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### The Past, Present, and Future of Health Development Campaigns: Reflexivity and the Critical-Cultural Approach

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# The Past, Present, and Future of Health Development Campaigns: Reflexivity and the Critical-Cultural Approach

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In contemporary society, health issues have gained increasing urgency in both political and academic spheres. Looking back at the failure of the modernist development initiatives, there is the need to realize that we live in a time of increasing sociopolitical complexity. The present moment is perhaps best understood in terms of a complex tension and linkage between the past and present, global and local, modern and postmodern. The critical-cultural approach to health campaigns is an approach that, through the reflexive interrogation of modernist assumptions underlying health communication campaigns, attempts to foreground the tensions inherent in the practice of health campaigns. This essay discusses the manner in which the critical-cultural approach interrogates modernist assumptions and provides an alternative paradigm for approaching the theory and practice of health campaigns by suggesting the necessity for reflexivity. Specifically, we discuss how the perspective interrogates the role of the media in development, the significance of culture, the locus of health responsibility, the impact of structural conditions, and the politics of knowledge, providing examples of campaigns that illustrate this reflexivity.

In contemporary society, health issues have gained increasing prominence and urgency in both political and academic spheres. Published macrolevel studies document that there are both health winners and losers in the globe, and that the global gap between the health-rich and the health-poor continues to increase exponentially. Investments in health care technologies and interventions have rapidly contributed to the increasing health status of the “health-haves,” accompanied by increasing lack of access to basic health capacities among the “have-nots” (Millen, Irwin, & Yong Kim, 2000).

The flow of health communication in this global health care landscape has been marked by the diffusion of health innovations carried out in the form of health campaigns that were conceptualized and implemented under the umbrella of

development communication. These health-based development campaigns were executed under the notion that health innovations such as family-planning techniques and immunization programs would bring about development in the underdeveloped sectors of the globe. A growing number of health campaigns have been instituted over the past decades, generated in nation-states at the center (primarily the United States and the United Kingdom) and directed at periphery nations of the world system (India, Nepal, Mexico, South Africa, etc.), the center/periphery locations being predicated on access or lack thereof to positions of power and guided by the master geographies conceived by the dominant states and institutions. Dichotomous categories such as developed/undeveloped, North/South, First/Third are central to the basic concept of campaigns; health campaigns have been traditionally conceived within the paradigm of development communication, driven by the fundamental notion that health interventions created at the

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center would bring about development in the periphery nation-states (Rogers, 1973). In this sense, health interventions such as family planning and immunization have been conceptualized as indicators of development and modernity.

The origin of health campaigns can be traced back to the development projects started by the United States in the 1950s that were framed within the modernist agenda of using health “innovations” to solve the problems of the South and to bring about development. Such “modern” innovations included immunizations, contraceptive technologies, sterilization programs, and other family-planning initiatives (Snyder, 2003). The very articulation of the dichotomous categories of developed and underdeveloped was based on assumptions about what it meant to be modernized and who had the knowledge to “modernize” the other. The “underdeveloped” sector was constructed in terms of absences; it did not have the technologies, interventions, values, or knowledge that were the markers of modernization at the center and therefore needed to be civilized; the South was the object of interventions conceptualized and acted on by the proponents of development at the center. The projects were based on the belief that governments at the center (primarily the United States and United Kingdom) could socially engineer “primitive” societies so as to improve lives of their peoples and were often funded by organizations such as the United States Agency for International Development (USAID; Dutta-Bergman, 2005a; Snyder, 2003). Development assistance also provided the means to politically influence other countries in the context of the Cold War and waning colonial ties (Dutta-Bergman, 2005a).

