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Theoretical Divides and Convergence in Global Health Communication

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Introduction

This chapter offers a survey of theories in global health communication. The goals are to analyze the genealogy of key theories and debates, compare concepts and arguments, and their differences, and to discuss the possibility of theoretical convergence.

Global health communication has straddled both academic debates and programmatic interventions. Given this position, theories were not only developed to produce evidence-based generalizations that explain relations among variables and offer predictions about a range of phenomena. They have also been formulated to provide conceptual guidance to health programs aimed at promoting changes and reaching specific outcomes. Such expectations about the empirical implications of theories have not been limited to conceptual frameworks produced in the mold of scientific positivism and empirical research. Theories rooted in the humanities and interpretative frameworks have also maintained close connections with health programs. Scholars in health communication (Fishbein, 2000; Fishbein and Yzer, 2003) and communication for development and social change (Melkote and Steeves, 2001; Morris, 2004; Gumucio-Dagron and Tufte, 2006; Servaes, 2008), the two fields that underpin the theoretical edifice of global health communication, have refined theories to contribute to addressing concrete health challenges. Just like general theories about public health, they are intended not simply to explain phenomena. They were designed to pursue specific programmatic goals based on normative imperatives too – in other words, to pursue social good (Kreps, 1989; Rogers, 1994).

Aside from whether scholars were primarily driven to provide programmatic prescriptions or contribute to academic debates, theoretical paradigms have been increasingly used to provide intellectual justification to global health interventions. The incorporation

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of theory into program design has been far from a linear and predictable process. Instead, given the predominance of biomedical approaches in global health, it has been a bumpy ride. Gradually, as program managers realized the need for social-behavioral approaches and acknowledged the solid conceptual foundations in communication studies, communication scholarship gained a stronger footing.

The main argument presented in this chapter is as follows: the field is still characterized by a theoretical divide between information/media effects and participatory/critical theories that mirrors broad differences in health communication and communication studies at large. Despite efforts to bridge these theoretical traditions, the divide remains grounded on different conceptions of communication and its place in promoting better health worldwide. Finding bridges, let alone reconciling differences, seems unlikely given that theories and models are based on antithetical epistemological and analytical premises and ask different questions about the nature of communication and the conditions required to address challenges in contemporary health that impede cross-pollination across disciplinary and conceptual traditions.

Theories about global health communication have conceptually drawn from theoretical debates in the field of communication at large, and have been empirically informed by hundreds of studies about the role of communication in health programs in diverse international settings. Conceptually, theories and models have been influenced by the evolution of development communication and health communication as two separate branches of communication studies. Therefore, the genealogy of the field is rooted in the convergence of theories originally intended to analyze and explain the role of communication in processes of social, economic, and political development as well as the role of communication in improving health conditions and indicators in the United States. Since then, global health communication has straddled both parallel lines of research in the discipline. Consequently, it has been influenced by theoretical debates and research with different goals.

Empirically, theories have largely been informed by international, rather than global, studies in health communication. This difference is not insignificant. "Global" refers to health and communication issues that affect the world as a whole and, concomitantly, to approaches that analyze them as phenomena with planetary dimensions and implications. Examples of such global framework are theories about the role of communication in addressing health risks and challenges that transcend geographical and cultural borders, whether the spread of infectious diseases or the impact of climate change. Conversely, "international" alludes to the intersection between health and communication in specific local, regional, and national cases throughout the world. Examples are the analysis of the role of communication in immunization campaigns in a given country or strategies to promote care and treatment of people living with HIV/AIDS in a community. Whereas the former put global perspective at the forefront, the latter are focused on specific local dimensions. No question, the vast majority of studies have fallen into this second category. Even as globalization theories and approaches have remarkably influenced contemporary debates in the social sciences, theory-building remains grounded in distinct community and national studies. Moreover, studies are also focused on individual health issues and experiences that reflect the stove piping mindset in global health at large (Brown, Cueto, and Fee, 1996).

The study of health communication in a global context needs to be placed as the prolongation of two scholarly traditions, "development communication" and "health communication," two separate fields of analysis and practice. This section discusses the former; the next section addresses the latter.

Health in Development Communication

Theory-building and conceptual debates in global health communication are linked to the genealogy of "development communication" in the 1950s. Specifically, the study of health communication in international context continued the analytical premises of modernization theory, which was the "dominant paradigm" in the field of development communication in its early decades. Although modernization studies were not primarily concerned with health outcomes, they were based on epistemological premises that are similar to the socio-psychological and communication theories that came to dominate the study of global health communication.

Modernization theory dominated the early generation of development communication studies. One of its basic tenets was that development problems were rooted in cultural obstacles, namely, the persistence of traditional attitudes and knowledge. As long as traditional cultures persisted, modernization theorists argued, development was impossible (McClelland, 1961; Hagen, 1962). Besides its uncritical assumption that development meant the Western model of development, modernization put forth a causal argument inspired by a particular socio-historical interpretation of the West. It was embedded in two key analytical premises. First, it offered a functionalist explanation of society according to which there is a necessary correlation between political, economic, and cultural systems. A "modern" democratic polity and capitalist economy necessitate a "modern" culture characterized by individualism, scientific values, innovation, entrepreneurship, secularism, and so on. Second, modernization argued that "culture" (including psychosocial characteristics as well as knowledge and attitudes) is the independent variable that explains "development." By embracing these premises, modernization offered a cultural-functionalist argument with obvious programmatic implications. Addressing the problems of underdevelopment required cultural change, that is, the transformation of prevalent psychological and cultural traits.

The blend of a view that emphasized the primacy of cultural change in large processes of social transformation with communication theories about powerful media effects set the paradigm that defined the field of development communication. If the mass media have significant impact on psychological and cultural attributes, as several studies have contended, then they could be instrumental in promoting cultural changes in "underdeveloped" countries. Put it differently, seminal writings (Lerner, 1958; Schramm, 1964) in development communication drew from both modernization theories (which were prevalent in international studies) and media studies to argue that exposure to the mass media was vital for cultural change and, subsequently, for "modern development." The "modern" media were viewed as agents of positive change, as they could expose people to "modern" knowledge and attitudes.

