

# Theory and Practice in Health Communication Campaigns: A Critical Interrogation

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In recent reviews of the body of work on health campaigns, communication scholars discussed the importance of reflective thinking about the capacity of campaigns to affect change; this reflective thinking is especially important in the realm of the increasing gaps in society between the health rich and the health poor and the increasing marginalization of the poorer sections of society. This article critically reviews 3 central theories of health communication campaigns that represent the dominant cognitive approach: theory of reasoned action, health belief model, and the extended parallel process model. After articulating the limitations of these theoretical approaches, the article summarizes new directions in theory, methodology, and application of health communication campaigns targeting marginalized populations.

The literature on prevention campaigns documents a long history, with important contributions in understanding individual-level behavior change (Community Intervention Trial for Smoking Cessation, 1995; Hornik, 2002; Luepker et al., 1994). A meta-analysis by Snyder (2002) demonstrated that health campaigns reach small and short-term effects when strategically planned. In addition to the small and short-term effects of campaigns, a review by Viswanath and Finnegan (2002) pointed out that low socioeconomic status groups, which face the greatest threats of ill health, fail to benefit equally compared to higher socioeconomic groups. The at-risk populations are most often left behind while campaigns continue to benefit the health rich; a substantive body of evidence on knowledge gap theory points out that health communication campaigns contribute to the existing gaps between the rich and the poor (Finnegan & Viswanath, 1997; Freimuth, 1990; Viswanath & Finnegan, 1995).

Addressing the increasing societal chasm between the haves and have nots, health communication scholars have called for a reconfiguration in the realm of campaigns, a reconfiguration that focuses on serving marginalized people (Marshall & McKeon, 1996). Such a reconfiguration is closely aligned with Viswanath and Finnegan's (2002) call for profound reflection about the capacity of campaigns to achieve population behavior change and has already been initiated within the fields of health communication and public health via novel individual campaign efforts. Although the different alternatives to extant health communication approaches have been developed in the form of individual campaigns, they have hitherto been systematically integrated within a single framework and positioned against the backdrop of the dominant approach to campaigns. In the following pages, I offer a critical review of the three most widely applied theoretical approaches that inform much of the published scholarship on campaigns: the theory of reasoned action (TRA), the health belief model (HBM), and the extended parallel process model (EPPM). I juxtapose my analysis against the backdrop of currently emerging reconfigurations in the field (Glanz & Rimer, 1995; Hornik, 2002; Witte, 1992; Witte & Allen, 2000). The analysis of the dominant theoretical approaches is contextualized by recent developments in the fields of health communication and public health, providing an exploratory platform for new solutions in the realms of theory building, methodology, and application development.

## CAMPAIGN THEORIES/MODELS

### Theory of Reasoned Action

The TRA explains volitional human behavior, proposing that one's intention to perform or not perform a behavior is the most critical determinant of human behavior. Behavioral intention is dependent on the individual's attitude toward the specific behavior, and his or her perception of the evaluation of the behavior by important others. The attitude of the individual, in turn, results from his or her salient beliefs about the outcomes of the behavior. Similarly, the individual's motivation to comply with salient others in his or her social network accompanied by the normative beliefs regarding the target behavior ascribed to these salient others produce his or her subjective norms (Fishbein, 1990; Fishbein & Ajzen, 1975).

### Health Belief Model

The HBM is founded on six components: severity, susceptibility, benefits, barriers, cues to action, and self-efficacy (Janz & Becker, 1984; Mattson, 1999; Rosenstock, 1974). Whereas perceived severity refers to the individual's assessment of the outcomes associated with the preventive behavior, perceived susceptibility fo-

cues on the individual's assessment of the extent to which he or she is likely to succumb to the negative outcomes. Both susceptibility and severity need to be high for the individual to consider altering his or her behavior. Benefits are the individual's beliefs regarding the effectiveness of the proposed preventive behavior in reducing the vulnerability to the negative outcomes (Mattson, 1999; Rosenstock, 1974). Barriers decrease the individual's ability to engage in the preventive behavior and are described as the evaluation of potential negative consequences that might result from the enactment of the espoused health behavior (Mattson, 1999; Rosenstock, 1974). Self-efficacy taps into the amount of confidence individuals have in their ability to perform the health behavior, and it positively predicts the adoption of the preventive behavior. Finally, cues to action are the specific stimuli that are needed to trigger the appropriate health behavior (Janz & Becker, 1984; Mattson, 1999).