The modernist position informed much theory building, research, and praxis during the early years of the development projects in the South based on the assumption that modern interventions could change the living conditions of underdevelopment. This position was based on the assumption of expertise of those at the center, who could examine an underdeveloped community, evaluate its needs based on scientific instruments, and propose solutions that would supposedly propel the community toward development; the category of the “underdeveloped” was fixed in its position as the object of interventions, its people portrayed as the “primitive” receivers of campaign messages who were incapable of development without the helping hand of the interventionists. In other words, the positions of the sender and the receiver were fixed under the modernist logic; indicators of development such as family size, conceptualized by the actors at the center, offered the criteria for categorizing national cultures on the primitive/modern dichotomy and offered solutions such as contraception based on privileged understandings of the solution. Inherent therefore in this position of the sender was the assumption that the receiver existed in a primitive state and needed interventions developed by the sender. This framework of development campaigns is also referred to as the dominant framework, as it served as the predominant mode of operation of development

campaigns, including campaigns of development focused on health.

Interrogating this one-way flow of communication from the center to the periphery inherent in the dominant framework, critical-cultural and postcolonial scholars argue that development initiatives drenched with colonial undertones contributed to the underdevelopment of Southern nations by creating fixed categories that undermined the agency of subaltern actors by privileging a secularized value system based on universal science that continued to undermine the values of local cultures and by pushing alien solutions in local cultures (Dutta-Bergman, 2004, 2005; Escobar, 1995). Fifty years later, the cumulative forces of modernization and globalization have only widened the health gap between the center and the periphery, suggesting the imminent need to interrogate the foundations of health campaigns that have constituted a significant proportion of development funding. In spite of health campaigns that continue to operate under the modernist logic, the gaps between the privileged and the disenfranchised sectors of the globe continue to increase; the narratives of those without access continue to direct us toward the imminent need for an alternative paradigm to the dominant logic of health campaigns that engages us with questions of application development and campaign evaluation from the standpoint of subaltern actors who have traditionally been conceptualized as receivers of campaign messages (Dutta-Bergman, 2004, 2005).

Voicing similar concern in an essay published in 1994, Lupton challenged health communication scholars to interrogate the modernist enterprise of campaigns and look toward alternative spaces for dialogue. These alternative spaces provide entry points for interrogating the very interventions that serve as the bases of the campaigns that are carried out under the rubric of development. In this essay, we discuss the importance of the critical-cultural approach to the study of health communication campaigns as an entry point for engaging contemporary health problems. With its emphasis on questions of power, ideology, inequality, structure, culture, and agency, the critical-cultural approach is particularly relevant in health communication because of the implicit ties of the field with application development, thereby connecting the field with real-world consequences (Zoller & Dutta, 2008). We will argue that a critical-cultural stance in development communication is unique in its negotiation of criticism and praxis, suggesting points of social change and providing points of dialogue with the dominant approach to development campaigns.

We will briefly discuss the criticisms levied against the early modernist development projects and subsequently present the notion of “reflexive modernity” as an organizing framework for theorizing about, conducting, and evaluating health communication campaigns in the realm of development. *Reflexive modernity* refers to the critical self-confrontation inherent in a modernist enterprise, and captures the

dialectical tensions between the modern and postmodern elements of contemporary theorizing. As modernist efforts, development-based health campaigns are married to this self-confrontation, the campaign producing a variety of tensions in its very conceptualization, implementation, and evaluation. The concept of reflexivity allows a discursive space for conceptualizing the tensions between the dominant and critical-cultural strands of development communication, and simultaneously explores spaces of collaboration between these tensions in campaign research. Therefore, the foregrounding of reflexivity in the discussion of campaigns drives the critical-cultural interrogation of campaigns, articulates points of social change suggested by critical-cultural scholars, and interrogates the ways in which these criticisms both resist the modernist tendencies of campaigns, and are sometimes co-opted by these modernist tendencies. Reflexive modernity suggests that the dominant approaches to development exist dialectically with the critical-cultural paradigm, thus making it imperative that we pay serious attention to the critical-cultural paradigm and explore the points of tension and dialogue between the dominant and critical-cultural approaches; it also suggests that reflexive interrogation is a continuous process as we go back and forth between the dominant and critical-cultural elements of campaign scholarship.

