was shaped by systemic fragility, cultural identity, and professional responsibility. Trust was not a static attribute but a negotiated practice, enacted across clinical and community settings under conditions of uncertainty.

Institutional Neglect and Mediation of Trust

The findings reveal that nurses' ability to act as mediators of trust was constrained by institutional neglect. Participants described how inconsistent information, lack of support, and dismissive responses to their concerns undermined their credibility with patients. One nurse reflected, *"We were expected to convince people, but we ourselves were not given clear answers. It felt like we were left alone*." This sense of abandonment illustrates how systemic fragility directly shaped their communicative labour.

This finding resonates with Wang et al. (2024), who argue that nurses' expectations of patients in high-risk environments are moderated by institutional trust and communication. When institutional support is weak, nurses' capacity to mediate trust is compromised. Similarly, Shin et al. (2025) demonstrate that patient-centred communication mediates nurses' safety-care activities, but only when supported by consistent institutional structures. In the Sub-Saharan context, Kwamea and Petrucka (2020) highlight that systemic barriers often silence nurses' voices, weakening their ability to build trust with patients. Abraham et al. (2024) further show that therapeutic communication in African nursing contexts is undermined when frontline workers lack access to reliable information, leading to weakened patient trust.

The dismissal of nurses' questions as "hesitancy" illustrates how institutional practices disrupted trust mediation. Participants argued that seeking clarity was part of their responsibility as communicators, yet authorities framed their concerns as resistance. This echoes Ekezie et al. (2024), who found that vaccination campaigns across Africa often relied on institutional authority, but uptake improved when nurses were recognised as legitimate interlocutors rather than being marginalised. UNICEF South Africa (2023) similarly emphasises that parents and caregivers place high levels of trust in nurses to provide accurate information about immunisation, underscoring the importance of institutional recognition of their communicative role.

The discussion therefore suggests that mediation of trust was contingent on institutional recognition and support. Nurses enacted trust through empathy, cultural familiarity, and everyday communication, but these practices were constrained by neglect and inconsistent messaging. By linking these findings to existing literature, it becomes clear that trust is not simply interpersonal but embedded in systemic conditions. This challenges simplistic narratives that frontline workers could act as unquestioned advocates of vaccination and underscores the need to view trust as a negotiated practice shaped by institutional fragility.

Communication and information gaps

The findings show that nurses' role as mediators of trust was significantly constrained by communication and information gaps during the COVID-19 vaccine rollout. Participants consistently described how they were expected to reassure patients and promote vaccination, yet they themselves were navigating uncertainty. One nurse explained, *"We were not given the same information all the time. Sometimes it changed, and we had to explain things we did not fully understand."* This account illustrates how fragmented communication weakened their confidence and disrupted the trust patients placed in them.

This finding directly connects to the literature reviewed in Chapter Two. Wang et al. (2024) argue that nurses' expectations of patients in high-risk environments are moderated by institutional trust and communication, highlighting how inconsistent messaging undermines professional credibility. Shin et al. (2025) similarly demonstrate that patient-centred communication mediates nurses' safety-care activities, but only when supported by reliable institutional structures. In the Sub-Saharan context, Abraham et al. (2024) found that therapeutic communication was undermined when frontline workers lacked access to consistent information, leading to weakened patient trust. These studies resonate strongly with participants' accounts in Eswatini, where communication gaps were not abstract but directly experienced in everyday practice.

Participants also criticised the way their own questions were dismissed as "hesitancy." They argued that seeking clarity was part of their responsibility as communicators, yet institutional responses often framed their concerns as resistance. One nurse explained: "*Honestly speaking, I never encouraged anyone to take the vaccine…Just guided the person to the right direction so that the person could decide on their own.*" Another admitted: "*I even prevented my elder family members from vaccinating because I did not trust it.*" These accounts show how hesitancy was deeply embedded in personal and professional contexts, shaping both patient interactions and family decision-making. At Hlatikulu, nurses described uncertainty when confronted with cultural remedies: "*People would ask us if steaming was better than the vaccine, and we did not know how to answer.*" Such examples illustrate that hesitancy was not abstract but lived, negotiated, and communicated in everyday encounters. This echoes Kwamea and Petrucka's (2020) review of nurse–patient communication in Sub-Saharan Africa, which found that systemic barriers frequently silenced nurses' voices, undermining their ability to build trust with patients. Ekezie et al. (2024) further show that vaccination campaigns across

Africa often relied on institutional authority, but uptake improved when nurses were recognised as legitimate interlocutors rather than marginalised.

New scholarship reinforces these insights. For example, Afolabi and Folayan (2023) argue that inconsistent communication during COVID-19 in Africa created confusion and mistrust, particularly when frontline workers were excluded from decision-making processes. Similarly, Oleribe et al. (2021) highlight that fragmented communication channels in African health systems exacerbated misinformation and reduced the effectiveness of vaccine campaigns. These studies confirm that communication gaps were structural, not incidental, and directly shaped how nurses enacted their role as mediators of trust.

The discussion therefore suggests that communication and information gaps were central to how nurses perceived and enacted their role. Their accounts demonstrate that trust was not simply a product of interpersonal skill but was contingent on access to reliable knowledge and transparent communication. By linking these findings to existing literature, it becomes clear that nurses' communicative labour was shaped by systemic fragility and institutional failures, challenging simplistic narratives of "hesitancy" and underscoring the importance of recognising nurses' need for timely, consistent information if they are to fulfil their role in vaccine communication.

Ethical Dilemmas

The findings reveal that nurses' role as mediators of trust was complicated by ethical dilemmas that emerged during the COVID-19 vaccine rollout. Participants described how they were expected to promote vaccination as part of their professional responsibility, yet many felt conflicted when the information available to them was inconsistent or incomplete. One nurse explained, "*We were told to encourage everyone, but at the same time we did not have full answers about side effects. It felt like we were pushing something we did not fully understand*." This illustrates the tension between professional duty and personal integrity, as nurses sought to balance institutional expectations with their responsibility to provide honest communication.

This finding connects directly to the literature reviewed in Chapter Two. Wang et al. (2024) argue that nurses' expectations of patients in high-risk environments are moderated by institutional trust and communication, highlighting how ethical tensions arise when institutional support is weak. Shin et al. (2025) similarly demonstrate that patient-centred

communication mediates nurses' safety-care activities, but only when supported by reliable structures. In the African context, Abraham et al. (2024) found that therapeutic communication was undermined when frontline workers lacked access to consistent information, leading to moral distress and weakened trust relationships. These studies resonate with participants' accounts in Eswatini, where nurses were caught between promoting vaccination and respecting patients' concerns.