### Extended Parallel Process Model

The EPPM posits that the evaluation of perceived threat and perceived efficacy related to a specific intervention determine the pathway taken by the target audience after exposure to a threatening message (Witte, 1992; Witte & Allen, 2000). On exposure to the message, the individual either attempts to control the danger by adhering to the recommendations of the message (engaging in the preventive behavior that minimizes the danger) or controls the fear through defensive avoidance or denial, not adopting the recommended action. Audience members first evaluate the perceived threat of the hazard. If the perceived threat elicited by the message is low, the individual is not motivated to further process the message; however, if and when perceived threat is moderate to high, the individual moves on to the second step—appraisal of the efficacy of the recommended action. In situations when both the perceived threat and the perceived efficacy of the recommended action are high, the message recipient is prompted to follow the recommended action. However, on processing a message triggered by high perceived threat and not being convinced of their ability to deter the threat, individuals use a defensive mechanism to cope with their fear (Witte, 1992).

## A CRITICAL PERSPECTIVE

### Foundation of a Critical Approach

In her essay *Toward the Development of Critical Health Communication Praxis*, Lupton (1994) locates and critiques some of the foundational issues that underlie health communication. She argues that communication in the health context is traditionally conceptualized as a top-down approach, with communication flowing from the centers of authority to peripheral locations. The critical perspective con-

structs health communication as a political process, marked by power relations that determine the relationship between the bourgeoisie and subaltern classes. Defined as “the ability to shape social contexts” (Wilkins & Mody, 2001, p. 198), power is central to how problems are defined and how solutions are framed (Mody, 2000; Wilkins & Mody, 2001). Campaigns, critical theorists argue, are dictated by the capacity of those with power to “select and frame social conditions and groups as problematic, legitimizing particular approaches to their resolution and not others” (Wilkins & Mody, 2001, p. 393). With its primary objective of persuasion, the epistemology of campaigns is based on a “desire for control and domination, for the act of changing establishes the power of the change agent over that other” (Foss & Griffin, 1995, p. 3).

Taking a critical stance allows scholars to raise typically taken-for-granted questions (Lupton, 1994). In this essay, I apply a critical stance to interrogate TRA, HBM, and EPPM, with the ultimate goal of using the criticism for creating a constitutive space that encourages the articulation, comparison, and synthesis of alternative approaches to health communication campaigns. A critical analysis of the theoretical, methodological, and practical issues in health communication campaign scholarship reveals that campaigns (a) are individualistic, (b) ignore the context within which communicative meanings are constructed and negotiated, and (c) are cognitively oriented.

### Individualistic Bias

With their roots in the social psychological tradition, campaign theories and models typically focus on the individual (Wallack, 1989). A specific aspect of the individual’s attitude, belief, and/or cognition is selected as the target of the campaign. The individual serves as the object of theory development and guides the methodological and practical choices of scholars and campaign planners (Airhihenbuwa, 1995; Lupton, 1994; Wallack, 1989). The primacy of beliefs in the TRA and the perceptual assessments in the HBM and EPPM are founded in an individualistic epistemology where the locus of choice is the individual. Located within the individual’s cognitive space, the enactment or nonenactment of a behavior is a result of individual-level processes that precede the behavior. Consider, in this realm, a collectivistic culture in which the emphasis is on collective identity, and the barriers to action are located within this collectivistic context. The behavior then gets located in the characteristics of the collective and becomes a part of the collective being of the culture (Triandis, 1994). The meanings associated with the behavior and the behavioral outcome might very well be located in the social networks, the collective fabric of the community.

Although proponents of the TRA might argue that subjective norms explain the role of the collective in individual decision making, it may be counterargued that subjective norms are driven by an individual motive orientation and, therefore, are

fundamentally unable to capture the locus of the decision in the collective. Subjective norms, although targeted on the individual's evaluation of the important others in the interpersonal network, do not effectively tap into the complexity of the social fabric that constitute the health behavior. Social influence moves beyond the realm of a few important others to the broader sociocultural context of the community. The individual might engage in a behavior because it is inherent in the broader collective rather than simply being motivated to comply with the important others within his or her immediate network. For instance, research on HIV/AIDS in India demonstrates the embeddedness of attitudes and beliefs regarding extramarital sex within the broader cultural context. In cultures such as the Philippines and Thailand, young men visit brothels as a rite of passage (Brown, 2000). In these instances, attitudes and beliefs regarding visits to brothels are not located in, or limited to, the important others. Instead, the source of influence is the broader community.