### THE DOMINANT PARADIGM OF DEVELOPMENT

Development campaigns in the 1950s and 1960s focused on transfer of technology, diffusion of agricultural innovations, and diffusion of population-control programs (Melkote, 2003). The dominant paradigm of development was predominantly top-down, assumed that the proposed innovation brought about desirable benefits in the target communities, and was guided by the cognitive-behavioral framework based on the notion that information and awareness brought about behavioral changes in the population. More specifically in the realm of health, these development campaigns assumed that changes in individual lifestyles would solve the problems of underdevelopment in underserved communities, and did not attend to the structural factors surrounding health in marginalized communities of the South. The dominant paradigm of development is intrinsically intertwined with the concept of modernity, based on the basic assumption that “unremitting diligence, constant progress in the production of material goods, the unbroken conquest of nature, the restructuring of the world into predictable, technologically and organizationally manipulable processes will automatically and simultaneously produce the conditions of human happiness” (Ullrich, 1992, p. 278). Under this paradigm, human happiness is predicated on the ability to generate, retain, and consume material goods; under the modernist logic, it is located in its relationship with capital. Essential to this dominant paradigm is the

economic logic, the ultimate value of a secular notion of rational economic growth that harnesses the power of modern technologies and bureaucracies to systematically intervene, control, and predict, aided by privileged access to the “truth” about development (Melkote, 2003). The emphasis on economic rationality, bureaucratic control, and the manipulation of processes is evident in population-control programs, the earliest examples of health campaigns. These programs were built on the rational economic argument of smaller family sizes being the solution to individual-, familial-, and national-level resource “problems” as articulated by the Northern/Western/First World campaign planners without paying attention to the cultural values of the target cultures and alternative articulations of solutions such as resource acquisition and structural readjustment.

These campaigns have been critiqued by critical and postcolonial scholars for their one-way conceptualization, execution, and evaluation (Melkote, 2003). The policies were criticized because they were based on a Western model of development synonymous with modernization (Melkote, 2003; Mody, 2003). The prevailing notion at the time was that for development to occur, societies must follow the path of the West. Not only was it imperative that societies modernized their infrastructures, but sociocultural structures had to be changed as well; researchers advocated certain attitudinal and value changes as prerequisites for the development project to be successful. The result was devastating; population growth remained high, campaigns increased the knowledge and resource gaps between the rich and poor, and projects ignored and threatened local cultures and increased environmental degradation (Snyder, 2003).

Critical-cultural scholars and postcolonial scholars argue that the development policies were imperialistic mechanisms of control that perpetuated the underdevelopment of the South by creating and reinforcing the fundamental category of underdevelopment (Escobar, 1995). The paradigm was criticized for the Eurocentric perspective of “modernizing” traditional people, and for neglecting to account for the influence of structural constraints on individual action or enterprise (Melkote, 2003). Furthermore, Western standards were used as benchmarks against which situations in the South were measured, which in turn served only to perpetuate the hegemonic idea of the West’s superiority (Escobar, 1995). Local cultures existed as undesirable entities that needed to be erased.

Scholars argue that representations of the “plight” of the peoples of the South were more a sign of the representer’s power than truth about the represented (Said, 1979). The beneficiaries of development aid had no autonomy over how they were represented; the Third World was “endowed with features such as powerlessness, passivity, poverty, and ignorance, usually dark and lacking in historical agency, as if waiting for the (white) Western hand to help subjects along, and not infrequently hungry, illiterate, needy, and oppressed by its own stubbornness, lack of initiatives, and

traditions" (Escobar, 1995, p. 8). The representations universalized, homogenized, and dehumanized the Third World in an ahistorical fashion, and privileged the developed world as the source of knowledge (Escobar, 1995).

The postcolonial criticism of health communication campaigns locates the dominant paradigm as a neocolonialist agenda that seeks to push Western ideology on the South as a means of maintaining the status quo and the privileged position of the developed world over the Southern nations. The criticism levied against the modernist development campaigns has illuminated the flaws of the past but has simultaneously created a crisis for practice in the present as campaigns continue to be conceived, implemented, and evaluated in global settings. How do we approach the condition of poor health today and what is the relevance of campaigns to conditions of poor health globally? Is there an alternative paradigm that provides a space for engaging with the tensions of contemporary health campaigns? And how can we theorize about health campaigns from an alternative paradigm in a field that has historically been committed to praxis? The concept of reflexive modernity provides a platform for theorizing about the tensions that are likely to play out between the dominant and critical-cultural paradigms of health communication scholarship, and suggests importance of a critical-cultural paradigm to the study and practice of health communication campaigns.

