NIU Journal of Educational Research Copyright©2026
Nexus International University ISSN: *3007-1844;* 12(1): 247-255

Health Education and Behavior Change Communication (BCC) in Disease Prevention: A Review of Effectiveness and Strategies

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Abstract. Health education and behavior change communication (BCC) represent foundational pillars of public health strategy, harnessing evidence-informed communication principles to modify health-related knowledge, attitudes, and practices across diverse populations. This narrative review synthesises peer-reviewed literature published between 2015 and 2026 to evaluate the effectiveness of health education and BCC interventions in the prevention of communicable and non-communicable diseases globally. Five principal mechanistic and strategic domains are examined: theoretical frameworks underpinning BCC design, multi-channel communication modalities, community-based participatory approaches, digital and mHealth innovations, and cultural competence as a determinant of intervention reach and impact. Evidence consistently demonstrates that theory-guided, culturally adapted, multi-channel BCC programmes produce significant improvements in health knowledge, preventive behaviour adoption, and disease incidence outcomes, with effect sizes moderated by intervention intensity, target population characteristics, and the fidelity of implementation. The review identifies critical gaps in long-term follow-up evidence, equity-focused evaluation methodologies, and the integration of structural determinants of health within BCC frameworks. Practice recommendations and future research priorities are outlined for public health professionals, programme designers, and policymakers committed to maximising the population-level impact of health communication investments.

Keywords: Health education, behavior change communication, disease prevention, health promotion, mHealth, community-based interventions, theoretical frameworks, cultural competence

1. Introduction

The global burden of preventable disease — communicable infections, vaccine-preventable illnesses, chronic non-communicable conditions, and the behavioral risk factors that sustain them — remains one of the defining challenges of 21st-century public health. Despite remarkable advances in pharmacological treatment, diagnostic technology, and health system infrastructure, the persistence of preventable morbidity and mortality in both high-income and low-and-middle-income countries (LMICs) underscores a fundamental truth: biomedical solutions alone are insufficient to produce population-level health improvements when individuals lack the knowledge, motivation, and social support needed to adopt and sustain protective health behaviours (Nutbeam & Lloyd, 2021). Health education and behavior change communication emerge from this recognition as indispensable complements to clinical and structural public health interventions — mechanisms through which populations are equipped with the information, skills, and normative frameworks required to reduce their exposure to disease risk.

Behavior change communication is broadly defined as a systematic, evidence-based process of developing, disseminating, and evaluating messages and strategies designed to promote positive health

behaviour among defined audiences, drawing on established theories of human behaviour and communication science (UNICEF, 2018). Distinguished from one-way information provision by its emphasis on dialogue, audience participation, and behaviour as the primary outcome, BCC has evolved substantially since its origins in social marketing and health promotion campaigns of the 1970s and 1980s. Contemporary BCC frameworks integrate insights from behavioural economics, communication theory, anthropology, and implementation science to produce interventions characterised by theoretical grounding, audience-specific message design, multi-channel delivery, and rigorous evaluation (Schiavo, 2020). The evidence base for BCC effectiveness has expanded considerably over the past decade, yet critical questions about the mechanisms of behaviour change, the optimal design of communication strategies, and the conditions under which BCC effects are sustained over time remain subjects of active investigation.

The disease prevention context for BCC encompasses both communicable and non-communicable disease domains. In communicable disease prevention, BCC has been applied to HIV/AIDS, tuberculosis, malaria, vaccine-preventable diseases, and — most recently and visibly — COVID-19, where communication failures and successes fundamentally determined the trajectory of the pandemic in different populations (Bedson et al., 2021). In non-communicable disease prevention, BCC addresses the behavioural risk factors — tobacco use, physical inactivity, unhealthy diet, harmful alcohol consumption — that collectively account for the majority of preventable non-communicable disease burden globally. Across both domains, the strategic principles of effective BCC — theoretical grounding, audience analysis, cultural adaptation, multi-channel delivery, and participatory design — are broadly consistent, even as the specific content and contextual adaptations required differ substantially.

This review is organised around five analytical domains: (1) theoretical frameworks that provide the mechanistic foundation for BCC design; (2) multi-channel and mass media communication strategies; (3) community-based and interpersonal communication approaches; (4) digital health and mHealth innovations in BCC delivery; and (5) cultural competence and equity as determinants of BCC reach and effectiveness. For each domain, the review evaluates the quality and consistency of evidence from 2015 to 2026, identifies moderating variables, and draws implications for practice and policy. A concluding section addresses limitations of the evidence base and priorities for future research.