Participants also reflected on the ethical challenge of reconciling their own doubts with the trust patients placed in them. Patients often assumed that nurses had access to reliable knowledge, yet nurses themselves were navigating uncertainty. As one participant noted, "*People believed we knew everything, but we were also waiting for clear information. It was difficult to advise when we were not sure*." This dilemma reveals how the expectation of certainty placed nurses in a precarious position, where withholding information risked undermining trust, but sharing their doubts risked being labelled as hesitant or unprofessional.

New scholarship reinforces these insights. Afolabi and Folayan (2023) argue that inconsistent communication during COVID-19 in Africa created ethical tensions for frontline workers, who were expected to promote vaccines without being fully informed. Similarly, Oleribe et al. (2021) highlight that fragmented communication channels in African health systems exacerbated moral dilemmas, as nurses were forced to navigate between institutional directives and community realities. These studies confirm that ethical dilemmas were structural, not incidental, and directly shaped how nurses enacted their role as mediators of trust.

The discussion therefore suggests that ethical dilemmas were not peripheral but central to how nurses perceived and enacted their role. Their accounts demonstrate that trust was shaped by the need to navigate conflicting responsibilities: promoting vaccination, respecting patient autonomy, and maintaining professional credibility in the face of uncertainty. By linking these findings to existing literature, it becomes clear that nurses' communicative labour was shaped by systemic fragility and institutional failures, challenging simplistic assumptions that frontline workers could act as neutral or uncontested advocates of vaccination.

Stigma and Separation

The findings reveal that stigma and social separation significantly shaped how nurses enacted their role as mediators of trust. Participants described being viewed with suspicion, both as

potential carriers of the virus and as enforcers of vaccination campaigns. One nurse reflected, "*Some people saw us as part of the problem, not the solution. They thought we were bringing the disease*." This perception undermined the relational trust that nurses relied on to communicate effectively with patients and communities.

Such accounts echo Abraham et al.'s (2024) scoping review, which found that therapeutic communication in African nursing contexts was weakened when frontline workers were perceived as unsafe or untrustworthy. They also extend Kwamea and Petrucka's (2020) analysis of systemic barriers in Sub-Saharan healthcare, showing how stigma silences nurses and erodes their credibility. The dismissal of nurses' questions as "hesitancy" created further separation, aligning with Wang et al.'s (2024) argument that institutional trust is critical in high-risk environments, and its absence leaves frontline workers vulnerable to suspicion.

Recent scholarship reinforces these insights. Afolabi and Folayan (2023) highlight that inconsistent communication during COVID-19 in Africa exacerbated stigma, as frontline workers were caught between institutional directives and community mistrust. Oleribe et al. (2021) similarly argue that fragmented communication channels intensified social separation, isolating nurses from both patients and institutional support.

Taken together, these findings and the literature demonstrate that stigma and separation were not incidental but structural, shaping how nurses perceived and enacted their role as mediators of trust. Trust was contested through social perceptions and institutional framings, underscoring the precarious position of nurses in fragile health systems.

RQ4: In what ways did cultural context and health beliefs influence vaccine communication?

The findings revealed that cultural identity and health beliefs were central to how nurses and their communities understood COVID-19 vaccination. Rather than being peripheral influences, cultural practices and narratives shaped vaccine communication directly, producing tensions between biomedical prescriptions and community epistemologies.

Cultural Remedies and Practices

Cultural beliefs did not remain abstract but directly influenced communicative practices. At Hlatikulu, nurses explained: "*People would ask us if steaming was better than the vaccine, and*

we did not know how to answer." This shows how cultural remedies created communicative dilemmas, forcing nurses to balance biomedical advice with cultural sensitivity. Similarly, at MGH, one nurse described the challenge of religious framing and misinformation: "*That was the toughest predicament. It was difficult to force that patient, especially if it was religion based…The challenge there was with social media because there were a lot of stories that came up with patients. It was difficult but we tried to encourage them to rely on information or sources that have accurate information, from sources such as WHO.*" These examples illustrate how cultural context shaped not only beliefs but also the way nurses communicated with patients, often cautiously, to maintain trust while negotiating conflicting worldviews. At RFM, participants described how traditional remedies such as steaming and herbal treatments were widely trusted within communities. One nurse explained: *"We used steaming and traditional herbs, and they worked for us."* From an interpretivist–constructivist paradigm, these accounts are understood as co-constructed meanings of health, where biomedical and indigenous practices intersect. Within the HBM, reliance on remedies can be interpreted as perceived barriers to vaccination, but the model risks pathologising cultural practices as irrational. Campinha-Bacote's framework provides a more nuanced lens, emphasising cultural knowledge and encounters as essential for understanding how nurses engaged with these remedies. Literature on African health systems confirms the persistence of indigenous practices and their influence on biomedical uptake (Mhlongo, 2016; Topp et al., 2022). Yet the Eswatini case shows that remedies were not simply barriers but legitimate alternatives within cultural frameworks, highlighting the limits of HBM's biomedical bias.

Vaccine Scepticism

Scepticism was widespread but framed differently across sites. At Mbabane, scepticism was expressed through biomedical reasoning, with nurses questioning the speed of vaccine development and worrying about side effects. One participant explained: *"We were not sure if the vaccine was strong enough, because it came too fast."* These concerns reflect perceived barriers in HBM terms, but they also show how scepticism was grounded in professional training and biomedical discourse. At Raleigh Fitkin Memorial, scepticism was experiential, shaped by observations of colleagues who developed side effects. One nurse recounted: *"Others developed sugar diabetes due to it, others hypertension."* While medically unsubstantiated, these accounts illustrate how experiential narratives carried more weight than

official communication. At Hlatikulu, scepticism was cultural, negotiated through remedies and communal practices.

HBM interprets scepticism as contested benefits and strong barriers, but it frames scepticism as deficit thinking, ignoring its grounding in biomedical logic, lived experience, and cultural identity. Campinha-Bacote's framework highlights cultural awareness and skill, but it risks assuming scepticism can be resolved through competence alone. Literature on vaccine confidence (Larson et al., 2014; Verger et al., 2021) confirms scepticism globally, but the Eswatini case extends this by showing scepticism as negotiated across epistemologies, not simply rejection.