The important role of culture might be particularly evident in the realm of habitual behaviors where the enactment of the behavior is based on an existing script without thoughtful and systematic assessments each time the behavior is enacted. Also, the role of the culture might be particularly highlighted in collectivistic cultures in which individual decision making is simply a reflection of cultural mores and rituals. For instance, in Cambodia, where buying sex is integral to almost all forms of evening entertainment for men, women are expected to contribute to the family's income at a very early age, leading to a sense of family obligation that drives women to enter the sex industry in the face of poverty (Mony, Salan, Youthy, Piseth, & Brown, 1999). In other instances, the individualistic messages of behavior change developed through the TRA, the HBM, or the EPPM might fundamentally counter the values of the collective. The proposed behavior might not exist in harmony with the values and goals of the collective. Take for instance, a campaign targeting middle-class high school students in metropolitan cities in India to use condoms for safe sex. Although an EPPM-based message might create a high threat and subsequently high response efficacy with respect to condoms, the use of condoms or the prospects of having extramarital sex do not gel with the mores and values of traditional Indian society.

To emphasize the location of the collective at the core of much health behavior, scholars have recently introduced the concept of collective efficacy and applied it in the realm of health campaigns (Bandura, 1995; Sood, 2002). Conceptualized as a system-level manifestation of Bandura's social cognitive theory, collective efficacy is defined as "people's beliefs in their joint capabilities to forge divergent self-interests into a shared agenda, to enlist supporters and resources for collective action, to devise effective strategies and to execute them successfully, and to withstand forcible opposition and discouraging setbacks" (Bandura, 1995, p. 33). Communities with collective efficacy are able to mobilize their efforts and resources to overcome external obstacles to the social change project (Bandura,

1995). In their examination of an entertainment–education program in India called Tinkha Tinkha Sukh (TTS), Papa and colleagues (2000) reported that the program led to the formation of informal listening groups, which became formalized into men’s and women’s radio listeners clubs. Members of the clubs “listened to the program collectively and discussed the content, charting new courses for environmental action” (Papa et al., 2000, p. 45).

Recognizing the critical nature of the collective in constituting health behavior, campaign planners working in collectivistic cultures have launched campaigns at the group or community level rather than at the individual level. An example of a campaign located at the collective level is the Sonagachi project on HIV/AIDS prevention started in Calcutta in 1992 (Jana et al., 1998). Involving sex workers, their clients, local organizations, and political leaders, the Sonagachi project sought to alter the sociocultural rubric surrounding unsafe sex by setting up health care service centers, recruiting sex workers as peer educators, forming cultural groups, and empowering sex workers to start their own organization dealing with relevant sociocultural issues including unsafe sex (Jana et al., 1998). The effectiveness of the Sonagachi project in gaining an increase of approximately 50% in the use of condoms in a red-light district was achieved by its use of group settings and community interactions as conduits for identifying the problem in the sociocultural environment and implementing a community-level change strategy that responded to the sociocultural system and enhanced collective efficacy.

Another campaign that moved beyond the individual level was the Bienvenida Salud! campaign fostering reproductive health in the Peruvian Amazon (Davenport Sypher, McKinley, Ventsam, & Valdeavellano, 2002). In addition to using a mass media component, the campaign trained a network of peer promoters to foster interpersonal communication among community members (Davenport Sypher et al., 2002). Yet other campaigns have focused on a social/ecological approach with the goal of influencing social policy and the community environment as prerequisites to transforming individual behavior (Mittelmark, 2001). The importance of expanding the locus of social change from the individual to the interpersonal context is also supported by a significant number of studies documenting that mediated campaigns often spur interpersonal communication about the media program (Valente, Poppe, & Payne-Merritt, 1996).

### Minimizing Context

The applications of the TRA, the HBM, and the EPPM do not typically capture the structural, measurement, and mediated contexts of the health behaviors being studied (Marmot & Wilkinson, 1999).

*Structural context.* By assuming that individual beliefs and perceptions hold the key to explaining health behavior, the theories/models ignore the con-

straints that might operate in the individual's environment, particularly in severely resource-deprived spaces such as third world nations (Marmot & Wilkinson, 1999). Structural resources and the access to such resources might be central to the development of an understanding of health communication in many Third World countries or resource-starved areas such as inner cities (Dutta-Bergman, 2003; Marmot & Wilkinson, 1999; McClelland, 1991). A media-based approach that addresses the benefits or barriers by providing information does not address the key structural elements of barriers that impede the enactment of behavior in particularly deprived parts of the world where individuals do not have the basic capabilities of life such as food, clothing, and shelter (Narayan, Chambers, Shah, & Petesch, 2000; Narayan, Patel, Schafft, Rademacher, & Koch-Schulte, 2000; The Synergy Project, 2002). Worthwhile to point out here is the fact that many of the structural barriers experienced in marginalized populations that are typical targets of health interventions might not be overtly related to the specific behavior being proposed or might not present themselves directly to the scrutiny of the external observer (Mony, Salan, Youthy, Piseth, & Brown, 1999; Sarkar et al., 1997). Health decisions might be located in the capability of community members to gain access to some of the primary resources of life, such as food, clothing, and shelter. In the face of the absence of these basic resources, engaging in higher order health behaviors such as getting mammograms, not smoking cigarettes, or having safe sex might seem irrelevant. Prioritization of risks therefore needs to fundamentally change, and this can happen only by the application of a bottom-up approach that puts the community at the center of decision making and focuses on equipping the community with basic resources (Narayan & Petesch, 2002; Nyamwaya, 2003).