2. Theoretical Frameworks Underpinning BCC Design

The theoretical grounding of BCC interventions is consistently identified as a predictor of effectiveness in systematic reviews and meta-analyses, yet the translation of theory into programme design remains uneven in practice. The most widely applied frameworks in BCC for disease prevention include the Health Belief Model (HBM), Social Cognitive Theory (SCT), the Theory of Planned Behaviour (TPB), the Transtheoretical Model (TTM), and the Social-Ecological Model — each offering distinct explanatory mechanisms and corresponding implications for message design and strategy selection (Glanz et al., 2015). The HBM, which posits that behaviour change is driven by perceived susceptibility, severity, benefits, barriers, cues to action, and self-efficacy, has been applied extensively in vaccine uptake campaigns, HIV prevention, and screening behaviour promotion, with meta-analytic evidence demonstrating consistent associations between HBM constructs and preventive behaviour adoption across multiple disease contexts (Jones et al., 2015).

Social Cognitive Theory, with its central constructs of observational learning, self-efficacy, and outcome expectancies, provides a particularly rich theoretical foundation for BCC interventions that employ role modelling, skills demonstration, and incremental goal-setting — strategies well suited to the cultivation of complex preventive behaviours requiring sustained motivation and practical skill (Bandura, 2004, as cited in Fernandez et al., 2019). The TTM's stages-of-change model, which conceptualises behaviour change as a dynamic process through which individuals move from pre-contemplation to maintenance via intermediate stages of contemplation, preparation, and action, has informed the development of stage-matched communication strategies that tailor message content to the audience's current motivational state — an approach demonstrated to improve intervention efficiency by avoiding the mismatch between change-promoting messages and audiences not yet ready to act (Prochaska et al., 2015). Increasingly, contemporary BCC frameworks adopt an integrative approach that draws on multiple theories simultaneously, recognising that no single theoretical model fully accounts for the complexity of human health behaviour in real-world social and environmental contexts (Michie et al., 2018).

The Behaviour Change Wheel (BCW) and its associated Capability-Opportunity-Motivation-Behaviour (COM-B) model have emerged as influential integrative frameworks in BCC programme design over the past decade, providing

systematic guidance on the identification of behavioural determinants and the selection of intervention functions matched to those determinants (Michie et al., 2018). Applied to disease prevention contexts in LMICs and high-income settings alike, the COM-B model distinguishes between capability barriers (lack of knowledge or skill), opportunity barriers (social norms, physical access, structural constraints), and motivation barriers (attitudes, habits, intentions), enabling programme designers to target intervention resources precisely at the behavioural bottlenecks that most constrain adoption of preventive behaviour in a given population. A systematic review by Prestwich et al. (2016) found that BCC interventions explicitly grounded in identified theoretical mechanisms demonstrated significantly larger effect sizes on behaviour change outcomes than theoretically unspecified interventions, providing empirical justification for the investment in theory-based programme design that characterises best practice in contemporary BCC.

3. Multi-Channel Communication Strategies and Mass Media

The selection of communication channels is a strategic decision with profound implications for BCC reach, engagement, and behaviour change impact. Mass media channels — television, radio, print media, and outdoor advertising — have historically been the backbone of large-scale health communication campaigns, offering the breadth of reach required to produce population-level shifts in health knowledge and social norms within relatively short timeframes. Meta-analytic evidence demonstrates that mass media health campaigns produce modest but consistent effects on disease prevention behaviours, with pooled effect sizes typically in the range of Cohen's d = 0.10 to 0.30 across diverse health outcomes — effects that translate into substantial public health impact at the population level given the scale of exposure (Wakefield et al., 2017). Radio, in particular, retains critical importance in sub-Saharan Africa and other regions where television and internet penetration remain limited, with community radio programmes that integrate local language, cultural reference, and participatory formats demonstrating superior engagement and behaviour change outcomes relative to standardised broadcast content (Storey & Figueroa, 2017).