Cultural Narratives of Exclusion and Mistrust

At Mbabane, nurses described how patients questioned the legitimacy of vaccines, often citing rumours or community narratives. One participant explained: *"People said the vaccine was for other countries, not for us."* These accounts reflect how health beliefs are socially constructed within narratives of exclusion and mistrust. Within HBM, this is interpreted as perceived barriers, but the model cannot capture the historical and political dimensions of mistrust. Campinha-Bacote's framework helps interpret this, emphasising cultural awareness and encounters, but it presumes institutions enable competence. In Eswatini, global discourses on vaccination failed to engage with local realities, reinforcing perceptions of marginalisation. Literature confirms that vaccine hesitancy in African contexts is often shaped by historical mistrust of global health interventions (Mutombo et al., 2022; Adedokun and Idowu-Collins, 2024).

Resilience and Solidarity

Despite scepticism and cultural disruption, nurses demonstrated resilience through communal solidarity. At Hlatikulu, resilience was framed through collective improvisation and emotional support. Nurses described sharing resources and coping strategies, sustaining one another in the absence of institutional backing. This reflects self-efficacy in HBM terms, but the model treats efficacy as individual belief. In Eswatini, resilience was communal and structural, showing HBM's individualistic bias. Campinha-Bacote's framework helps interpret resilience through cultural desire and encounters, but resilience was also necessitated by neglect, revealing that competence alone cannot sustain advocacy. Literature on resilience in African

contexts (Munyewende et al., 2014) supports this, but the Eswatini case highlights resilience as a cultural and structural phenomenon rather than simply psychological coping.

Therefore, cultural context and health beliefs were not peripheral influences but central determinants of vaccine communication. Remedies, scepticism, and narratives of mistrust shaped how nurses and communities negotiated vaccination. HBM explains perceptions of barriers and benefits but oversimplifies cultural practices as obstacles. Campinha-Bacote's framework provides richer insight into cultural competence but assumes supportive structures that were absent in fragile systems. By applying both frameworks critically, the study demonstrates that vaccine communication in Eswatini was relational, cultural, and structural, requiring strategies that engage with indigenous practices and address systemic inequities.

Additionally, these findings underscore the importance of applying an intersectional lens to vaccine communication. While the Health Belief Model illuminates how nurses assessed risk, severity, and perceived barriers, and the Cultural Competence framework highlights the systemic and cultural contexts shaping their practices, intersectionality reveals how these dimensions overlapped in lived experience. Nurses' communicative labour was conditioned simultaneously by gendered expectations, socio-economic positioning, linguistic authority, and professional hierarchies. Themes such as trauma, stigma, resilience, and scepticism were not experienced uniformly but were mediated by these intersecting identities and structures. By explicitly foregrounding intersectionality, the discussion demonstrates that vaccine hesitancy and trust cannot be reduced to either individual cognition or cultural context alone; rather, they emerge at the nexus of overlapping identities and systemic inequalities. This integrative perspective strengthens the study's contribution by showing how nurses negotiated authority and trust in fragile health systems through complex social positioning.

Revisiting Hesitancy and Trajectories

The findings presented across the three research questions confirm and extend the problematisation of vaccine hesitancy and trajectories introduced in Chapters One and Two. Rather than treating hesitancy as a static refusal or acceptance of biomedical intervention, the Eswatini case demonstrates that hesitancy was a negotiated phenomenon, shaped by biomedical reasoning, lived experience, and cultural identity. At Mbabane, scepticism was grounded in professional logic, with nurses questioning the rapid development of vaccines. At Raleigh Fitkin Memorial, hesitancy was experiential, framed through peer narratives of side

effects. At Hlatikulu, hesitancy was cultural, mediated through remedies and disrupted rituals. These variations show that hesitancy was not irrational resistance but a relational process embedded in epistemologies and systemic fragility.

Similarly, vaccine trajectories were not linear progressions from hesitancy to acceptance, as dominant models often imply. Instead, trajectories diverged across sites: biomedical duty sustained uptake at Mbabane, experiential narratives complicated advocacy at RFM, and cultural disruption reshaped trajectories at Hlatikulu. Nurses' accounts reveal that trajectories were plural and contested, reflecting the interplay of professional identity, cultural frameworks, and institutional neglect. This challenges conventional framings that assume uptake follows predictable stages, highlighting instead that trajectories are contingent on context and co-constructed through social and cultural negotiation.

By revisiting hesitancy and trajectories in light of the findings, the study demonstrates continuity between theoretical critique and empirical evidence. The Eswatini case shows that vaccine communication cannot be understood through deficit models of hesitancy or linear models of uptake. Instead, it requires recognition of hesitancy as negotiated meaning and trajectories as contingent pathways shaped by cultural identity, systemic fragility, and professional mediation. This contribution extends global debates on vaccine communication, offering a more nuanced understanding that foregrounds relational, cultural, and structural dimensions.

Conclusion

This chapter has critically discussed the findings in relation to the study's three research questions, conceptual frameworks, and wider scholarship. By situating nurses' experiences within the interpretivist–constructivist and critical paradigms, the analysis has shown that vaccine communication in Eswatini was not simply a matter of information transfer but a complex process shaped by trauma, stigma, institutional neglect, scepticism, cultural identity, and resilience.

The Health Belief Model provided useful insights into perceptions of susceptibility, severity, benefits, barriers, self-efficacy, and cues to action, while Campinha-Bacote's model of cultural competence illuminated the importance of cultural awareness, knowledge, skill, encounters, and desire. Yet the Eswatini case revealed the limits of both frameworks. HBM's cognitive

orientation underplayed the relational and structural dimensions of trauma, stigma, and neglect, while Campinha-Bacote's emphasis on competence assumed supportive institutional conditions that were often absent. By applying these frameworks critically, the study demonstrated both their explanatory value and their insufficiency, thereby extending theoretical debates on vaccine communication in fragile health systems.

The findings also carried forward the problematisation of vaccine hesitancy and trajectories introduced in Chapters One and Two. Hesitancy was not irrational resistance but a negotiated phenomenon, grounded in biomedical reasoning, experiential narratives, and cultural practices. Trajectories were not linear progressions from hesitancy to acceptance but plural and contested pathways shaped by professional identity, cultural frameworks, and systemic fragility. This continuity between theoretical critique and empirical evidence underscores the study's contribution: vaccine communication must be understood as relational, cultural, and structural, rather than through deficit models of hesitancy or linear models of uptake.

Overall, the chapter demonstrates that nurses in Eswatini were not passive implementers of biomedical policy but active mediators of trust, negotiating between professional duty, cultural identity, and systemic neglect. Their experiences highlight the need for communication strategies that are culturally competent, structurally responsive, and institutionally supportive. By integrating empirical findings with critical engagement of conceptual frameworks, the study contributes to scholarship on health communication and offers new insights into how vaccine uptake is negotiated in fragile health systems.