Emphasizing the importance of addressing poverty and undernourishment in marginalized communities, multiple public health campaigns in marginalized populations have developed poverty and food-based components as the first step to creating healthy communities (Nyamwaya, 2003). The microcredit program of the Bangladesh Rural Advancement Committee successfully improved health knowledge among poor women in rural Bangladesh by tying it in with a grass-roots poverty reduction program that gave collateral-free credit to poor rural women, accompanied by support services such as group meetings, skills training, basic literacy, and primary health care services. Study results demonstrated that the program successfully served as a conduit for disseminating health information among the hard-to-reach at-risk rural women (Hadi, 2001). The Sonagachi project in Calcutta recognized that an HIV/AIDS campaign in a severely resource-undernourished, high-risk sex worker community would fail if it simply focused on distributing condoms and generating behavioral change through message design (Jana et al. 1998; UNAIDS, 2000). Instead, the project emphasized the imminent contextual risks such as lack of access to money, arguing that the women in the community might need to sell their bodies to earn just enough money and might, therefore, be willing to forgo condom use if threat-

ened by a client (The Synergy Project, 2002; UNAIDS, 2000). The sex workers of Sonagachi formed a consumer's cooperative called the Usha Multipurpose Cooperative Society that would "help the sex workers save money and avoid the exorbitant interest charged on small loans by money lenders in the area" (UNAIDS, 2000, p. 70). Recognizing the strong interlinkage between economics and safe sex practices among sex workers, the Shakti project in Bangladesh offered skills training in alternative modes of supplementing income, such as embroidery and sewing (UNAIDS, 2000). On a similar note, the SWEAT project in South Africa fostered the development of exit programs, support programs, job creation schemes, and skills training programs for sex workers, while the Prerana project in India provided education, shelter, and health and vocational training to the children of sex workers (The Synergy Project, 2002).

*Measurement and message context.* The measurement techniques of the TRA, the EPPM, and the HBM are typically unable to capture the actual context of behavioral enactment. The measurement of perceptual indicators and belief structures is typically conducted in a cognitively loaded scenario in which the respondent fills out a survey. In other words, the method of measurement perhaps lends itself to the cognitive orientation of the theoretical framework (to be discussed in the next section) although it might be far removed from the reality of the situation under which the individual engages in the behavior. Instead of, prior to, and/or complementary to using survey-based instruments, formative and evaluation researchers need to use methods such as participant observation, ethnography, and focus groups in deciphering and unraveling the meaning of structures that circulate within cultures. For instance, Davenport Sypher and colleagues (2002) applied a social constructionist approach to develop a preliminary understanding of the culture in the Peruvian Amazon before conducting a large-scale survey. They argued, "the social constructionist approach in this project demanded an understanding of local knowledge before conducting a meaningful, large-scale audience survey of the radio listeners" (Davenport Sypher et al., 2003, p. 202). The researchers analyzed letters received by the radio station, conducted focus group interviews, and utilized participant observation and in-depth interviews (Davenport Sypher et al., 2002).

Ignored in the conceptualization of individual response is the surrounding context within which the individual might be embedded while viewing, reading, or hearing the message (Nathanson, 2001; Nathanson & Botta, 2003; Schmitt, Woolf, & Anderson, 2003; Steele, 1999). The recipient is highlighted; his or her media environment within which the message is received is ignored (Steele, 1999). A college student watching a message alone in a dorm room will perhaps respond very differently to the message as opposed to being exposed to the message amidst a group of friends at the student union. Or take, for instance, the case of audience exposure to a fear-inducing advertisement right after watching a positive, emo-

tion-inducing television program (a situation comedy). The viewer might simply be likely to avoid the message to maintain his or her positive emotional state (Kamins, Marks, & Skinner, 1991; Shapiro, MacInnis, & Park, 2002). Similarly, Mitchell (2001) demonstrates that sad moods generate greater perceptions of susceptibility and severity. By simply highlighting the basic elements of a message, the dominant approach fails to take into account the role of the context in driving the reception of the message.

It is important to point out that the theories/models reviewed in this article are likely to find support when studied in a laboratory setting; the student is exposed to the single message and a response is elicited (high internal validity). However, the artificiality of the very laboratory setting removes the contextual factors that surround the reception of a message and therefore suffers from problems of external validity. These issues of external validity are important because mediated messages are almost always embedded within the context; the loss of the surrounding context is not something that can be written off in the limitations section of a study on message effects.