### REFLEXIVE MODERNITY

The concept of modernity is based on the rational economic model that sees progress in terms of science, technology, economics, and efficiency; the postmodern turn was seen as a response to modernity, depicting the fragmented nature of reality and questioning the universal rational scientific discourse of modernity by fracturing the homogenized notion of the world. Postmodernity, however, suggests that the "modernity" has ended, that we have somehow transcended the project of control and manipulation embedded in the secular scientific discourse of the modern period. Some scholars argue that we are a society in transition but one that has not abandoned the project of modernity. Acknowledging the tensions between the modern and postmodern that coexist in contemporary systems, these scholars suggest that the present moment is perhaps best understood as a complex tension between the global and the local, the past and the present (Giddens, 2001).

Scholars such as Giddens and Beck suggest that our times do not represent a radical break with modernism but rather an extended version of modernity brought on by increased interconnectivity, complex interdependence, and time-space compression (Beck, 1994; Beck, Giddens, & Lash, 1994). In this complex state, the modern is interpenetrated with the postmodern; the modern is confronted with its consequences that cannot be assimilated into the prevalent

system of standards (Beck, 1994). These fragmented realities and unintended consequences exist simultaneously with the rational, economic models of modernity, ultimately threatening to destroy the foundations of industrial society (Beck, 1994). Scholars often label this contemporary period "high modernity" (Giddens, 1990), or "reflexive modernity" (Beck, Giddens, & Lash, 1994).

The concept of reflexive modernity responds to the simultaneity of this tension by opening up discursive spaces for theorizing the problematics of modernity, and by suggesting creative means of engaging the modern and the postmodern. Reflexive modernity "arises in the continuity of autonomized modernization processes which are blind and deaf to their own processes and threats" (Beck, 1994, p. 6). To be adequately responsive to the paradoxical nature of current global society, scholars suggest that theorizing in this contemporary period needs to be sensitized to the dialectical tensions and paradoxes that manifest themselves in the human condition of the contemporary era, drawing on the constant interfacing of the modern and the postmodern, reflecting on the bases and limits of modernity. In recent years, critical-cultural scholars have engaged with this notion of reflexive modernity in response to the need for critique in the face of the postmodern loss of metanarratives to ground these critiques. In doing so, they have engaged in dialogue with the subaltern sectors of the globe and attempted to ground their discussions in the experiences of those voices that have typically been erased from the mainstream discursive spaces (Dutta-Bergman, 2004).

One of the psychological implications of these complex times is the condition of "reflexivity." Several scholars have alluded to current society as needing to become one that is more "self-conscious" or "reflective" because of the evident limits of modernity; however, the explanation for reflexivity provided by Beck, Giddens, and Lash (1994) is perhaps the most descriptive. The reflexivity of modern life is one in which institutions are "self-critical" and "self-confrontational" (Beck, 1994, p. 5). The very project of modernity is embedded in the tensions that contradict it. Reflexive modernization implies coming to terms with the limits and contradictions of the modern order; reflexivity is created by circumstances of modern society in which the constantly renewing flow of information simultaneously revises that society's modernity (Beck et al., 1994). The condition of reflexivity is accompanied by the need for reflexive monitoring of action wherein social practices are constantly examined and reformed in the light of new relevant information about these practices, and every aspect of the way we operate is subjected to critical review, albeit incomplete and partial, in the light of alternatives (Beck, Giddens, & Lash, 1994). In a reflexive sense, the task of criticism is never really complete; the grand narrative never comes to closure, as we continuously question the ways in which our practices serve hegemonic interests.

In the realm of health communication campaigns, reflexivity brings with it the tensions between the critique and praxis of campaigns. On one hand, critics of development projects point out that we can no longer make pronouncements about the emancipation of humanity through the application of the universal principles of modernity; on the other hand, campaign theorists and practitioners continue to theorize about, implement, and evaluate campaigns within the very modernist framework that is criticized (Dutta, 2006; Dutta-Bergman, 2005). The notion of reflexive modernity applied to health campaigns confronts us with the latent side effects and consequences that are produced by the modernist agenda of campaigns. It is through these points of reflection that campaign planners can continuously become aware of their positions of power and the ideologies they serve in the process of planning and executing campaigns.