CHAPTER EIGHT

CONTRIBUTIONS AND RECOMMENDATIONS

Introduction

This chapter sets out the contributions of the study to knowledge and practice, while also presenting recommendations that flow directly from these contributions. Building on the critical discussion in Chapter Seven, the chapter isolates the originality of the thesis by highlighting empirical, theoretical, methodological, and practical contributions. At the same time, it recognises that contributions must extend beyond academic debates to inform policy and practice in fragile health systems.

This study demonstrates that vaccine hesitancy among nurses in Eswatini cannot be adequately explained by either individual cognition or cultural context alone. The Health Belief Model illuminates how nurses assessed risk, severity, benefits, and barriers, while the Cultural Competence framework highlights the systemic fragilities and cultural identities that shaped their communicative practices. Yet the findings show that these dimensions overlapped in lived experience: nurses' communicative labour was conditioned simultaneously by gendered expectations, socio-economic positioning, linguistic authority, and professional hierarchies. By integrating HBM and Cultural Competence through an intersectional lens, this research advances health communication scholarship beyond reductive framings of hesitancy. It foregrounds the complex negotiations through which nurses mediated trust and authority in fragile health systems, offering a more nuanced theoretical and practical understanding of vaccine communication in under-resourced contexts.

The study's empirical findings provide new insights into nurses' lived experiences of vaccine communication in Eswatini, revealing how trauma, stigma, scepticism, and resilience were co-constructed through cultural identity and systemic fragility. Theoretically, the study extends and critiques the Health Belief Model and Campinha-Bacote's cultural competence framework, demonstrating both their explanatory value and their limitations in fragile contexts. Methodologically, it shows the value of Interpretative Phenomenological Analysis and focus group dynamics in capturing collective meaning. Practically, it highlights the need for culturally competent and structurally responsive communication strategies.

From these contributions arise clear recommendations. Policy frameworks should integrate cultural competence into pandemic preparedness, recognising nurses as cultural agents as well as biomedical professionals. Institutional support must extend beyond resource provision to include recognition, training, and transparent communication, thereby reducing stigma and moral distress. Communication strategies should engage indigenous practices such as steaming and herbal remedies, not as barriers but as cultural realities that shape vaccine trajectories. Future research should explore comparative contexts and longitudinal patterns to deepen understanding of how hesitancy and trajectories evolve over time.

By combining contributions and recommendations in a single chapter, the thesis demonstrates both scholarly originality and practical relevance. The sections that follow are organised under four headings: empirical, theoretical, methodological, and practical/policy contributions, with recommendations integrated to show how the study advances knowledge while informing action.

Contributions

Empirical Contributions

The study provides new empirical insights into nurses' lived experiences of COVID-19 vaccine communication in Eswatini, a context underrepresented in global scholarship. Existing literature has documented healthcare worker trauma, stigma, and hesitancy in high-income settings (Shanafelt et al., 2020; Ramaci et al., 2020), but few studies have explored how these phenomena are shaped by cultural identity and systemic fragility in sub-Saharan Africa.

- The study shows that trauma was not only psychological but also cultural, intensified by disrupted funeral rituals and communal grieving practices.
- It demonstrates that stigma was relational, institutional, and cultural, challenging the assumption that stigma is simply individual prejudice.
- It reveals that vaccine scepticism was grounded in biomedical reasoning, experiential narratives, and cultural remedies, extending global debates on hesitancy by showing it as negotiated rather than deficit.
- It highlights resilience as a communal and structural phenomenon, sustained through solidarity and improvisation rather than individual coping alone.

By documenting these layered experiences, the study contributes empirical depth to the literature on vaccine communication in fragile health systems, showing how nurses act as mediators of trust between biomedical authority and cultural identity.

Theoretical Contributions

The study makes theoretical contributions by critically applying and extending two conceptual frameworks: the Health Belief Model (HBM) and Campinha-Bacote's model of cultural competence.

- **Health Belief Model:** The study confirms the relevance of HBM constructs such as susceptibility, severity, benefits, barriers, and self-efficacy, but demonstrates their limits. HBM's cognitive orientation underplays relational, cultural, and structural dimensions of trauma, stigma, and neglect. The Eswatini case shows that vaccine communication cannot be reduced to individual risk perception but must be understood as socially and culturally negotiated.
- **Campinha-Bacote's model:** The study highlights the importance of cultural awareness, knowledge, skill, encounters, and desire, but critiques the model's assumption that competence can be enacted if desired. In fragile systems, institutional neglect and resource shortages constrained nurses' ability to practice cultural competence.
- **Problematisation of Hesitancy and Trajectories:** Building on the critique introduced in Chapters One and Two, the study demonstrates empirically that vaccine hesitancy is not irrational resistance but a negotiated phenomenon, and that trajectories of uptake are plural and contested rather than linear. This reframing extends theoretical debates on vaccine communication by foregrounding relational, cultural, and structural dimensions.

Together, these contributions show that existing frameworks must be adapted to account for systemic fragility and cultural identity, offering a more nuanced theoretical lens for understanding vaccine communication in low-resource contexts.

Methodological Contributions

The study also contributes methodologically by demonstrating the value of Interpretative Phenomenological Analysis (IPA) and focus group dynamics in exploring collective meaning in fragile health systems.

- IPA allowed the study to capture the depth of nurses' lived experiences, foregrounding meaning-making as co-constructed through professional identity, cultural context, and systemic neglect.
- Focus groups provided insight into collective negotiation of meaning, revealing how nurses constructed shared narratives of trauma, stigma, and resilience. This extends methodological debates by showing that IPA, often applied to individual interviews, can be productively adapted to group settings in contexts where collective identity is central.
- The study also demonstrates the importance of combining interpretivist–constructivist and critical paradigms, allowing analysis to move beyond description to interrogate systemic inequities and institutional neglect.

These methodological contributions highlight the value of qualitative approaches that privilege lived experience and collective meaning, particularly in under-researched fragile health systems.

Practical and Policy Contributions

Finally, the study offers practical and policy contributions relevant to health communication and system strengthening in Eswatini and comparable contexts.

- It underscores the need for culturally competent communication strategies that engage with indigenous practices rather than dismiss them.
- It highlights the importance of institutional support and recognition for nurses, showing that resilience cannot be sustained through sacrifice alone.
- It demonstrates that communication strategies must move beyond top-down information dissemination to relational engagement that acknowledges cultural identity and systemic fragility.