Implicit in this line of argument was a conceptual model that basically understood communication as the transmission of information and the study of persuasion. Media technologies were critical because they allowed the mass distribution of information and, as "propaganda" studies suggested, were capable of influencing knowledge and attitudes among large numbers of people. Communication was conceived as a unidirectional process by which those with access to the media can influence the minds of the many who don't. It is about how ideas are disseminated in society, and how people can be persuaded to believe, think, and act in certain ways.

Such an "informational/persuasion" view of communication was present in Everett Rogers' (1962) study about the diffusion of innovations. Rogers suggested that information is a critical yet not sufficient condition for the adoption of new ideas. His well-known model of five stages and his distinction between types of "adopters" stressed the significance of awareness and knowledge of innovations (whether new farming methods or scientific advances) in adopting them. Knowledge does not necessarily lead to effective change, but the latter does require modifications in levels of awareness and knowledge. According to Rogers, development communication was the intentional transference of ideas and information to change belief and behaviors. It is about how sources persuade receivers.

Rogers and Schramm eventually moderated early assumptions about the power of the media. They acknowledged the importance of interpersonal communication in processes of persuasion. Also, they recognized the importance of sociocultural factors in motivating people to change beliefs and behaviors. In response to his critics, Rogers (1976) even admitted that participation should be a key component of communication. For him, communication is a "process in which participants create and share information with one another in order to reach a mutual understanding" (Rogers, 1986, p. 199). Yet the paradigm still espoused the conception of communication as information transmission and persuasion. Even if it was recognized that people participated on more leveled conditions, communication was basically conceived as information sharing. Put it differently, despite the widening of who participated, the basic conception of communication didn't change.

What matters for understanding the intellectual lineage of international/global health communication is that fundamental tenets of modernization theories resonated with the early systematic application of communication theories to health issues as development problems. Just like modernization, those studies subscribed to the view that communication was primarily concerned with information and persuasion – it was a scientific field interested in conditions and strategies that maximize the impact of information transmission on knowledge, attitudes, and behaviors. The role of theory, then, was to identify continuities and develop explanations about how information dissemination and exchange modify awareness, knowledge, and beliefs about health issues and, ultimately, contribute to changing health practices.

The strong push for family planning programs in international aid in the 1960s and 1970s set the stage for a wealth of studies about the impact of communication programs on health indicators. Evidence of this approach was the work of Schramm (1971) and Rogers (1973) who extensively analyzed communication interventions implemented to support population programs worldwide. As a consequence, conclusions and theories

about health (as well as development) communication were largely informed by findings about the effect of interventions and media campaigns on beliefs about family size, knowledge of family planning methods, information about health systems, and the like. These studies summarized previous findings and identified key questions that were subsequently addressed by a wealth of studies (Piotrow *et al.*, 1997).

Theories about Health Communication: Behavior Change and Media Effects

At the same time, health communication emerged as distinct scholarly field of inquiry in the United States (Kreps, Bonaguro, and Query, 1988). The combination of pioneering theoretical insights and landmark programmatic experiences (Farquhar and Maccoby, 1975) shaped the flourishing of health communication. Theoretically, the field has been defined by the combination of interdisciplinary approaches (Kreps and Maibach, 2008; Nussbaum, 1989) and concepts grounded in social psychology and the "media effects" research in communication studies. Analytically, it has engaged with a vast range of communication processes and health issues (Parrott, 2004). A detailed analysis of the development of key theories falls outside the scope of this chapter. Several articles have already compared core concepts and arguments as well as the applicability of theoretical constructs across health issues and settings (Brashers and Babrow, 1996; Noar and Zimmerman, 2004).

What matters for understanding theory in global health communication is how theoretical concepts and methodological approaches developed by health communication, primarily in US academia, exerted a notable influence. First, because groundbreaking studies were rooted in social psychological theories, communication has been typically understood as a human process of information transmission and reception. This also explains why the focus has been on individuals rather than on broad social, political, and economic forces. The impact of the latter on health communication has been eclipsed by the paramount interest in barriers and motivations at the individual level. Questions about individual cognition and psychological and social attributes in exposure to and the processing of health information have been dominant. Second, individualistic premises underlay the research on the impact of health information on behaviors. Collective behaviors were basically conceived as the aggregation of individual practices rather than as distinct phenomena explained by specific dynamics and causes. Third, the tradition of empirical research and applied knowledge in health communication also influenced the research agenda of global health communication. Theory was meant to provide solid conceptual footing and evidence to guide interventions to affect health behaviors. Finally, the ascendancy of the media effects tradition also left a clear mark on studies about health communication worldwide.

The field of health communication was born out of scholarly interest in issues located at the intersection of information, individual decision making, and health behaviors. Because it was located at the crossroads of various disciplines, "communication" has been used interchangeably with other terms such as education, promotion, marketing,

and information. Such loose usage certainly helped to define a broad field of interdisciplinary inquiry which included communication, psychology, education, and public health (Glanz, Marcus Lewis, and Rimer, 1990). Also, it allowed scholars to reach out to academic communities, journals, and professionals across disciplines. It put in place, however, the conditions for persistent conceptual confusion. Communication is not identical with information (Berry, 2004), promotion and other adjacent concepts. Certainly, such confusion isn't unique to global health communication. One could reasonably argue that it mirrors the perennial conceptual cacophony in the study of communication at large (Craig, 1993, 1999) which also resulted from the convergence of dissimilar disciplinary and theoretical traditions.

As the field of health communication progressively embraced behaviorist theories and goals, communication became associated with information dissemination, materials, interventions (campaigns), target audiences, and messages. Questions have been focused on the factors that contribute to the promotion of healthy behaviors. Put it differently, as behavior change issues became dominant in the literature, communication was synonymous with information and its role in health behaviors. Such an understanding of communication is one among several possible competing definitions.