Reflexivity in health communication campaigns taps into the array of unhealthy conditions and risks that are produced by the continuity of autonomized health campaigns. The acknowledgment of this reflexivity opens the field to the multiple possibilities that arise through dialogue and criticism; criticism lies at the heart of interrogating current practices of campaigns as modernist endeavors and examining the ways in which such practices participate in the marginalization of postcolonial subjects. Therefore, reflexivity is a tool that allows critical engagement by asking the questions, How does the campaign reflect the modernist paradigm? What are the latent consequences of the campaign that are typically placed outside the realm of campaign scholarship?

Reflexivity also creates an opportunity for improvement, for looking at current practices and finding ways of improving them, adapting them to the transitive cultural contexts that encompass human existence in the globalized world, and simultaneously interrogating the co-opting of the criticism by the dominant paradigm. An example of this reflexivity is the development of the PEN3 model of health communication campaigns by Airhihenbuwa (1995) that begins by criticizing the dominant paradigm of health campaigns based on individual responsibility, cognitive choices, and its Eurocentric bias, and suggests an alternative by encouraging the consideration of the sociocultural context surrounding HIV/AIDS. Similarly, Dutta-Bergman (2004, 2005) criticizes existing health communication campaigns that privilege Western thinking, and suggests a polymorphic approach to health campaigns based on multiple truths and the privileging of cultural voices. In both of these instances, reflexivity involves the questioning of the dominant practices, suggestions of alternatives to these dominant practices, and further questioning alternatives.

As these projects suggest, reflexivity in health campaigns therefore provides a space for the constant interplay between the dominant and critical approaches to health campaigns. It suggests that the modernist period of health campaigns is not yet over, as alluded to by some scholars

who have co-opted the critical-cultural interrogation of campaigns (Storey, 1999); rather the modern exists in continuous tension with the postmodern. Health campaigns today are inherently postmodern, reflecting the fragmentation tied to the opening up of the field to multiple criticisms, interpretations, and understandings, and they are simultaneously modern endeavors reflecting a top-down flow of communication from centers of power to peripheries. Reflexivity is both an organizing framework for locating the dominant and critical-cultural approaches to campaigns and a tool that ought to be continuously deployed to understand the consequences of health campaigns.

### CRITICAL-CULTURAL PARADIGM AND HEALTH COMMUNICATION DEVELOPMENT CAMPAIGNS

The critical-cultural paradigm explores the intersections among politics, economics, and cultural practices in the context of media and knowledge systems, products, and processes (Kline, 2003). It interrogates the interplay of power in the context of access to modes of cultural production, exploring the roots of what we know about the world, how we come to know what we know about the world, and the relationship of this knowledge with power structures (Horkheimer & Adorno, 1944). With an emphasis on interrogating the taken-for-granted assumptions that circulate in cultures, the critical-cultural approach examines the relationship between cultural structures and cultural practices. By locating the role of ideology and hegemony in shaping the very nature of knowledge, this approach seeks to transform knowledge. Ideology refers to "the taken-for-granted assumptions about reality that influence taken-for-granted perceptions of situations and events" (Deetz & Kersten, 1983, p. 162), and hegemony refers to the process of manufacturing consent among those that are subordinated such that the dominant group can maintain its power (Gramsci, 1971). Therefore, critical-cultural knowledge serves the interest of change and emancipation through the uncovering of the alienating power structures by reflexive engagement. With its emphasis on the ideological operations of media structures in contemporary society, the critical-cultural approach examines (a) the role of media in (b) the context of cultural practices and (c) structural conditions (Kline, 2003). It further examines the ways in which (d) the production of knowledge is politically situated within the realm of power, maintaining the positions of privilege of the few that control its production and circulation.