- It suggests that policy frameworks should integrate cultural competence into pandemic preparedness, recognising nurses as cultural agents as well as biomedical professionals.

These contributions provide actionable insights for policymakers, health managers, and communication practitioners seeking to strengthen vaccine advocacy in fragile health systems.

Having outlined the empirical, theoretical, methodological, and practical contributions of the study, it is important to consider how these insights can inform action beyond the academic sphere. Contributions demonstrate originality in knowledge production, but their value is fully realised when translated into strategies that strengthen communication, support nurses, and engage communities in fragile health systems. The Eswatini case highlights that vaccine communication is relational, cultural, and structural, requiring responses that move beyond deficit models of hesitancy and linear trajectories of uptake. Building on these contributions, the following section sets out recommendations for policy, practice, and future research, ensuring that the study's findings not only advance scholarship but also provide guidance for more culturally competent and structurally responsive health interventions.

Recommendations

Policy Recommendations

- **Integrate cultural competence into pandemic preparedness:** Health policies should recognise nurses as cultural agents as well as biomedical professionals. This requires embedding cultural awareness and engagement into vaccination campaigns, ensuring that indigenous practices are acknowledged rather than dismissed.
- **Strengthen institutional support:** Ministries of Health and hospital administrations must provide consistent training, transparent communication, and adequate resources. Support should extend beyond material provision to include recognition of nurses' sacrifices, thereby reducing stigma and moral distress.
- **Address systemic inequities:** Policy frameworks should prioritise equitable resource allocation to rural and under-resourced hospitals, ensuring that institutional neglect does not exacerbate vulnerability during health crises.

Practice Recommendations

- **Enhance communication strategies:** Nurses should be equipped with clear, consistent, and culturally sensitive information to strengthen their credibility as vaccine advocates. Communication must move beyond top-down dissemination to relational engagement that acknowledges community narratives.
- **Support nurses' dual identities:** Training and workplace cultures should recognise that nurses are both professionals and community members. Practical support systems — such as counselling, peer solidarity groups, and recognition schemes — can help mitigate trauma and stigma.
- **Engage indigenous practices:** Health practitioners should be trained to engage with remedies such as steaming and herbal treatments as cultural realities. Rather than framing these practices as barriers, they should be incorporated into dialogue as part of broader health communication.

Research recommendations

- **Comparative studies:** Future research should explore vaccine communication across other fragile health systems, enabling cross-contextual insights into how cultural identity and systemic fragility shape hesitancy and trajectories.
- **Longitudinal research:** Studies should track vaccine communication over time, examining how hesitancy and trajectories evolve beyond the immediate crisis.
- **Intersectional analysis:** Further research should investigate how gender, age, and professional hierarchies intersect with cultural identity to shape nurses' experiences of advocacy and resilience.

Conclusion

This chapter has highlighted the originality of the study by setting out its contributions to knowledge and practice, and by presenting recommendations that flow directly from these contributions. Taken together, these contributions demonstrate that the study advances scholarship on vaccine communication, cultural competence, and fragile health systems, while also offering actionable insights for policy and practice.

Empirically, the study provides rich accounts of nurses' lived experiences of COVID-19 vaccination in Eswatini, a context often marginalised in global debates. By documenting

trauma, stigma, scepticism, resilience, and professional identity as co-constructed phenomena, the study extends understanding of how vaccine communication is negotiated in fragile health systems. These findings challenge deficit models of hesitancy and linear models of uptake, showing instead that trajectories are plural, contested, and deeply shaped by cultural identity and systemic fragility.

Theoretically, the study makes important contributions by critically applying and extending the Health Belief Model and Campinha-Bacote's cultural competence framework. While both frameworks provided useful lenses, the Eswatini case revealed their limits: HBM's cognitive orientation underplayed relational and structural dimensions, while Campinha-Bacote's model assumed supportive institutional conditions that were absent. By problematising hesitancy and trajectories, the study reframes vaccine communication as relational, cultural, and structural, offering a more nuanced theoretical lens for future scholarship.

Methodologically, the study demonstrates the value of Interpretative Phenomenological Analysis and focus group dynamics in capturing collective meaning in fragile health systems. By adapting IPA to group settings and combining interpretivist–constructivist and critical paradigms, the study shows how qualitative approaches can illuminate both lived experience and systemic inequities. This methodological contribution underscores the importance of privileging collective voices in contexts where communal identity is central.

Practically, the study highlights the need for culturally competent and structurally responsive communication strategies. Nurses in Eswatini were not passive implementers of biomedical policy but active mediators of trust, negotiating between professional duty, cultural identity, and systemic neglect. Recognising this dual role is essential for designing communication strategies that are effective and sustainable.

From these contributions arise clear recommendations. Policy frameworks must integrate cultural competence into pandemic preparedness, strengthen institutional support, and address systemic inequities. Practice must enhance communication strategies, support nurses' dual identities, and engage indigenous remedies as cultural realities. Future research should pursue comparative, longitudinal, and intersectional studies to deepen understanding of vaccine communication trajectories.

In sum, this chapter demonstrates that the study contributes to knowledge in multiple dimensions: empirical, theoretical, methodological, and practical. It also ensures that these contributions are matched by recommendations that can inform policy, practice, and future research. By combining scholarly originality with practical relevance, the study underscores the importance of understanding vaccine communication not as a technical exercise but as a relational, cultural, and structural phenomenon. This expanded conclusion positions the thesis as both a contribution to academic debates and a guide for action in fragile health systems. Therefore, the findings provide the foundation for articulating the study's theoretical contribution, which lies in integrating existing frameworks through an intersectional lens.

CHAPTER NINE

CONCLUSION

Introduction

This final chapter draws together the threads of the thesis, restating its aims, summarising the key findings, and reflecting on the contributions made to knowledge and practice. It also acknowledges the study's limitations and outlines directions for future research. In doing so, the chapter provides a coherent conclusion that highlights the originality and significance of the study, both within academic debates and in the practical realities of vaccine communication in fragile health systems.

Restating the aim and research questions

The study set out to explore nurses' perceptions and experiences of COVID-19 vaccination in Eswatini, with the aim of understanding how cultural identity, professional responsibility, and systemic fragility shaped vaccine communication. Three research questions guided the inquiry:

1. How did nurses experience vaccine communication during the COVID-19 pandemic?
2. What challenges did nurses face in advocating for vaccination within fragile health systems?
3. How did cultural context and health beliefs shape nurses' perceptions of vaccination?
4. In what ways did cultural context and health beliefs influence vaccine communication?