Health communication was born with the unmistakable imprint of social psychology. Just as the study of human communication partially developed as a branch of psychology in previous decades, the study of health communication carried over basic premises and questions from psychological studies. Between the mid 1960s and mid 1970s, sociopsychological theories laid the conceptual bedrock. They asked questions and put forth propositions that remain central to theoretical inquiry and practical interventions. During those formative years, key writings were published about social learning and modeling (Bandura, 1963, 1969, 1971) health beliefs (Rosenstock, 1966), media effects (McGuire, 1969), persuasion (Tichenor, Donohue, and Olien, 1970), and individual rationality (Fishbein and Ajzen, 1975).[1]

During the 1970s, studies similarly informed by sociopsychological theories built on previous work. They refined original arguments about the role of cognition, individual attributes, and personal attitudes on health behaviors (Becker and Maiman, 1974). These theoretical perspectives left a powerful imprint as they articulated basic principles and propositions that informed countless studies since then.

The rise of social marketing (Kotler, 1972; Kotler and Zaltman, 1971) also contributed to the consolidation of health communication in the United States. Social marketing was neither a "theory" *stricto sensu* not solely preoccupied with health issues. Rather, it encompassed a set of approaches that proposed the utilization of commercial marketing techniques to promote social behaviors, including health practices and outcomes. It aimed to promote social goods by drawing upon theories of consumer behavior that conceptualized the processes of needs creation and consumer decision-making (Novelli, 1990). At the core of social marketing was the exchange model according to which individuals, groups, and organizations receive perceived benefits in exchange for purchased products.

With social-psychological theories, social marketing shared the interest in understanding individual behaviors as well as the factors that influence decision making. Whereas scholarly theories were primarily concerned with explaining health behaviors

and drawing propositions for further testing, social marketing applied to health issues was mainly interested in affecting behaviors (Andreasen, 1994). In doing so, it proposed that it was necessary to produce nuanced understandings about the factors that influence behavior change. Systematic, research-based information about consumers was deemed indispensable for effective interventions. Marketing research techniques are valuable for finding out thoughts and attitudes about a given issue that help prevent possible failures and position a product. For its advocates, one of the main strengths of social marketing is that it allows products and concepts to be positioned in traditional belief systems. Social marketing's emphasis on research and the segmentation of "target" publics implicitly put less emphasis on information as the main driver of behavior change. Social marketing's well-known "4 P model" outlined several factors that may affect health decision making: product, price, place, and promotion. Promotion, social marketing's term to refer to communication and information, was theorized as one factor affecting practices.[2]

The field of health communication matured during the 1980s and early 1990s. It became consolidated in academic units, conferences, and journals as well as in terms of public and private funding (Ratzan, 1996; Rogers, 1994). Studies developed more nuanced theoretical models to fill gaps in previous research (Janz and Becker, 1984; Rosenstock, Strecher, and Becker, 1988). The number of studies applied to a range of health issues proliferated. Questions about the role of information in modifying individual knowledge, beliefs, and health behaviors sprang to the forefront.

Dominant approaches continued to theorize communication in terms of information dissemination intended to change individuals' perception of threats and benefits, and readiness to act. The cybernetic model underlay the study of communication in terms of information disseminators, interpreters, and input/output flows (Donohew and Ray, 1990). Theories that defined central questions in the research agenda in subsequent decades, most notably the Theory of Reasoned Action (Fishbein, 1980) and the Theory of Planned Behavior (Ajzen,1985), proposed that individual attitudes and subjective norms determine behavioral intentions. Likewise, models such as the Precede–Proceed, outlined a multistage development of health behaviors. Concepts such as self-efficacy (Rosenstock, Strecher, and Becker, 1988) were proposed to better understand multiple factors that affect individual decisions to perform specific health behaviors. Scholars (Freimuth, 1990) made calls to close the extensively documented gap between information and practices. Interest in the range of interpersonal and mediated communication on health behaviors remained central in the study of social norms (Lapinski and Rimal, 2006).

The interest in behavioral and cognitive issues dovetailed with the tradition of "media effects" in communication studies. Going back to the beginnings of the field, the literature on "media effects" has remained central, particularly in the United States. The blend of social-psychological approaches with long-standing interest in media effects steered the field in a definite direction: the study of the impact of information dissemination through mediated and interpersonal channels on individual behaviors. Given the dominant interest in media effects, key arguments and findings in the health communication literature have been adjacent to the extensive literature on media effects. Just as the behaviorist bent meant that health communication offered extensive and sophisticated theories about

behavior change, the focus on media effects similarly made its conclusions directly relevant within the tradition of media effects in communication studies.

Interest in media effects has driven research on key components of information processes and media effects: audiences, channels, and messages (Flay, DiTecco, and Schlegel, 1980; Maibach and Parrott, 1995). Underlying this line of inquiry has been the intention to understand how to maximize the impact of communication interventions on health knowledge, attitudes, and behaviors. Scholars refined ways to theorize audience segmentation (Slater, 1996), and understand the psychosocial characteristics of specific audiences (Keller and Lehmann, 2008). Studies have analyzed the social, cultural, and psychological characteristics of various audiences differentiated by age (Greene *et al.*, 1996) , education (Salmon *et al.*, 1996), race (Kreuter *et al.*, 2003; Pratt *et al.*, 2003), gender, and other variables (Dearing, 2004). Questions about impact have also informed research about channels. Studies have assessed the merits of different channels to maximize reach, reception, comprehension, and other factors. From the use of various channels in a multi-media world (Randolph and Viswanath, 2004) to the strengths of tailored print materials (Kreuter and Wray, 2003; Skinner *et al.*, 1999), they have produced a rich literature. The issue of effectiveness has also driven research on message design. Studies have assessed the quality of messages to promote health behaviors by keeping and holding attention from various audiences (Donohew, Lorch, and Palmgreen), and using different appeals (Witte and Allen, 2000).