In the arena of health campaigns, the critical-cultural approach examines the interplay of power, ideology, and hegemony in the assumed expertise of the campaign theorists and interventionists; the knowledge used to conceptualize and implement the campaigns; the identification of problems, the design and implementation of campaigns, and the evaluation of such campaigns. The

critical-cultural approach to health campaigns is an approach that foregrounds and interrogates the tensions inherent in contemporary health campaigns, bringing to the forefront the taken-for-granted assumptions that constitute knowledge and practice of these campaigns. By questioning the monolithic reality of an individual behavior promoted in the dominant paradigm of health campaigns, it provides a window into the fractured nature of knowledge, the multiple realizations of truths as seen through multiple cultural lenses.

On one hand, this approach provides new points of entry into theory and praxis by questioning the taken-for-granted and by writing theory in reverse through the transformation of hegemonic and ideological structures; on the other hand, it suggests the importance of continuous reflexivity as the dominant approach interacts with it and co-opts it. Criticism in the critical-cultural approach, therefore, is dialectically connected with praxis. Furthermore, on one hand the criticisms provided in the critical-cultural approach suggest opportunities for change in the dominant paradigm, and on the other, they create opportunities for co-optation, bringing forth situations where the old master learns new tricks, thus suggesting the need for maintaining the critical stance.

This section of the article discusses the manner in which the critical-cultural approach reflexively interrogates the modernist assumptions of health campaigns. Drawing on the four key areas of the critical-cultural approach suggested earlier, we discuss how critical-cultural researchers question the role of the media in health development campaigns, the significance and the taken-for-granted assumptions of culture, the ideology of individual health responsibility played out in campaigns, the role of structural conditions and the absence of structural considerations in campaigns, and the politics of knowledge in theory and practice of campaigns. The very interrogation of the monolithic truths presented in health campaigns reflects a post-modern interpretation by opening up the discursive space to multiple realizations of the reality of health; such an interpretation, however, needs to acknowledge simultaneously the modernist nature of health campaigns that seek to control, dominate, and push the agenda of the status quo.

### Question of the Media

Starting with the development initiatives in the 1950s and 1960s and continuing into the current practice of health development campaigns, the mass media typically serve as agents and indexes of modernization in the South; they are considered the “magic multipliers” of development benefits in the South (Melkote, 2003). According to the modernist logic of development campaigns, the media fill the information gap, expose people to new ways of living, and prepare individuals in developing nations for rapid change by establishing a “climate of modernization” (Melkote,

2003). Health campaigns under the dominant framework of development historically tended to apply the principles of linear models of behavior (e.g., theory of reasoned action and health belief model) to mass communication health campaigns based on the assumption that creating awareness through media campaigns would lead to behavior change at the individual level, and individual behavior change would solve the problem of underdevelopment.

A critical-cultural examination of such media-based campaigns foregrounds the capitalist ideology underlying traditional development campaigns, based on the logics of efficiency, reaching many audiences at the same time. Mass media are seen as efficient tools of modernization that allow campaign planners to reach large proportions of the target audience with the message of development manufactured at the center. Measurements of campaign success are tied to the ratings of programs. The capitalist roots of such campaigns are also evident in the diffusion of communication modalities such as television and radio so that media messages from the center may reach out to many participants simultaneously; creating the much-desired markets for capitalist goods and services through the media (in the form of advertisements). The introduction of health campaigns into cultures have often been accompanied by the introduction of new risks introduced into the culture through media-based systems. For instance, health campaigns promoting condom use in Southern contexts have been criticized for increasing the risks of sexually transmitted diseases by promoting promiscuous behavior to a larger audience within the culture (sending out the message, “as long as you use a condom, you are safe”; Dutta-Bergman, 2005). Similarly, the introduction of a health campaign in India (*Hum Log*) that promoted the concept of advertising-based television programming in the country introduced a host of other risks by pushing a consumerist lifestyle and by providing advertising access to consumer products, many of which (such as convenience foods) had unhealthy consequences for the culture (Singhal & Rogers, 1999).