These questions provided the framework for analysis, enabling the study to capture both the lived realities of nurses and the broader systemic and cultural dynamics that shaped vaccine trajectories.

Summary of key findings

The findings revealed that nurses' experiences were complex, layered, and deeply contextual.

- **Trauma and stigma** were pervasive, but framed differently across sites: biomedical at Mbabane, institutional at Raleigh Fitkin Memorial, and cultural at Hlatikulu.
- **Institutional neglect** undermined advocacy, manifesting as fragmented training, symbolic exploitation, and material shortages.

- **Scepticism** was widespread but grounded in biomedical reasoning, experiential narratives, and cultural remedies, challenging deficit models of hesitancy.
- **Communication gaps** reflected both inconsistent biomedical messaging and cultural contestation, undermining nurses' credibility.
- **Resilience and dedication** were sustained through professionalism, solidarity, and sacrifice, but often necessitated by systemic neglect.
- **Professional identity** was tested by ethical dilemmas, as nurses navigated tensions between duty to patients and responsibility to family and community.
- **Cultural context and health beliefs** were central, shaping vaccine perceptions through indigenous practices, narratives of mistrust, and communal solidarity.

Together, these findings demonstrate that vaccine communication in Eswatini was relational, cultural, and structural, requiring strategies that move beyond biomedical framings and deficit models of hesitancy.

Contributions to knowledge

As outlined in Chapter Eight, the study makes contributions across four dimensions:

- **Empirical:** Documenting nurses' lived experiences of vaccine communication in Eswatini, extending global debates by foregrounding cultural identity and systemic fragility.
- **Theoretical:** Critically applying and extending the Health Belief Model and Campinha-Bacote's cultural competence framework, reframing vaccine hesitancy and trajectories as negotiated and contingent.
- **Methodological:** Demonstrating the value of Interpretative Phenomenological Analysis and focus group dynamics in capturing collective meaning in fragile health systems.
- **Practical/Policy:** Offering insights for culturally competent and structurally responsive communication strategies, recognising nurses as cultural agents as well as biomedical professionals.

These contributions underscore the originality of the study and its significance for scholarship and practice.

Recommendations

Building on these contributions, the study offers recommendations for policy, practice, and research:

- **Policy:** Integrate cultural competence into pandemic preparedness; strengthen institutional support through training, recognition, and resources; and address systemic inequities in healthcare provision.
- **Practice:** Equip nurses with clear, consistent, and culturally sensitive information; support their dual identities as professionals and community members; and engage indigenous remedies as cultural realities rather than barriers.
- **Research:** Pursue comparative studies across fragile health systems, longitudinal research on vaccine communication trajectories, and intersectional analyses of how gender, age, and professional hierarchies shape experiences.

These recommendations ensure that the study's findings are not only academically significant but also practically relevant.

Limitations

The study acknowledges several limitations. First, reliance on focus groups may have constrained individual expression, though collective dynamics were central to the study's aims. Second, the rapidly evolving nature of the pandemic means that perceptions captured at one point in time may shift over longer trajectories. These limitations do not undermine the study's contributions but highlight areas for caution and further inquiry.

Future directions

Future research should build on this study by exploring vaccine communication in other fragile health systems, enabling comparative insights. Longitudinal studies are needed to examine how hesitancy and trajectories evolve beyond the immediate crisis. Intersectional approaches could deepen understanding of how professional identity interacts with gender, age, and hierarchy. Finally, research should investigate how indigenous practices can be meaningfully integrated into biomedical communication strategies, ensuring culturally competent and structurally responsive health interventions.

Closing reflection

This thesis has shown that vaccine communication in Eswatini was not a simple matter of information transfer but a complex negotiation shaped by trauma, stigma, resilience, cultural identity, and systemic fragility. By problematising vaccine hesitancy and trajectories, and by critically engaging with conceptual frameworks, the study contributes to scholarship while offering practical guidance for policy and practice. Nurses in Eswatini were not passive implementers of biomedical policy but active mediators of trust, navigating between professional duty, cultural identity, and systemic neglect. Recognising this dual role is essential for designing communication strategies that are effective, sustainable, and just.

In closing, the study underscores the importance of understanding vaccine communication as relational, cultural, and structural. By foregrounding the voices of nurses in a fragile health system, it contributes to global debates on health communication and offers pathways for more culturally competent and structurally responsive interventions. The originality of the study lies not only in its empirical insights but also in its theoretical reframing and methodological innovation, ensuring that its contributions resonate across scholarship, policy, and practice.

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ANNEX ONE

SCREENER FOR FOCUS GROUP DISCUSSIONS AND INTERVIEWS– NURSES EMPLOYED AT THE RALEIGH FITKIN MEMORIAL/ HLATIKULU GOVERNMENT AND MBABANE GOVERNMENT HOSPITALS THAT ARE SITES FOR THIS STUDY

This screener is for recruiting participants for a focus group discussion on understanding perceptions and experiences of the COVID-19 vaccine among healthcare workers in three hospitals in Eswatini

Using this screener: Please keep a record of the number of people who end up being selected.

Please recruit:

- 4 male nurses
- 4 female nurses
- Able to participate using English or Siswati
- All participants should be fulltime employees at one of any of the three hospitals
- Participants must indicate willingness to participate by signing a consent form.
- Participants must have access to the Internet and have a gadget that allows connection to Zoom in the case of restrictions due to COVID-19

It is very important to ensure that the participant selected are available and committed to attending the focus group discussion and/or interviews.

ANNEX 2

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL
For research with human participants

INFORMED CONSENT RESOURCE TEMPLATE

Note to researchers: Notwithstanding the need for scientific and legal accuracy, every effort should be made to produce a consent document that is as linguistically clear and simple as possible, without omitting important details as outlined below. Certified translated versions will be required once the original version is approved.

There are specific circumstances where witnessed verbal consent might be acceptable, and circumstances where individual informed consent may be waived by HSSREC.

Information Sheet and Consent to Participate in Research

Date:

Dear Sir/ Madam

My name is Nqobile T. Ndzinisa and I am a Doctor of Philosophy student from the department of Culture, Communication and Media Studies, and also referred to as the Centre for Communication, Media and Society (CCMS). CCMS falls under the Applied Human Sciences Faculty at the University of KwaZulu-Natal.