Entertainment-education (E-E) — the strategic embedding of health and social messages within entertainment content including soap operas, drama series, radio serials, and popular music — represents one of the most evidence-supported mass media BCC strategies, exploiting the emotional engagement, parasocial relationships, and narrative immersion of entertainment formats to promote attitude change and social norm shifts that are resistant to the reactance and message fatigue that explicitly didactic health messaging often generates (Singhal et al., 2019). Longitudinal studies of E-E programmes addressing HIV prevention, family planning, and childhood vaccination in sub-Saharan Africa, South Asia, and Latin America have demonstrated significant positive effects on knowledge, attitudes, and reported behaviour change, with the strength of parasocial relationships between audience members and programme characters identified as a key mediating variable (Bouman et al., 2021). The theoretical mechanism — Bandura's modelling processes and Singhal and Rogers' elaboration of E-E theory — is well specified, providing a strong basis for programme design choices including character design, narrative arc, and the balance between positive role models, negative role models, and transitional characters whose evolving behaviour mirrors the desired audience change trajectory.

Multi-channel campaign designs that combine mass media exposure with interpersonal communication, community mobilisation, and point-of-service reinforcement consistently outperform single-channel approaches in randomised controlled trials and quasi-experimental evaluations, reflecting the synergistic mechanisms through which different channels address different behavioural determinants and reach different audience segments (Wakefield et al., 2017). The reach of mass media establishes awareness and shifts social norms at the population level; interpersonal communication from health workers, peers, and community leaders translates awareness into personal motivation and practical skill; and environmental and structural interventions remove the opportunity barriers that would otherwise prevent motivated individuals from acting on their intentions. The design of integrated multi-channel campaigns requires systematic audience segmentation, channel mapping, and message consistency planning — a process supported by tools including the Communication for Development (C4D) framework and the P-process developed by Johns Hopkins Bloomberg School of Public Health (Schiavo, 2020).

4. Community-Based Participatory and Interpersonal Communication Approaches

Community-based participatory approaches to health education and BCC — variously described as community-led, community-owned, or community-centred — have gained substantial empirical and normative traction as alternatives and complements

to top-down, externally designed communication programmes. Rooted in the participatory action research tradition associated with Paulo Freire and applied to health promotion through community health worker (CHW) models, participatory rural appraisal, and community dialogue methodologies, these approaches prioritise the engagement of community members as active agents in the analysis of their health problems, the design of solutions, and the implementation and evaluation of BCC activities (Freire, 1970, as cited in Wallerstein & Duran, 2017). The theoretical rationale — that interventions designed with and by community members achieve superior cultural alignment, community ownership, and sustained behaviour change than those designed for communities by external experts — is supported by a growing body of rigorous evaluation evidence across diverse disease prevention contexts.

Community health workers, as the primary interpersonal communication channel in most LMICs and as an increasingly recognised asset in high-income country public health systems, occupy a strategically pivotal position in community-based BCC. A comprehensive Cochrane review by Lewin et al. (2021) found strong evidence that CHW-delivered health education and counselling significantly improved uptake of preventive health services including vaccination, antenatal care, and HIV testing and treatment, with larger effects observed in programmes that provided CHWs with structured training, supportive supervision, and adequate logistical support. The interpersonal communication modalities employed by CHWs — home visits, group counselling, peer support groups, and community health dialogues — address the social influence, self-efficacy, and practical support mechanisms identified in Social Cognitive Theory as critical determinants of behaviour change, and the trusted relationships that effective CHWs build within their communities enable the sustained engagement required for the cultivation of complex preventive behaviours that mass media campaigns alone cannot produce.

Participatory community dialogues, including those conducted through the Participatory Learning and Action (PLA) cycle methodology evaluated by Prost et al. (2016) in the context of maternal and newborn health promotion, represent a particularly promising approach to BCC in which community groups collectively analyse their health situation, identify barriers to preventive behaviour, develop locally appropriate solutions, and implement and evaluate behaviour change activities over iterative cycles. A cluster-randomised trial of PLA-based women's group programmes in rural settings across Nepal, India, Bangladesh, and Malawi demonstrated significant reductions in neonatal mortality in intervention communities relative to controls, mediated through improvements in birth preparedness, hygiene practice, and care-seeking behaviour — outcomes that the authors attributed to the combination of knowledge acquisition, social norm change, and collective agency development that the participatory methodology uniquely produces (Prost et al., 2016). The scalability of participatory approaches, however, presents implementation challenges that structured CHW programmes and mass media campaigns do not face to the same degree, and the adaptation of participatory methodologies to urban, fragmented, and high-mobility community contexts remains an area requiring methodological innovation.