This body of literature has offered nuanced approaches to the study of media effects. It has addressed immediate and long-term, intentional and unintentional, positive and negative effects of communication interventions (Cho and Salmon, 2007; Salmon and Atkin, 2003). Also, media effects issues have been the subject of numerous meta-analyses of information campaigns across health issues (Snyder, 2007; Noar, 2006). This wealth of data has contributed to refining theoretical concepts and informed conclusions about the need for integrated approaches to health communication interventions

Global Health Communication Theories

Rogers's theory of diffusion of innovations applied to health (Bertrand, 2004) and dominant theoretical approaches in health communication set the course for global research. Those paradigms laid the fundamental epistemological and analytical premises and raised the theoretical questions that defined the field. Consequently, much of global health communication has been focused on behavioral change and media impact. It has been primarily driven to produce applied knowledge to help inform aid programs and local interventions. It has largely subscribed to the individualistic premises of social-psychological theories focused on behavior decisions and obstacles at the personal level. It has embraced the concept of communication as information dissemination through interpersonal and mediated channels.

From these perspectives, two set of interests have animated research on international health communication. On the one hand, scholars have been concerned with how communication interventions support programs to address health challenges that disproportionately affect the global South. Much of the literature has focused on the

linkages between communication and three health issues: family planning/reproductive health, child health (including nutrition and immunization), and HIV/AIDS. When population growth and nutrition issues dominated international health and aid in the 1960s and 1970s (Robinson and Ross, 2007), the agenda of international health communication was focused on those issues, too. The experiences of communication programs in support of child health (Hornik *et al.*, 2002) and family planning (Piotrow *et al.*, 1997) behaviors provided plenty of cases for theory building. The HIV/AIDS crisis from the 1980s onwards shifted considerable attention to questions about how communication affects sexual behavior. Ongoing research has particularly paid attention to how communication relates to stigma, social norms, and gender roles as key behavioral determinants.

Given the close proximity between theory and practice, it is not surprising that much research has dealt with issues that have received significant levels of funding from aid agencies during the past decades. Certainly, other priorities in international health and aid have been examined, such as specific infectious diseases (malaria and tuberculosis most notably). The bulk of the attention, however, has remained closely aligned with the main priorities of major aid donors.

On the other hand, global health communication has offered opportunities to conduct research on the same questions that drove interest in the field of health communication, and test the applicability of theories originally formulated mainly in the United States. International cases bring up a wealth of evidence to determine the explanatory power of propositions regarding behavioral and media-impact issues. Underlying this approach is the assumption that scientific theories should be able to generalize and predict results regardless of social and cultural settings. Theories make universal claims that need to be probed across settings. Variations help us to refine the explanatory and predictability power of theories. This premise has animated decades-long research and theory in global health communication.

International experiences thus have offered countless cases to determine the strength of theoretical hypotheses with respect to the interaction between information processes and health behaviors. Like the field of health communication at large, much of the literature has been interested in assessing the mechanisms that contribute to activating or moderating intervention/campaign effects at the individual and social levels.

Whereas conclusions generally agree that "ideational" factors play an important role in health behaviors, studies have analyzed the impact of different communication (information) issues and strategies on social-psychological behavioral determinants. It is impossible to summarize the state of the findings across communication programs and health issues within the scope of this chapter. The impressive body of evidence does not lend itself to parsimonious and categorical conclusions. Studies have confirmed the circuitous process of interpersonal and mediated influence on health behaviors, and the multiple ways in which we should study the linkages between interventions and effects (Piotrow and Kincaid, 2001). Recent studies have documented the small to moderate effects of programmatic interventions in changing various behavioral determinants at the individual and social levels (e.g., knowledge, attitudes, perceptions, social norms) and promoting healthy behaviors.

Besides the intention to contribute to program design and thus to the improvement of health conditions, this body of literature is characterized by an interest in assessing the

explanatory power of central propositions in health communication. Studies have shown the strengths of key theories and approaches to explain the contributions of communication programs to modifying behavioral determinants in health behavior. There is no shortage of examples of research conducted around the world on various health issues similarly interested in testing key theories in health communication. An illustrative sample includes studies on the theory of reasoned action (Kwadwo, 2001; Pick, 2007), social marketing (Agha, Karlyn, and Meekers, 2006), the health belief model, the extended parallel process model (Witte, 1998), self/collective efficacy (Smith, Ferrara, and Witte, 2007; Storey *et al* 2007), risk perception (Agha, 2003), social cognition (Smith, Downs, and Witte, 2007), and social networks and interpersonal communication (Sood, Shefner-Rogers, and Sengupta, 2006 ; Valente, Paredes, and Poppe, 2006).

How have behavioral and information processing theories helped to understand what works at the programmatic level? It is difficult to offer a summary of findings that captures the wealth of experiences documented in dozens of studies. Whereas studies have helped to refine theoretical understanding of information questions, we still lack a parsimonious explanation about the link between information processes and health behaviors. The data show that information campaigns and other interventions positively affect knowledge, attitudes, risk perception, and other components of the ideational processes (Bond and Valente, 1999; Boulay and Valente, 1999). Evidence, however, is more ambiguous about whether changes in information and attitudes are mirrored in transformations in health behaviors. Also, because most studies have analyzed the impact of single interventions around a specific health issue, we still lack comparative analyses to know whether information interventions have a similar impact across health programs and behavioral determinants. Even meta-studies of campaign effects, which offer a comprehensive overview across interventions, are focused on single health programs.