My research is entitled: **Much Ado About COVID -19 Vaccine[s]: Understanding Perceptions and Experiences of the COVID-19 vaccine among Healthcare Workers in Three Hospitals in Eswatini.**

You are being invited to consider participating in a study that involves research into **understanding Perceptions and Experiences of the COVID-19 vaccine among Healthcare Workers in Three Hospitals in Eswatini**. The aim and purpose of this research is to understand experiences of the COVID-19 vaccines among nurses and as well as explore concerns that nurses might have about the vaccines. The purpose is to understand the ways in which nurses can enable and promote more effective COVID-19 prevention. The study is expected to enroll 24 participants in total, eight in each hospital at the following hospitals: Raleigh Fitkin Memorial, Mbabane Government and Hlatikulu Government Hospitals. It will involve the following procedures; two socially distanced focus groups at Hlatikulu Government Hospital and the Raleigh Fitkin Memorial Hospital as well as face to face interviews at the Mbabane Government Hospital. In case of COVID-19 restrictions; these might have to be done online through Zoom. The duration of your participation if you choose to enroll and remain in the study is expected to be 1 -1.5 hrs for focus groups and 45minutes to 1 hour for interviews. The study is not funded.

The study will provide no direct benefits to participants. However, scientific benefits of the study will result include enhancing an understanding of how nurses in Eswatini have adapted their cultural knowledge when providing care during the COVID-19 pandemic as well provide nurses with a platform in which they can propose ways in which they think can enable and promote more effective COVID-19 prevention in the country.

No risk is anticipated in this study, as the aim to understand your experiences; however, if traumatic memories are triggered, you will be referred to the National Psychiatric Centre for counselling.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number_____).

In the event of any problems or concerns/questions you may contact the researcher at [redacted] / 2160892@stu.ac.za or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Please note that participation in this research is voluntary and you are allowed to withdraw participation at any point. In the event of refusal or withdrawal of participation, you will not incur penalty or loss of treatment or other benefit to which you are normally entitled. For orderly withdrawal, please refrain from signing this form and inform me via WhatsApp. Please note that you will not be allowed to participate in the study if you are sick, or display disorderly conduct or are under the influence of drugs or alcohol.

It is expected that you will not incur any costs as a result of your participation in this study, except in the case of COVID-19 restrictions which might limit travel. Your name and personal information will not be collected during data collection and a pseudonym will be used to refer to you in the study.

All data including recordings from interviews will be securely stored in a password-protected file and will be accessible to myself and my supervisor. After a period of five years, in line with the University rules, all data will be disposed of and deleted.

CONSENT (Edit as required)

I (Name_____) have been informed about the study entitled Much Ado About COVID -19 Vaccine[s]: Understanding Perceptions and Experiences of the COVID-19 vaccine among Healthcare Workers in Three Hospitals in Eswatini by Nqobile Thobile Ndzinisa.

I understand the purpose and procedures of the study.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at (provide details).

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Additional consent, where applicable

I hereby provide consent to:

Audio-record my interview / focus group discussion	YES / NO
Video-record my interview / focus group discussion	YES / NO
Use of my photographs for research purposes	YES / NO

_____ _____
Signature of Participant **Date**

_____ _____
Signature of Witness (Where applicable) **Date**

_____ _____
Signature of Translator (Where applicable) **Date**

ANNEX 3

Much Ado About COVID -19 Vaccine[s]: Understanding Perceptions and Experiences of the COVID-19 vaccine among Healthcare Workers in Three Hospitals in Eswatini

Study Population Form

Gender_____

Age group (please pick your age range): 20 - 29 years 30-39 years 40 -49 years 50 and above

Department:_____

Years in service:_____

Vaccinated against COVID? Yes_____ No_____

Rather Not Say_____

ANNEX FOUR

Semi-Structured Interview Guide

Introductions:

Introduce myself and thank participants for their time

State: The purpose of this interview is to explore nurses' experiences and perspectives on COVID-19 vaccination, including how trauma, stigma, resilience, cultural identity, and professional responsibility have shaped those experiences.

There are no right or wrong answers, I am just interested in your honest views and stories. Everything you share will be treated with respect and confidentiality. Participation is voluntary, and you may choose not to answer any question or stop at any time.

To make sure that you feel comfortable, let's agree on a few ground rules:

- I will keep what is shared here private outside this group.
- Share only what you feel comfortable discussing.

I'll guide you with some questions, but please feel free to expand, give examples, or raise issues that matter to you. My role is to listen and learn from your experiences.

Section 1: Experiences and Interpretations (Trauma, Stigma, Resilience)

Core Question:

Can you describe your personal and professional experiences with COVID-19 vaccination?

Probes:

- How did the vaccination process intersect with the trauma of working during the pandemic?
- Have you experienced or witnessed stigma related to vaccination?
- What strategies or sources of resilience helped you cope?
- How do you interpret the meaning of vaccination in your role as a nurse?

Section 2: Concerns and Scepticism (Cultural Identity, Responsibility, Systemic Fragility)

Core Question:

What concerns or scepticisms did you or your colleagues have about the COVID-19 vaccines?

Probes:

How did cultural identity shape these concerns?

- Did systemic challenges (e.g., supply shortages, communication gaps, mistrust in institutions) influence your views?
- How did your sense of professional responsibility affect your stance on vaccination?
- Were there moments when your personal beliefs conflicted with professional expectations?

Section 3: Mediators of Trust (Clinical and Community Settings)

Core Question:

How do you see your role in building trust around COVID-19 prevention and vaccination?

Probes:

- Can you share examples of how you communicated with patients or community members about vaccines?
- What challenges did you face in promoting trust?
- What strategies worked best in bridging gaps between clinical knowledge and community beliefs?
- How did patients or communities respond to your efforts?

Section 4: Cultural Context and Health Beliefs

Core Question:

- How did cultural context and health beliefs influence vaccine communication in your hospital or community?

Probes:

- Were there specific cultural narratives that made communication easier or more difficult?
- How did you adapt your communication to align with these beliefs?
- Did you collaborate with community leaders or cultural figures to strengthen vaccine messaging?
- How do you think cultural context will continue to shape health communication in the future?

Wrap-Up

- Looking back, what lessons have you learned about vaccine communication and trust-building?
- What recommendations would you give to policymakers, hospital administrators, or fellow nurses for future health crises?
- Is there anything else you'd like to share that we haven't covered?