5. Digital Health and mHealth Innovations in BCC Delivery

The proliferation of mobile telephone access and internet connectivity across global populations has fundamentally transformed the landscape of health communication, creating new channels for BCC delivery that combine the broad reach of mass media with the personalisation and interactivity historically associated only with interpersonal communication. Mobile health (mHealth) interventions — encompassing SMS text messaging, smartphone applications, social media platforms, interactive voice response systems, and web-based health education portals — have been evaluated across a wide range of disease prevention contexts and populations, with a rapidly expanding evidence base that, while still characterised by significant heterogeneity in design and evaluation quality, points consistently toward net positive effects on health knowledge, self-efficacy, and preventive behaviour adoption (Stephani et al., 2016). The theoretical mechanisms through which digital BCC produces behaviour change include the enhanced personalisation that enables message tailoring to individual stage of change, risk profile, and sociodemographic characteristics; the interactivity that enables two-way dialogue, question-answering, and real-time feedback; and the accessibility of just-in-time information delivery at moments of decision relevance that static mass media cannot achieve.

SMS-based BCC programmes have accumulated the strongest evidence base among mHealth modalities, reflecting the near-universal penetration of basic mobile telephony in LMICs and the technical simplicity of SMS delivery that enables implementation at low cost without smartphone ownership or data connectivity. A Cochrane systematic review of SMS interventions for health behaviour change by Free et al. (2021) found strong evidence of positive effects on smoking cessation, antiretroviral therapy adherence, and appointment

attendance, with moderate evidence for improvements in physical activity, dietary behaviour, and chronic disease self-management. The characteristics of effective SMS BCC programmes identified across multiple reviews include message personalisation, bi-directional interactivity, theory-based message design, appropriate message frequency, and cultural and linguistic adaptation — characteristics that require careful programme design investment but that distinguish effective from ineffective SMS health communication in the evidence base. Smartphone applications for disease prevention have demonstrated promising effectiveness in high-income country contexts for conditions including diabetes prevention, cardiovascular risk reduction, and mental health self-management, but their equity implications — dependent as they are on smartphone ownership and data literacy — require careful consideration in programme design, particularly in LMICs where smartphone penetration remains uneven.

Social media platforms have emerged as BCC channels of unprecedented reach and influence, particularly for younger populations for whom Facebook, Instagram, TikTok, WhatsApp, and Twitter constitute primary information environments. The COVID-19 pandemic provided the most extensive and rapidly evolving natural experiment in social media health communication in public health history, demonstrating both the extraordinary potential of social media for rapid, wide-reach dissemination of health guidance and the devastating consequences of misinformation spread through the same channels — a phenomenon described as the 'infodemic' by the World Health Organization (WHO, 2020). Bedson et al. (2021) systematically reviewed evidence on digital BCC during COVID-19 and found that well-designed social media health communication campaigns significantly improved knowledge and compliance with non-pharmaceutical interventions including mask-wearing, hand hygiene, and physical distancing, while poorly designed or contested communication generated confusion, distrust, and behaviour contrary to public health recommendations. The implications for BCC programme design are clear: social media health communication must be integrated with systematic mis/disinformation monitoring and counter-messaging strategies, and must leverage trusted messengers — including healthcare professionals, community leaders, and credible peer influencers — whose social media presence can reach target audiences through channels that algorithmic filtering may otherwise suppress.

6. Cultural Competence, Health Literacy, and Equity in BCC

Cultural competence — the capacity of BCC programmes to design, deliver, and evaluate health communication in ways that are sensitive to, respectful of, and congruent with the cultural values, beliefs, language, and lived experiences of target populations — is consistently identified as a critical determinant of BCC effectiveness, particularly in contexts of cultural diversity, health disparities, and historical mistrust between marginalised communities and health institutions (Kreuter & McClure, 2017). The evidence base for cultural adaptation of health education interventions is substantial: a meta-analysis by Bhatt et al. (2023) examining culturally adapted health promotion interventions across diverse populations found a significantly larger pooled effect size for culturally adapted versus non-adapted interventions (Cohen's $d = 0.45$ vs. 0.18), with the largest benefits observed in populations characterised by strong cultural identity, limited English proficiency, and prior negative experiences with formal healthcare systems. Cultural adaptation extends beyond surface-level features such as language translation and image representation to encompass the deep structural dimensions of health belief systems, family and community decision-making processes, gender norms, religious frameworks, and the role of traditional healers and community authority figures whose engagement or alienation fundamentally shapes BCC receptivity.