The highly contextualized nature of media consumption is particularly critical in collectivistic cultures in which individuals consume media in family and community settings, necessitating the development of measurement tools that capture the media consumption context (Davenport Sypher et al., 2002; Steele, 1999). For instance, research documenting the listenership of TTS indicated that community members formed informal groups that later became formalized into radio clubs that listened to the program as a group and subsequently discussed the program content; these radio clubs actively participated in their local and surrounding communities, spreading the message of the social change project (Papa et al., 2000). The example of TTS documents the interpenetration of the intrapersonal, interpersonal, mediated, group, and community levels of communication. The communal nature of radio listening is also captured in a project conducted in the Peruvian Amazon by Davenport Sypher and colleagues (2002).

### Cognitive Orientation

Central to all three theories/models is the role of cognition in shaping audience outcomes. The TRA emphasizes beliefs in the formation of attitudes and subjective norms. Rooted in the ability of humans to reason, the theory suggests that individuals systematically identify and weigh outcomes to form attitudes. Behavioral change is induced by adding a new belief, increasing or decreasing the favorability or unfavorability of an existing belief, and increasing or decreasing the belief strength, depending on the nature of the behavior (Fishbein, 1990). Similarly, the HBM assumes that rationally acting individuals go through a cost-benefit analysis to determine the severity, susceptibility, barriers, and benefits related to a health behavior before adopting the behavior (Mattson, 1999). Pointing to the cognitive

orientation of earlier models and theories, Witte (1992) argues that EPPM is an improvement over earlier models and theories of health communication because it takes into account the role of emotions in information processing. However, it is worthwhile to point out that much of the experience of emotions in EPPM is dependent on cognitive appraisal.

The persuasive process documented in the theories/models discussed in this article is primarily information based, providing the target audience with necessary pieces of information to create the desirable attitude toward the behavior (Budd, North, & Spencer, 1984; Hausenblas, Carron, & Mack, 1997). This emphasis on information and rational choice becomes particularly problematic in the case of certain choices that are made on the spur of the moment or choices that do not involve deliberate cognitive evaluation (habitual behavioral choices). Affective-laden behavioral choices are not accommodated within the framework of the cognitive-based theories/models. This is a critical drawback of the theory, given the affect-laden nature of decision making involved in many health-based behaviors (Dutta-Bergman, 2003). For instance, although an individual might engage in cognitive elaboration and decide to use a condom during sex after a detailed conversation with the sex counselor at a university clinic, he or she might forget about the entire conversation when encountering the possibility of a one-night stand with an attractive target at a bar (Mattson, 1999). Acknowledging the affective element of health decision making, health communication researchers are increasingly using affect-based campaigns (Dutta-Bergman, 2003; Singhal & Rogers, 2002; Stephenson & Palmgreen, 2001). The growth in health communication research on personality factors such as sensation seeking and self-monitoring underscores the importance of emotions in audience reception of messages and the choice of health behaviors (Dutta-Bergman, 2003). Highlighting the importance of affect in health behaviors, a study of the TTS entertainment–education campaign in India reported that those individuals who “engaged in high levels of referential-affective involvement with TTS were more likely to communicate interpersonally with their friends and family members” (Sood, 2002, p. 168).

Campaign planners typically use information-heavy communicative materials such as booklets, brochures, and public service announcements. Selective exposure theory documents that individuals selectively orient their attention to those stimuli in their environments that match their existing predispositions, values, and behaviors. Therefore, campaign materials that propose to alter the belief structure of the receiver of the message are not likely to be adhered to. Instead, those individuals who are already interested in the issue end up learning from the message. This selectivity in the reception and processing of the message contributes to the increasing knowledge and behavioral gaps between the healthy and the unhealthy individuals within a population. Also, such information-based campaigns do not recognize the low literacy levels, the lack of access to media types, and the contextual noise that often prevent the exposure and processing of the message among marginalized populations (Dutta-Bergman, 2004; Hadi, 2001).

In an attempt to mitigate the increasing knowledge gaps in society, current communication campaigns are increasingly using entertainment strategies to place messages in entertainment programs that are more likely to be consumed by those at risk (Davenport Sypher et al., 2002; Singhal & Rogers, 2002). The increasing popularity of the entertainment-education strategy led to the dedication of an entire issue of *Communication Theory* to the topic. Campaigns are also effectively using communities as conduits for reaching out to those who are most at risk and who are difficult to reach via the traditional mass media (Hadi, 2001; Jana et. al., 1998; Mittelmark, 2001). Finally, more and more campaigns are focusing on fine-tuned segmentation and message targeting to reach at-risk groups (Marshall & McKeon, 1996).