The Dominant Paradigm and its Critics

The widespread application of behavioral and "media effects" theories in global health communication has been the subject of several criticisms. Informed by a range of interpretative/cultural and participatory theories, scholars have targeted the conceptual and epistemological assumptions of those theories, and have tried to reorient the field around different sets of questions and theoretical premises. The focus and tenor of the critiques reflect similar arguments in both the fields of health communication (Zoller and Kline, 2008) and development communication (Morris, 2004; Servaes, 1996). The critique can be summarized as follows: the tradition of media effects on health behaviors is premised on narrow understandings of both communication and health. It carries specific theoretical and epistemological premises that are problematic for studying the rich and complex relation between communication and health in a global context.

One set of criticisms has questioned the prevalent definition of communication in behavioral and media effects studies. From participatory and ritualistic perspectives, the notion of communication *qua* information dissemination is conceptually incorrect for it focuses exclusively on the transmission of information from, put in the parlance of traditional cybernetic studies, "senders" (health programs, campaign organizers) to

"receivers" (individuals). Absent is a conception of communication that stresses the exchange of ideas and participation in public life and the development of critical consciousness. The focus on "health/communication" campaigns, which has attracted considerable analytical and theoretical attention, denotes a misguided conceptualization of communication that fails to rigorously distinguish communication from information. Put simply, campaign communication is not communication, but rather, it is an instance of massive distribution of information by certain (typically powerful) actors, who carefully assess how target audiences may react to key messages. Health communication, instead, should bring to the fore questions of how people talk and make sense of issues related to health, disease, and well-being. It is about how citizens participate in public spaces through debating health issues, identifying challenges and solutions, and determining courses of action. Several studies have shown how communication skills are central to the process by which people identify, understand, discuss, and act upon health challenges (Campbell and Jovchelovitch, 2000; Campbell and MacPhail, 2002). This should be the analytical focus of communication research: how societies problematize health and disease, and establish priorities for action.

Another set of writings has questioned the individualistic premises of the behaviorist/media effects paradigm. This critique has centered on the dominant epistemology in much health communication research. Scholars have questioned the applicability of individual-centered models in non-Western societies (Airhihenbuwa, Makinwa, and Obregon, 2000; Buhler and Kohler, 2002). In societies where communal values are dominant, they argue, it is mistaken to theorize about health communication based on the premise that the individual is the core social actor. Such approaches may apply in Western societies characterized by strong individualism, but they are inappropriate where the concept of personhood is subsumed under a broad set of group identities.

This line of criticism should not be interpreted as simply stating that "culture matters," and calling on us to consider cultural diversity as a central dimension of global health communication. In fact, the question of how culture underpins health communication in international settings has been present in much of the research on innovations and behavior change (Rogers and Shoemaker, 1971). The critique pushes the field in a different direction: It is not just about considering the weight of community issues such as norms and attitudes as they influence individual behaviors, but rather, the need to rethink the epistemology of global health communication, basically shifting the analytical focus from individuals to communities. Community and cultural context should not be considered another set of behavioral determinants that affect individual decisions and practices; instead, they should be foregrounded in the analysis.

This criticism is linked to a questioning of the rationalistic, modernistic premises of health behaviorism and communication (Dutta and de Souza, 2008). Much of global health communication follows the model of individual rational decision making underpinning health communication and behavioral research. For example, the "knowledge–behavior gap," an issue that has been extensively discussed in the literature, is premised on the notion that knowledge should lead to behavior change. If individuals were aware and properly informed about health risks, they would act "rationally" to maximize individual benefits and therefore practice healthy behaviors. Such an assumption needs to be questioned on the grounds that "individual rationality" needs to be contextualized.

What rationality means in one context, either defined in terms of the articulation of means and ends in utilitarianism philosophy or incentives and benefits in behavioral economics, is different across cultural contexts. Rationality is culturally defined according to social expectations, norms, and attitudes. This makes it necessary to understand how communities and individuals experience, think, and make decisions about health in order to better comprehend communicative processes.

Scholars have also raised questions about the behavioral focus of global health communication research. Communication studies, they argue, should be primarily concerned with participation and power, issues largely absent in much of the literature (Lupton, 1994). Behavioral and campaign theories are not primarily concerned with issues surrounding power, such as the influence of political-economic forces on health, gender inequity, the impact of health and other (e.g. labor, environmental) policies on the well-being of individuals and communities, the struggles of underrepresented and subaltern groups to improve health conditions, and so on (Melkote, Muppidi, and Goswami, 2000). Questions such as how power shapes health communication or how communication about health can transform power are notoriously absent. Such questions are absent given that dominant theories are primarily concerned with different set of questions. Socio-psychological theories and health campaign/communication theories are primarily interested in questions about information processing, behavior modeling, and media effects and therefore offer propositions to explain such phenomena.

What is troubling if health communication research focuses on those issues at the expense of power and participation? The silence on macro-power structures and emphasis on individual behaviors implicitly assumes that health is, above all, a matter of individual responsibility. Health communication focuses on the power of individuals who weigh different information and other considerations in making decisions about health. What is missing in this approach is the analysis of how power and policies structurally affect health conditions before individuals are confronted with information or options (Airhihenbuwa, Makinwa, and Obregon, 2000; Erni, 2004). Therefore, it is necessary to consider power asymmetry at different levels to properly assess the role of personal, interpersonal, and social forces in health communication.

Communication needs to consider how citizens participate to change conditions that affect health, and how they mobilize to advocate for policies to improve access to better health (Diop, 2000; Ford, Odallo, and Chorlton, 2003; Waisbord, Michaelides, and Rasmuson, 2007). Growing interest in community participation in health policy and health advocacy (Usdin *et al.*, 2000) shows the importance of questions about power, policy, gender, and politics for health communication research and practice. Likewise, participatory experiences designed to address a range of health issues, such as HIV/AIDS (Gao and Wang, 2007) and tuberculosis (Waisbord, 2010), attest to the strengths of community–based approaches to promote health goals in various countries.