ANNEX FIVE

Study Title: Much Ado About COVID -19 Vaccine[s]: Understanding Perceptions and Experiences of the COVID-19 vaccine among Healthcare Workers in Three Hospitals in Eswatini

Focus Group Guiding Questions

Introductions:

1) Introduce yourselves one at a time. Tell us your name and where you are from.
2) Icebreaker Exercise

Explaining of ground rules

I would like to get as much information from you as possible, so I encourage everyone to participate. There is no wrong or right answer. Please observe common courtesy by letting one person speak at a time. Please feel free to agree or disagree and anyone can contribute to the discussion at any time, however, I ask that this be done in a friendly and orderly manner. I also request your permission to tape this discussion and if anyone is uncomfortable with this, please let me know. The taped conversation will also remain confidential. We will spend one hour to one and a half hours on the discussion and refreshments will be served midway through the discussion. I will let you know 10 minutes before our time ends so that we can conclude our discussion.

The Moderator will read through consent form and allow participants to sign consent forms (7 minutes)

Warm-Up Questions

Can you share a little about your role and daily responsibilities at your hospital?

What was your first reaction when COVID-19 vaccines became available in Eswatini?

Main Discussion Areas

1. **Experiences and Interpretations (Trauma, Stigma, Resilience)**

- How did the pandemic and vaccination process affect you personally and professionally?
- Have you encountered stigma related to vaccination (from patients, colleagues, or community)?
- What helped you cope or remain resilient during this period?

2. **Concerns and Scepticism (Cultural Identity, Responsibility, Systemic Fragility)**

- What concerns or doubts did you or your colleagues have about the vaccines?
- How do you think cultural identity shaped these concerns?
- Did systemic challenges (e.g., supply shortages, communication gaps) influence your views?
- How did your sense of professional responsibility affect your decision-making?

3. **Mediators of Trust (Clinical and Community Settings)**

- How do you see your role in building trust around COVID-19 prevention?
- Can you share examples of how you communicated with patients or community members about vaccines?
- What strategies worked best in promoting trust?

4. Cultural Context and Health Beliefs

- How did local cultural beliefs influence vaccine communication in your hospital or community?
- Were there specific cultural narratives that made communication easier or more difficult?
- How did you adapt your communication to align with these beliefs?

Wrap-Up Questions

- Looking back, what lessons have you learned about vaccine communication and trust-building?
- What recommendations would you give to policymakers or hospital administrators for future health crises?

Eswatini Nazarene Health Institution (ENHI)
Raleigh Fitkin Memorial (RFM) Hospital
& the Community Health Clinics
Ndzwabangeni, Mshingishingini, Piggs Peak, Bhalekane, Nkwangeni, Shiselweni, Malandzela, Sitsatsaweni, Mliba, Bhekinkhosi, Mahatsini, Siteki, New Village, Vulamehlo, Mangwenya, Mpaka, Phunga, Sigcaweni, Ngculweni, Bulunga
CHURCH OF THE NAZARENE

01 November 2021

Nqobile Ndzinisa
University of KwaZulu-Natal
Durban
South Africa

Dear Madam

RE: AUTHORIZATION TO DO RESEARCH IN THE HOSPITAL

Your request on the fore mentioned endeavors has been duly considered and permission granted on the following conditions please:

a). That confidentiality is strictly observed
b). That the hospital receives a copy of the report on the proposed research.

You [redacted]

Leonard S. Dlamini (Mr.)
HOSPITAL ADMINISTRATOR

CC: Matron 1
SMO

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THE KINGDOM OF ESWATINI

MINISTRY OF HEALTH
P.O. BOX 5
MBABANE
ESWATINI

30 November 2021

University of KwaZulu-Natal
School of Applied Human Sciences
Centre for Communication, Media and Society (CCMS)
Howard College Campus
Durban 4041
South Africa

RE: PERMISSION TO CONDUCT RESEARCH- GATEKEEPER'S LETTER -216073982

To whom it may concern,

The Ministry of Health hereby permits Ms. Nqobile Thobile Ndzinisa, PhD candidate (Student number 216073982) in the Centre for Communication, Media and Society (CCMS), University of KwaZulu-Natal (South Africa), to conduct research relating to health communication in Eswatini with the relevant staff in our hospitals. The nursing staff of Hlathikulu Government Hospital and the Mbabane Government Hospital are part of two of the three hospitals that are being studied by Ms. Ndzinisa in her proposed research titled: **Much Ado About COVID -19 Vaccine(s): Understanding Perceptions and Experiences of the COVID-19 vaccine among Health Care Workers in Three Hospitals in Eswatini.**

This gatekeeper's letter serves to grant Ms. Ndzinisa access to the hospitals' nursing staff who will participate in her research as expert interviewees on a voluntary basis. The permission is subject to the researcher's observance of ethical procedures in the research process.

Permission granted by:

[redacted]

DR. S. V. MAGAGULA
DIRECTOR OF HEALTH SERVICES

MINISTRY OF HEALTH
DIRECTOR OF HEALTH SERVICES
30 NOV 2021
P.O. BOX 5
MBABANE
ESWATINI

ESWATINI
HEALTH AND HUMAN
RESEARCH REVIEW BOARD
MBANDZENI HOUSE, 3RD FLOOR, CHURCH STREET
P.O. BOX 5, MBABANE, ESWATINI

ONE YEAR RESEARCH PROTOCOL APPROVAL CERTIFICATE

BOARD REGISTRATION NUMBER	FWA 00026661/IRB 00011253								
PROTOCOL REFERENCE NUMBER	No Ref.								
Type of review	Expedited	X		Full Board					
Name of Organization	**PHD Student**								
Title of study	Understanding Perceptions and Experiences of vaccines among Healthcare Workers in Three Hospitals in Eswatini								
Protocol version	1.0								
Nature of application	New	Amendment		Renewal		Extension		CT updates	
	X								
List of study sites	Raleigh Fitkin Memorial, Hlathikhulu Government Hospital and Mbabane Government Hospitals								
Name of Principal Investigator	**Ms. Nqobile Thobile Ndzinisa**								
Names of Co- Investigators	N/A								
Names of steering committee members in the case of clinical trials	N/A								
Names of Data and Safety Committee members in the case of clinical trials	N/A								
Level of risk (Tick appropriate box)	Minimal		More than minimal		High				
	X								
Initial study Approval information	Approved	X	Study completion date	31/12/2023	Certificate expiry Date	05/07/2023			
	Approval date	05/07/2022							
Study renewal approval information	Renewal date				End date				
Study amendment approval information	Amendment date								
Study extension approval information	Exte[redacted] date				End date				
Signature of Chairperson									
Signing date	05/07[redacted]								
Secretariat Contact Details	Name of contact officers		Babazile Shongwe						
	Email address		ehhrbeswatini@gmail.com/es@ehhrrb.org.sz						
	Telephone no.		[redacted]						

0 5 JUL 2022

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