The criticism of the dominant approaches to health communication demonstrates that these approaches typically are individualistic, ignore the context, and are cognitively biased. The critical exercise, however, remains incomplete without the discussion of new possibilities based on the criticisms offered in this essay (Deetz, 1994). Whereas one of the roles of critical scholarship is to open up the discursive space to excavate the taken-for-granted positions in the dominant discourse, yet another important role is, I believe, to suggest a constructive space for dialogue and collaboration for further development of theory and practice. In that spirit, the criticism of the popular social psychological models and theories in the campaigns literature is offered as a stepping stone for new directions and possibilities.

### NEW DIRECTIONS AND POSSIBILITIES IN HEALTH CAMPAIGNS

As my review of the three most popular theories/models of health communication campaigns demonstrates, the dominant approach to health behavior change is fixed at the level of the individual. This location of the health behavior in the individual is problematic because it reflects an individualistic cultural bias, ignores the role of context and structure, and is cognitive oriented. With an emphasis on mediated communication that seeks to produce individual change, communication scholars have traditionally focused on developing mediated message materials rather than engaging in articulations about the location of the health behavior and its enactment (Hornik, 2002).

Current trends in communication campaign research direct us to new vistas beyond mass media messages; they point out that to accomplish social change, scholarship of health communication campaigns needs to integrate and join the efforts of the mutually disparate subdisciplines of mass communication, interpersonal communication, and organizational communication. Mediated messages fail in certain scenarios and are limited by structural barriers, especially when marginalized groups are addressed. In the following sections, I summarize

some new directions for looking at communication and its role in the realm of health campaigns, making specific recommendations for theorizing, methodology, and application in the realm of health campaigns.

### Recognizing the Role of Structures and Basic Capabilities

Structure defines, limits, shapes, and constrains the nature of communicative practices; this is especially the case when the campaign seeks to impact the health of underserved populations (Senderowitz, 2000; The Synergy Project, 2002). Given the fact that underserved populations are at maximum risk, it is especially important to orient current and future health communication practice toward such populations. To get individuals to engage in behaviors such as using condoms and wearing seatbelts, campaign planners need to ensure adequate supply of the basic resources of food, clothing, and shelter. Elucidating the role of basic resources in human health, Sen (1992) articulates that capability building is the first and foremost step toward greater and better health of people and communities. Capability building involves providing cultural participants with fundamental life resources such as food, clothing, and shelter, which members of at-risk communities need to continue living (Sen, 1992). Theoretical approaches to health campaigns ought to locate poverty and the lack of basic resources at the center of human behavior and communicative choice; basic capabilities need to be taken into account in theorizing. Practical approaches incorporating structural deprivation are currently under way in different marginalized sectors of the globe, with an emphasis on skills training, income generation, education and literacy, cooperative loan programs, food drives, etc. (Gillis, 1999; Jana et al., 1998; The Synergy Project, 2002; UNAIDS, 2000). The focal point of the structural approach, therefore, is not just the targeted individual, but also the individual's social network of partners; family members; friends; communities; the infrastructure and the institutions in his or her environment; and the legal, political, and economic realities that encompass his or her life (Senderowitz, 2000; Sweat & Denison, 1995; The Synergy Project, 2002).

Methodologically, individual-level surveys and measurement techniques need to be complemented by focus groups, group discussions, participant observations, ethnographies, network analyses, and geographical plots. The "People Assisting Their Health" (PATH) campaign in Nova Scotia, Canada is an example of a campaign approach that shifted the locus from the individual to the community (Gillis, 1999; Mittelmark, 2001). Applying a structural approach aiming to create social responsibility for health within the community, community members participated in citizen meetings, designed community health impact assessment tools, and ensured the implementation of the assessment tools in community health planning and in municipal decision making.

To create successful structurally resourceful programs such as the Sonagachi and Prerana projects, communication scholars ought to interrogate, examine, and develop best practices for mobilizing communities such that community members can work together in identifying the structural impediments and in collaborating to remove these impediments (Freire, 1970). It is both theoretically and practically important to examine the role played by strategic communication in bringing people together and in equipping them with necessary skills for securing structural access to resources. Scholars studying interpersonal, small group, and organizational communication would have critical theoretical contributions to make in understanding the processes of community mobilization and in developing projects that focus on securing structural resources through mobilization. For instance, one area of research might focus on theorizing, measuring, and applying individual-level and community-level competence in target communities. Freire (1970) discusses the central role of generating critical consciousness among the members of resource-deprived populations so they can play an active role in articulating their voices and in determining their goals. Thus, members can actively participate in creating conducive living conditions that support their health. Communication scholars working within the structure-centered paradigm of health communication could emerge as key players in the development of both theory and practice in Freire's critical consciousness raising. One area of inquiry might focus on the communication skills needed by peer educators and opinion leaders within the community to facilitate critical consciousness raising. Yet another area of scholarship might emphasize identifying and minimizing the communicative barriers in the process of critical consciousness raising.