Linked to this argument is another criticism: standard health communication theories uncritically accept the model of power embedded in the biomedical model of health. Biomedical notions largely dominate global health programs. Implicit in the biomedical model is a definite conceptualization of power with respect to knowledge and authority that has great implications for theorizing health communication. Whereas medical experts are granted full power, citizens are cast as passive actors. Standard discourse is reflective of

such premises. Whereas experts are assigned central, unchallenged authoritative roles in determining appropriate behaviors, people are cast as "patients" who are expected to "adhere/comply" with prescribed actions. Issues of "lay" knowledge and contestation over knowledge/power, to put it in Foucault's terms, are typically absent. In light of these relatively unexplored ideological assumptions, critical perspectives favor the examination of assumptions about health knowledge and expertise, and propose multilayered analyses of communication in the construction of power relations in health (Waisbord, 2008).

Critical approaches also question standard methodologies used in global health communication research (Zoller and Kline, 2008). They find the dominant position of positivist and experimental research troubling. It overshadows interpretive and qualitative analyses which, in their minds, are better suited to analyzing the social construction and representation of health and illness. Drawing from anthropology and critical social studies, they underscore the need for discourse analysis, ethnography, and other qualitative, in-depth methods to grasp how societies define certain understandings of health, how health inequalities are formed and maintained, how public debate informs health decisions, and so on. These problems, which are viewed as central to the overall intellectual enterprise in health communication, need be approached with methodologies that capture the relationship between critical dimensions of communication, such as sense-making processes (Dutta-Bergman, 2004), cultural difference, and dialogue (Lambert and Wood, 2005), and the socioeconomic and political conditions of health systems around the world.

This range of criticisms reflects theoretical divides in the field of communication. Theories start from different epistemological premises, are interested in different dimensions of the intersection between health and communication, and are driven by different questions. Not surprisingly, then, they have produced quite different explanations, propositions, and predictions.

Whereas such theoretical eclecticism reflects the diversity and inclusiveness of the field, it also exposes significant divides. One could argue that these two theoretical traditions, one focused on information processing and behavioral change and the other concerned with power, participation, and public debate, have existed in parallel. One could perfectly well conduct research within one tradition without having to reach out or recognize alternative theories. Doubtlessly, the task of finding common ground between these two streams of research is not easy. Both paradigms are rooted in quite different theoretical and intellectual traditions.

Towards Theoretical Convergence?

Difficulties notwithstanding, it is important to recognize several attempts to incorporate analytical insights and issues that had been hitherto separated in two theoretical streams in global health communication. Although such efforts have not put to rest long-standing divisions, they herald a phase of theoretical efforts to condense conceptual insights and findings from different traditions. These efforts suggest the rise of scholarship receptive to cross-theoretical pollination that recognizes the strengths of theoretical models grounded in different epistemologies and academic traditions.

Efforts towards theoretical convergence are animated by the perception that although original theories still provide basic foundations, they are insufficient to assess the complexity of social determinants of health, and inform strategic thinking about actions to promote changes at both individual, social, and policy levels (Freimuth and Crouse Quinn, 2004). Key scholars working in the tradition of behavior change and media effects have made persuasive arguments about the need to produce more nuanced, multi-leveled analysis of behavioral determinants, and rethink the meaning of communication interventions to address health challenges. Behavior change theorists have acknowledged the need to conceptualize interventions as part of broad actions for social change in countries with enormous power and social inequalities as well as persistent disparities in access to healthcare. By the same token, single interventions ("campaigns") need to be included as part of comprehensive, collective, and multi-actor strategies to change a range of conditions that negatively affect health. It is not simply about "the power of the media" or one single campaign, but rather, the combined power of broad-based actions.

Approaches grounded in social psychological theories have stressed the need to adopt multiple levels of analysis to address the influence of social and policy factors in health behaviors (Fishbein and Yzer, 2003). Examples are the transtheoretical/stages of change model (Prochaska, Norcross, and DiClemente,1994), and the ecological model (Abroms and Maibach, 2008) which propose ways to address a range of individual, social, and policy factors that affect health behaviors.

Recent studies in global health communication have reached similar conclusions. They make calls for integrated behavioral theories and multivariable analysis to understand communication issues around health practices, and guide interventions (Murray-Johnson *et al.*, 2005; Odutolu 2005; Vijayakumar, 2008) Particularly applied to HIV/AIDS prevention and family planning/reproductive health issues, they subscribe to basic principles of the ecological model on account of its offering an integrated perspective to analyze a range of behavioral determinants. At the individual level, it emphasizes the importance of knowledge and attitudes about transmission, prevention, and care, risk perception about certain practices, self efficacy to successfully implement new behaviors, and perceived norms informing behavioral choices. At the level of social networks, the model stresses the role of partners, family members, and peers in relation to power, trust, influence and gender and other social norms underlying prevention and care practices. At the level of the community, it indicates the need to consider issues related to social capital, participation, empowerment, access to information and resources, and collective attitudes and efficacy to practice and change behaviors. At the societal level, the model emphasizes the need to assess the influence of large social and political structures, the policy and media environment, cultural and religious norms, and economic factors influencing practices related to HIV prevention and care.

Another important point of convergence is the call to theorize the role of community mobilization in processes of behavior change. None other than Albert Bandura (1998), author of seminal writings underpinning behavioral theories in health communication, has stressed the importance of linking health promotion/communication to collective actions for social change and policy to transform environmental/social factors affecting health. Likewise, several studies in global health communication (Rogers and Storey, 1987) have examined the positive impact of collective mobilization. Interest in community

mobilization and health communication resonates with a rich literature on community-based health services, and the role of social mobilization in health/development.

Perhaps no area of study in global health communication suggests growing interest in theoretical integration as clearly as research on "education-entertainment" (E-E). E-E has not only become the focus of much attention in the field in the past decades, given its application in family planning, HIV/AIDS and other health programs around the world. Equally important, its intellectual trajectory has made E-E a leading case in assessing the possibilities of blending different theoretical approaches. It has attracted attention from studies informed by different conceptual and epistemological premises (Brown, in Chapter 6 of this volume, provides a detailed account of the evolution and conceptual premises of E-E).