Health literacy — the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions — represents a related but distinct determinant of BCC effectiveness that intersects critically with cultural and socioeconomic dimensions of health inequity (Berkman et al., 2021). Low health literacy, prevalent across education levels and social strata but disproportionately concentrated among elderly populations, recent immigrants, individuals with limited formal education, and residents of under-resourced communities, fundamentally limits the effectiveness of health education materials designed for general audiences. The evidence-based principles of health literate communication — use of plain language, avoidance of medical jargon, visual reinforcement of key messages, teach-back verification of comprehension, and active audience participation — are well established in the literature but inconsistently applied in practice, creating systematic gaps in BCC reach among those with the highest disease burden and the greatest need for effective health education (Berkman et al., 2021; Rowlands et al., 2017).

The equity dimensions of BCC extend beyond cultural adaptation and health literacy to encompass the structural determinants of health — poverty, housing, food security, occupational exposure, and discrimination — that shape both the health risks individuals face and their capacity to adopt preventive behaviours that BCC promotes. A critique of conventional BCC frameworks by Braveman et al. (2022) argued that interventions focused exclusively on knowledge and attitude change as proxies for behaviour change systematically underestimate the degree to which structural barriers prevent motivated individuals from translating intention into action, and that BCC programmes that do not address these structural determinants are likely to widen rather than narrow health disparities by improving behaviour change outcomes primarily among the most advantaged members of target populations who already possess the material and social resources to act on improved knowledge. The implication — that BCC must be designed and evaluated as a component of comprehensive, multi-level health promotion strategies that simultaneously address individual, interpersonal, community, and structural determinants of health — represents a fundamental conceptual evolution in the field that is increasingly reflected in best-practice BCC programme frameworks but is still incompletely operationalised in many real-world health communication programmes.

7. Evidence of Effectiveness Across Disease Prevention Domains

The effectiveness of health education and BCC has been evaluated most rigorously in specific disease prevention contexts that provide the strongest evidence base for programme design. In HIV/AIDS prevention, the combination of mass media campaigns, peer education, and community mobilisation within the UNAIDS prevention package has demonstrated measurable reductions in new HIV infections in high-prevalence sub-Saharan African settings, with behaviour change — particularly delayed sexual debut, increased condom use, and reduction in concurrent partnerships — identified as the primary mechanism of incidence reduction (Pettifor et al., 2019). In vaccine-preventable disease prevention, BCC addressing vaccine hesitancy has emerged as a critical public health challenge, with systematic reviews demonstrating that motivational interviewing-based counselling, trusted community messenger strategies, and the correction of specific misinformation beliefs are the most effective communication approaches for improving vaccination uptake in hesitant populations, while confrontational or purely information-based approaches may paradoxically reinforce hesitancy through psychological reactance (MacDonald & the SAGE Working Group, 2015).

In the non-communicable disease prevention domain, BCC addressing tobacco cessation, physical activity promotion, and healthy diet adoption has generated the most extensive evaluation evidence. A comprehensive Cochrane review of brief advice interventions for smoking cessation found that even minimal health education delivered by primary care providers — advice of less than five minutes' duration — produced significant increases in cessation rates relative to no advice, with more intensive counselling producing proportionally larger effects (Stead et al., 2017). Community-based BCC for diabetes prevention, evaluated in multiple randomised controlled trials across diverse populations, has demonstrated significant reductions in the incidence of type 2 diabetes through lifestyle behaviour change programmes that combine group health education, behavioural counselling, dietary guidance, and physical activity promotion — with the largest effects observed in high-risk prediabetic populations and in programmes achieving the highest fidelity to the evidence-based curriculum (Knowler et al., 2020). The consistent finding across disease domains is that BCC works best when it is theoretically grounded, culturally adapted, multi-component, and supported by environmental and structural changes that remove barriers to the adoption of the behaviours promoted.

8. Limitations of the Evidence Base and Future Research Directions

The evidence base for health education and BCC in disease prevention, while substantial, is characterised by several systematic limitations that temper the confidence of conclusions and identify priorities for future research. The preponderance of short-term outcome measures — assessing knowledge, attitude, and self-reported intention rather than sustained behaviour change or disease incidence — limits the ability to determine whether BCC effects translate into durable health improvements beyond the duration of programme delivery (Nutbeam & Lloyd, 2021). Publication bias toward positive findings, inadequate description of intervention components limiting replication, and the frequent use of non-validated outcome measures further compromise the internal and external validity of the accumulated evidence. The absence of standardised theoretical frameworks and behavioural outcome taxonomies — addressed by the emergence of the Behaviour Change Technique Taxonomy (BCTTv1) as a common language for describing active ingredients of BCC interventions

— has historically limited cumulative knowledge development through systematic review and meta-analysis (Michie et al., 2018).