The goals of the structure-centered approach are most recently informed by findings that socioeconomic inequalities play a critical role in shaping the health of communities; communities with the greatest inequities of health are also typically the unhealthiest communities (World Health Organization, 1998). To generate better health, therefore, a plethora of health promotion campaigns in recent years have worked toward minimizing socioeconomic disparities and creating a more equitable community/society. The advocacy role of communication is particularly critical here, especially in the context of theorizing about and developing applications for media agenda setting by community groups. Public relations scholars might play a critical role in documenting the processes and developing insights about media relations and political relations for grassroots activist groups. Communication that serves to create a more equitable society through processes of redistributive justice achieved by policy changes, tax implementations, media coverage, grant generation, etc. is much needed. However, it is also critical to remember that these community-based approaches will perhaps fail to achieve their effects if they are nontargeted; specific attempts will need to be made at targeting the resource-deprived and marginalized communities to mitigate the patterns of knowledge gaps documented in mass-mediated campaigns. In addition to foster-

ing coalitions among deprived peoples, campaigns might also target key stakeholders within the community with relevant themes such as social responsibility (Mittelmark, 2001).

### Culture-Centered Approach

The culture-centered approach locates culture at the center of theorizing about communication processes; in other words, communication theories develop from within the culture or community instead of originating from outside (Airhihenbuwa, 1995; Dutta-Bergman, 2004; Escobar, 1995). Explanations of phenomena and articulations of pragmatic solutions based on the nature of the phenomena emerge from within the culture or subculture being studied; when fused with the capability building and consciousness raising approaches discussed earlier, the culture-centered approach becomes the conduit through which members of indigenous communities find ways to articulate their voices and participate in social change (Airhihenbuwa, 1995; Dutta-Bergman, 2004; Escobar, 1995; Spivak, 1988). Problems are configured and reconfigured; solutions are generated and worked on based on the needs of the community as defined by community members. Theoretically, a culture-centered approach suggests that the thrust for constructing and explaining problems should come from within the culture, embodying a community-based approach and epitomizing the interdependence of theory and practice. Examples of the community-based approach include campaigns such as PATH, Sonagachi, SWEAT, and TTS. The call for a culture-centered approach resonates with Foss and Griffin's (1995) articulation of an invitational rhetoric that emphasizes mutual understanding rooted in "equality, immanent value and self determination" (p. 5) as the goal of an alternative rhetoric beyond persuasion.

Methodologically, the culture-centered approach uses participatory communication methodologies such as focus groups, community meetings, team building exercises, and ethnographies that focus on social construction of meanings constituted by the culture. It also suggests that researchers spend adequate time learning about the cultures and immersing themselves within these cultures to better development applications and assessment tools (Davenport Sypher et al., 2002). The pragmatic solution of the culture-centered approach lies in community capacity building such that community members can find the conduit to articulate their concerns and problems and participate in solving these problems (Mittelmark, 2001). Necessitating that researchers immerse themselves in the communities with which they work, the culture-centered approach essentially and fundamentally captures the intertwined nature of theory and practice in health communication.

The culture-centered approach becomes a conduit for legitimate theory building from marginalized spaces; social change is achieved through the presence of the marginalized voices and through the participation of these voices in securing resources and participating in redistributive justice. Instead of speaking for the

subaltern, the culture-centered approach focuses on creating conduits for the expression of the subaltern voice. By talking to the subaltern participant, the researcher finds an outlet for the subaltern voice within the dialogue between the researcher and the subaltern speaker (Dutta-Bergman, 2004; Guha & Spivak, 1988; Spivak, 1988). The researcher perhaps simply becomes a facilitator; the theories, concepts, and explanations developed are those of the members of the culture in dialogue with the researcher (Airhihenbuwa, 1995; Dutta-Bergman, 2003, 2004; Guha & Spivak, 1988; Spivak, 1988).

### Polymorphic Communication Theorizing

That it is important to synthesize the levels of theorizing, application, and analysis is one of the most obvious dictates of both the structure-centered and culture-centered approaches; this synthesis is epitomized in the philosophy of polymorphism. Polymorphism focuses on the many realities that coexist in the experience of the world. In other words, polymorphism articulates that there are many truths in this world (Dutta-Bergman & Doyle, 2001). Mikhail Bakhtin (1981) sensitized us to this concept of multiple possibilities and interpretations in any social situation in his discussion of heteroglossia. How we see the world depends on how we approach it; the lens used by the researcher in locating and describing the practices of the world is fundamental to the way the world is constructed (Bakhtin, 1981; Cheney, 2000; Dutta-Bergman & Doyle, 2001).