Both the history and key findings of E-E have been extensively analyzed elsewhere. It is generally understood as the application of entertainment strategies to disseminate information in order to promote healthy behaviors and, more broadly, social good. For the purpose of this chapter, it is important to highlight that E-E is a theoretical hybrid embedded in analytical premises from a range of frameworks and models. Miguel Sabido's original ideas drew from Bandura's (1977) social learning theory, specifically, the notion that individuals learn behavior by observing role models in the media. Imitation and influence are the expected outcomes of interventions. Pioneering E-E *telenovelas*, for example, were based on Bandura's model of cognitive subprocesses: attention, retention, production and motivational processes that help understand why individuals imitate socially desirable behavior. This process depends on the existence of role models in the messages: good models, bad models, and those who transition from bad to good. Besides social learning, entertainment-education strategies are based on the idea that expected changes result from self-efficacy, the belief of individuals that they can complete specific tasks (Bandura, 1994; Maibach and Murphy, 1995). Evaluation analyses have concluded that interventions based on E-E principles have had several positive consequences: they prompt conversations about health (including many hard-to-talk-about issues), increase sensitivity about specific issues, and reinforce messages and social norms (Farr *et al.*, 2005; Piotrow *et al.*, 1992; Singhal and Rogers, 1999). Evidence about impact on behavior change, however, is more ambiguous as studies haven't always found significant increase in demand for health services (Yoder, Hornik, and Chirwa, 1996; Westoff and Rodriguez, 1995).

The rich trajectory of E-E illustrates a dynamic process of theoretical borrowing and increased openness to insights from various frameworks. In their landmark book, Singhal and Rogers (1999, p. xii) defined E-E as "the process of purposely designing and implementing a media message to both entertain and educate, in order to increase audience knowledge about an educational issue, create favorable attitudes, and change overt behavior." Later (Singhal and Rogers, 2002), they expanded their original understanding beyond individual-centered knowledge and behaviors to include community and social change and actions.

Recent studies show the possibility of theoretical convergence around E-E. Scholars have praised not only the impact of E-E on collective agency and social change, but also the participatory nature of the design of E-E programs. Research has shown that E-E programs have positive effects, including the activation of social networks and

collective efficacy, issues which are critical for promoting wide changes (Papa *et al.*, 2000; Sood, 2002).

Simultaneously, studies informed by critical and participatory theories have assessed the potential of E-E to facilitate opportunities for the expression and empowerment of the disempowered actors. Positions are clearly divided: whereas some scholars recognize that E-E can adequately provide opportunities for participation (Tufte, 2005), others conclude that the epistemological premises and conditions of global health programs hamper the participatory ambitions of E-E. The former position argues that E-E programs offer opportunities for marginalized populations to think critically, gain a better understanding of their circumstances, and become empowered in the process. The experience of Soul City, originally in South Africa and later in other countries in the region, and of the NGO Puntos de Encuentro (Meeting Points) in Nicaragua, powerfully demonstrates the potential of E-E to approach communication within a wide agenda for spearheading social change (Tufte, 2000). Not only it is premised on core emancipatory ideals that put people at the center of social change, it also tackles obstacles at multiple levels. Along similar lines, Jacobson and Storey (2004) have argued that, if they are designed on the basis of participatory premises, E-E experiences can effectively advance ideals of democratic communication.

Dutta (2006) has eloquently expressed reservations about such arguments. For him, E-E is inevitably hamstrung by individualistic and universalistic premises, as well as the overall limitations of health programs supported by international donors. Despite the rhetoric of participation, E-E programs are top-down vehicles for predetermined ideas and agendas that reflect Western interests in the global South. They leave untouched the modernizing ambitions of traditional global health communication. Subaltern groups are not fully involved in the identification of problems and the selection of the strategies best suited to addressing problems of exclusion and disempowerment.

How do we interpret the fact that critical scholars draw opposite conclusions? Scholars like Tufte, Jacobson, Storey, and others who positively assess the potential of E-E to bridge theoretical divides and promote participatory ideals, draw conclusions from single experiences. These experiences show that, indeed, E-E designed with participatory ideals in mind can advance objectives linked to better health and equality. One is left wondering, however, whether E-E necessarily achieves such objectives. Entertainment programs can simply include health/social messages aimed at changing specific health knowledge and attitudes, without being part of collective actions to facilitate critical consciousness, question power inequalities, or modify structural factors. Put it differently, we lack sufficient evidence to conclude inductively from a few cases that E-E interventions necessarily bridge theoretical divides and advance participatory goals. At best, they show the potential of E-E to support different goals and illustrate various theoretical arguments.

Nor does it seem that Dutta's sharp critique applies *in toto* to E-E. The diversity of experiences doesn't lend itself to drawing categorical, normative generalizations. It is a mistake not to differentiate between entertainment programming with social messages broadcast by major, profit-driven media corporations and those aired by rural community-owned radio stations. They are part of very different media structures with different linkages to audiences/communities. E-E is not simply a way to advance commercial goals and deepen the entertainment, profit-driven characteristics of media industries.

Nor is it obvious that, just because E-E programs are funded by major aid donors, they act as the tools of the economic-political forces that perpetuate global health inequalities, or promote a monolithic set of values (e.g., a population control agenda). The reality of health aid programs, including communication experiences, is more messy and unpredictable than Dutta acknowledges. Nothing in the theoretical premises of E-E necessarily tilts the overall experience (from design to broadcast to evaluation) in favor of certain principles. The Soul City experience, for example, foregrounds the participatory ideal in ways that may not be typical across E-E interventions, which mainly aim to modify ideational factors to affect health behaviors. Moreover, if "active audience" theories have it right, just because certain texts are designed to promote certain values (e.g. reproductive health choices, safe sex, family planning), we should not conclude *a priori* that publics wholeheartedly embrace those ideals or adopt them in health practices. In fact, evaluation research echoes arguments about the inherent openness of media texts and the problem of inferring "effects" from the conditions underlying media production or the motivations of media producers. The fact that E-E programs have resulted in contested meanings and conversations, and that participatory evaluation yielded a wealth of complex consequences not predicted during the design phase, should make us cautious about drawing generalizable conclusions. Without comparative analysis across several experiences, we lack sufficient evidence to draw positive or negative conclusions about the impact of E-E.