Future research should prioritise the development and application of adaptive trial designs that enable real-time programme optimisation in response to emerging evidence — approaches including Sequential Multiple Assignment Randomised Trials (SMARTs) and Multiphase Optimization Strategy (MOST) that are well suited to the complex, multi-component nature of BCC programmes but rarely applied in health communication research to date. The equity implications of BCC programmes require systematic evaluation through pre-specified subgroup analyses and equity-focused reporting frameworks that disaggregate outcomes by socioeconomic status, gender, ethnicity, and geographic location, ensuring that improvements in average outcomes are not masking widening health disparities within target populations (Braveman et al., 2022). Longitudinal cohort designs tracking behaviour change and health outcomes over years to decades are needed to determine the persistence of BCC effects and to identify the maintenance strategies — booster interventions, environmental supports, community reinforcement mechanisms — that sustain initial behaviour change over the lifecourse. Finally, the integration of implementation science frameworks into BCC research and practice — systematically studying the conditions under which effective BCC strategies are successfully adopted, implemented, and sustained within real-world health system contexts — represents an essential bridge between the production of evidence and its translation into population health impact.

9. Implications for Practice and Policy

The evidence synthesised in this review supports a set of practice and policy recommendations for maximising the effectiveness of health education and BCC investments in disease prevention. Programme designers should ensure that BCC interventions are explicitly grounded in identified theoretical frameworks, with the choice of theory driven by systematic analysis of the behavioural determinants operating in the specific target population rather than by theoretical convention or disciplinary preference (Glanz et al., 2015; Michie et al., 2018). Multi-channel campaign designs that integrate mass media, community mobilisation, and interpersonal communication should be prioritised over single-channel approaches, with channel selection driven by audience-specific media consumption patterns, communication preferences, and the distinct mechanisms through which different channels address different behavioural determinants. Cultural adaptation should be treated as a non-negotiable programme quality standard rather than an optional enhancement, with deep structural adaptation — engaging community members in message design, validating materials with target communities, and embedding culturally resonant messengers and communication formats — prioritised over surface-level translation-only adaptation (Kreuter & McClure, 2017).

Health system policymakers and programme funders should invest in the monitoring, evaluation, and learning systems that generate the evidence needed to continuously improve BCC programme quality and impact, including the standardised outcome measurement frameworks, implementation fidelity assessment tools, and equity-disaggregated reporting requirements that are currently absent from many national health communication monitoring systems. The integration of digital BCC strategies — particularly mHealth and social media — into national health communication portfolios should be pursued with careful attention to digital equity implications, ensuring that the benefits of digital health communication reach populations across the digital divide rather than concentrating among the already advantaged (Stephani et al., 2016; Bedson et al., 2021). Finally, national health communication policies should explicitly position BCC as a component of comprehensive, multi-level health promotion strategies that address the structural determinants of health alongside individual behaviour change — recognising that communication alone cannot overcome the poverty, discrimination, and systemic disadvantage that are root causes of preventable disease in the most affected populations.

10. Conclusion

Health education and behavior change communication occupy an irreplaceable position in the architecture of disease prevention, translating public health knowledge into population behaviour through the systematic application of communication science and behavioural theory. This review has demonstrated that BCC can be highly effective in promoting preventive health behaviours and reducing disease burden when designed with theoretical rigour, cultural competence, multi-channel integration, and attention to the social and structural determinants that shape individuals' capacity to act on health information. The rapid evolution of the BCC landscape — driven by digital transformation, growing appreciation of equity and structural determinants, and the methodological advances of implementation science — promises continued improvements in the precision, reach, and sustained

impact of health communication interventions. Realising this potential requires sustained investment in programme quality, evaluation capacity, and the integration of community voice and lived experience in all phases of BCC design, delivery, and assessment. At its best, health education and BCC do not merely inform populations about health risks; they equip communities with the knowledge, skills, social support, and collective agency to claim their right to health and to build the healthier, more equitable societies that effective disease prevention ultimately requires.

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