A polymorphic approach to theorizing and application development focuses on locating and harnessing the multiplicities of communication, on integrating the rich body of communication theories, and simultaneously retaining their diversity (Dutta-Bergman & Doyle, 2001; Mumby, 2000). As articulated in the previous sections, no one level of analysis (intrapersonal, interpersonal, small group, organizational, or mass mediated) or no one paradigmatic approach is adequately positioned to capture the complexity of communication; for campaigns to be successful, multiple levels of communication from multiple perspectives need to be simultaneously activated (Cheney, 2000). Recent years have documented an exponential growth in the number of campaigns that move beyond the intrapersonal and mass mediated levels to include interpersonal, small group, organizational, community, social, economic, and cultural levels (Gillis, 1999). For instance, the marriage of the theory of reasoned action (microlevel) with the diffusion of innovations theory (macrolevel) would provide interesting and important guidelines for the campaign theorist. The amalgamation of the health inequities research with the TRA would locate the relationship between health inequities and the distribution of specific health beliefs within communities.

Methodologically, the synthesized theories would need to be tested at the micro, meso, and macro levels, calling for multimethod approaches. For instance, the combination of network analysis with survey instruments could inform a theory

that combines diffusion of innovation with the theory of reasoned action. Also, to tap into the multiple levels of communication embodied in a polymorphic approach, methodological tools would need to simultaneously interrogate different stakeholders (the individual, spouse, parents, siblings, neighbors, community members, etc.) using different instruments.

Although the initial attempts at theory building, informed by a social psychological approach, have emphasized parsimony, focusing on a singular level of communication to minimize the complexity, increase internal validity, and tease out the effects of individual communicative factors (mostly mass mediated in the realm of campaigns), the reality of message exposure and behavioral change can only be captured when the broader context is introduced into the framework. The polymorphic framework therefore calls for collaboration among communication scholars in different subdisciplines (interpersonal, small group, organizational, and mediated) and with different paradigmatic approaches (positivist, interpretivist, critical structuralist, and critical radicalist) to generate positive social change in resource-starved communities. A dialectical–dialogical engagement among the scholars with the different paradigmatic approaches operating at the different communicative levels will be fundamental to the development of well informed programs of research. It is important to note the emphasis on dialogue among the multiplicity of paradigmatic approaches. The polymorphic stance seeks to extend the conventions of critical scholarship by looking to synthesize and construct, rather than merely to critique.

The polymorphic approach needs to be present not only in cross-paradigmatic cross-level dialogues, but also within individual works of scholars; it is critical for campaign scholars to engage in multiple realizations of the world, to see the limits of particular discursive approaches, to acknowledge these limits and to seek out complementary approaches and alternative paradigms that would throw light on these limits (Deetz, 2000; Mumby, 2000). Although this article took a critical approach to defining the boundaries of the dominant theories of campaigns, it is also worthwhile to point out in the polymorphic vein that the three theories/models (the TRA, the HBM, and the EPPM) have made vastly important contributions to the way we understand health campaigns. The point of this review was not to suggest that we throw these theories away as a part of the deconstructive exercise; instead, the illumination of limitations was intended to open up the space for alternative articulations that could very well complement these theories and dialectically engage with them. Some or many of these limitations can perhaps be effectively dealt with when the theory or model is integrated or supplemented with other theories and models. For instance, integrating the health belief model with network analysis (from organizational communication) might provide adequate opportunities for campaign development for securing access to structural resources and subsequently changing individual behaviors by addressing perceived barriers.

As demonstrated throughout the article, one of the most important concerns of the health communication campaign scholar of the new millennium is to find ways of reaching out to marginalized groups. The paradigm shift in theorizing, methodology development, and practical solution to campaign research is sparked by a growing emphasis on speaking from the margins, on building epistemologies from the margins, on creating alternative discursive spaces for the conceptualization of meanings of health (Airhihenbuwa, 1995; Dutta-Bergman, 2004; Mittelmark, 2001). The new direction evident in much of the growing research on community-based campaigns puts importance on acknowledging marginalized people's capability to determine their own choices, model their own behaviors, and develop epistemologies based on self-understanding (Dutta-Bergman, 2004; Escobar, 1995; Mittelmark, 2001). Future scholarship needs to theorize and empirically test the roles of culture, structure, media, familial, and interpersonal contexts in the realm of health communication campaigns.

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