This debate illustrates the fact that E-E remains a fertile ground not only to explore further the possibilities of combining theoretical traditions, but also to assess how theoretical convergence may be feasible. It encapsulates the theoretical tensions and methodological differences in the field.

Conclusions

Beyond E-E, the field needs to examine a diversity of experiences to assess how theoretical convergence is possible and why it is desirable.

It is important not to lose sight of the fact that, despite growing interest in exploring the possibilities of theoretical convergence, this goal is rarely at the forefront of program design. Frequently, donor-funded programs are mainly driven by short-term and pragmatic considerations. "Theory-testing" is hardly a main priority. This is particularly problematic if future theory-building efforts in global health communication remain largely dependent on aid funding. The question is, then, how scholarly objectives, specifically the continuous need for theory refining and experimentation, can be pursued in the context of aid programs subjected to bureaucratic imperatives and the complex politics of donors and local actors (governments, non-government organizations, the private sector) (Waisbord, 2008). Programs aren't necessarily embedded in critical, participatory principles because stakeholders aren't aware of those premises or narrow theoretical scholarship undergirds conceptual guidelines and design. Rather, too often partners in both the North and the global South are primarily interested in goals, such as program visibility and political gain (Tomaselli, 1997), which are better served by run-of-the-mill, informational interventions rather than innovative programs aimed at testing theoretical breakthroughs and promoting participatory ideals.

Future directions to continue exploring theoretical convergence include conducting comparative research across communities/countries and health issues. The bulk of the literature features single cases at the community or national levels focused on specific health challenges. This division reflects broad compartmentalization of health programs in separated, silo-like structures according to "disease" and "country." Consequently, we have a significant amount of findings by "disease" (HIV/AIDS and family planning/reproductive health surely rank atop), but little comparative research to argue convincingly that theoretical propositions apply across experiences/communities and health issues. This is unfortunate, given that comparative studies may help to test the applicability of theories across programs, and thus produce solid evidence to support broad claims.

One possible path to further cross-theoretical research is to identify common questions that are both theoretically and practically relevant. If research questions remain bounded within the conceptual confines of any given theory, it is unlikely that scholars would try to find theoretical bridges. Theory-specific questions continue to provide much of the intellectual impetus for theory-building in the field (e.g., What works in persuasion? Do communication interventions prompt social networks to talk about health? What leads people to participate in order to redress health conditions? How does health advocacy affect health behaviors?). Therefore, it is not surprising that, like ships passing the night, scholars embedded in different theoretical traditions only occasionally communicate with each other.

From a perspective that believes that global health communication should be linked to broad thinking about social change, we believe that it is important to ask questions that cut across a wide swath of research in the field. To mention some examples: When does collective action make a difference in health conditions? How does communication contribute to promoting and maintaining community participation in health? How do consciousness-raising activities lead people to overcome feelings of disempowerment around health matters? What do we know about effective programmatic sequences to promote changes at individual, social, and policy levels?

Although we believe in the merits of probing the prospects of theoretical convergence, we are mindful about inherent limitations given deep theoretical cleavages in the field Just like the adjacent fields of health communication (Babrow and Mattson, 2003) and communication for global/development and social change (Waisbord, 2000), the prospects for theoretical synthesis are caught in underlying tensions that do not seem easy to resolve. Nor we can expect that theoretical ambitions will be mainly interested in resolving those tensions or addressing the vast range of issues that fall in the agenda of global health communication research.

As long as communication is defined in antithetical terms (information/participation), it seems implausible that different traditions would easily converge on key principles. As long as researchers assume that different health determinants (individual/social/system) should be the focus of theoretical development and practice, it is hard to envision a common set of questions that might bring cross-theoretical collaboration. As long as some scholars remain primarily concerned with questions about information and persuasion, and others prioritize issues of power, resistance, and participation, theoretical cross-pollination seems improbable. As long as there is no consensus on the purpose of

academic enterprise in global health communication, whether to support changes in health behaviors, promote health changes through participatory strategies, or question the modernizing goals of health and development programs, the search of common questions and theoretical frameworks is elusive. Put it differently, the persistence of different theoretical questions and research interests, grounded in the multidisciplinary genealogy of the field, undercuts the possibilities for bringing traditions closer together. Despite occasional and valuable ventures across the theoretical divide, conceptual fragmentation and parallel scholarship may still define the field in the future.

Notes

1 It is also important to point out that several studies examining interpersonal communication in medical settings were published around that time. This line of inquiry, however, did not become as influential as socio-psychological approaches in international health communication which has remained focused on mass campaigns and interventions.

2 Since then, global health programs have used social marketing to promote condom use, breastfeeding, and immunization. For Chapman Walsh *et al.* (1993, p. 108), "The first nationwide contraceptive program social marketing program, the Nirodh condom project in India, began in 1967 with funding from the Ford Foundation." The substantial increase in condom sales was attributed to the distribution and promotion of condoms at a subsidized price. The success of the Indian experience informed subsequent social marketing interventions such as the distribution of infant-weaning formula in public health clinics. The application of social marketing wasn't free of criticisms. Analysts questioned the motivations of commercial sponsors to promote health products and the effectiveness of programs. The well-known controversy around the marketing of powdered milk in the global South encapsulated skeptics' doubts about social marketing. They questioned the validity of promoting commercial products at the expense of other healthy practices (e.g. breastfeeding) and the unintended negative consequences in resource-poor settings (e.g. price prompted people to dilute powdered milk; lack of access to safe water to mix formula caused diarrheal diseases).

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