The historical underpinnings of the dominant approach have been criticized because of its roots in the magic bullet theory of mass media effects based on the notion that the media could serve the persuasive agendas of campaign planners in changing audience attitudes, beliefs, and behaviors (Mody, 2003). Within the modernist framework, members of the public were often regarded as “apathetic and ignorant, needful of persuasion to change their behavior, resistant to change, obstinate, recalcitrant, lacking self-efficacy, chronically uninformed and hard to reach” (Lupton, 1994, p. 56). Critical-cultural scholarship questions the rational scientific model of the modernist approach, interrogating the underlying belief that people are always rational actors, and that if an individual is fully aware of the risks certain behaviors pose, he or she will take adequate measures for self protection (Airhihenbuwa, 1995; Dutta-Bergman, 2005). Further, the critical-cultural perspective

argues that the simple linear relationship between knowledge and action conceptualized at the individual level does not take into account the political, socioeconomic, and cultural contexts that surround health behaviors, as well as the more true-to-life emotional responses that accompany certain behaviors (Dutta-Bergman, 2005). Responding to the critiques of development campaigns based on the knowledge–attitude–behavior linkage, some strands of campaign scholarship in development communication have started taking into account the roles of structure and culture in campaign design and development. By acknowledging the roles of structure and culture within the broader framework of behavior change initiatives, these campaigns depict the ways in which reflexivity provides a space for engaging in dialogue between the dominant and critical–cultural elements.

Although a large number of current health-based development campaigns continue to use media-based strategies, with a predominant use of radio- and television-based programs, there is the growing recognition within the dominant paradigm of health campaigns that health interventions cannot ignore “the complexity of social change processes that require interaction, deliberation, and action by members of the social system” (Papa et al., 2000, p. 33). Such campaigns, it may be argued, have reflexively responded to the critique of one-way flow by seeking to engage with the voices of cultural members and by seeking out audience participation in the design and development of messages. For instance, entertainment education programs have been designed with the participation of the audience, such that the programs are homophilous with the audience (Singhal & Rogers, 1999; Storey, 1999). An example of such an entertainment education program is the *Cut Your Coat According to Your Cloth* campaign implemented in Nepal that involves audience participation to communicate to cultural members about population control (Storey, 1999). Similarly, Pratt, Barbeau, and Pratt (1997) emphasize participatory research and the value of dialogue, negotiation, mutuality, and feedback in using media for edutainment purposes; the scholars further advocate the use of folk media or “oramedia” (e.g., folktales, theater, and festivals) in the planning, implementation, and evaluation of nutrition communication programs in Africa that adapt to the oral culture of the communities.

A reflexive stance, however, suggests that reflection is a continuous process and directs us toward further dialogue, suggesting the need to reflexively engage with the ideological and hegemonic functions of campaigns that evolve out of the dialogue between the dominant and critical–cultural elements. It suggests that we continue to ask questions such as, How is participation conceptualized in such campaigns? How is it deployed by campaign planners? What functions does it serve in the broader context of the campaign? Whom does it serve? To the extent audience participation is used as formative research for development of a more effective campaign that pushes the agenda of the funding agencies

and campaign planners, it serves as a hegemonic device by manufacturing consent through the co-optation of participatory platforms (see Huesca, 2003). In such instances, audience members are invited to the table for the purposes of figuring out the best way to change their minds; participation gets used to bolster the agenda of the dominant paradigm. More specifically, participation in this context serves the agenda of the funding agencies and campaign planners, not that of the cultural communities (see Zoller, 2000, for discussion of community dialogues). For instance, Dutta-Bergman and Basnyat (2006) point out that the program *Cut Your Coat According to Your Cloth* serves the agenda of USAID by enlisting participation to achieve the objective of population control.

Some scholars discussing the participatory orientation of entertainment education campaigns argue that not only are media used in a participatory manner to get a message across, but the media are also seen as a catalyst for the development of a public sphere. Papa et al. (2000), in their examination of an entertainment-education program in India, *Tinkha Tinkha Sukh*, reported that the program led to the formation of informal listening groups that became formalized into men’s and women’s radio listeners’ clubs; members of the clan “listened to the program collectively and discussed the content, charting new courses for environmental action” (p. 45). In the *Bienvenida Salud!* campaign (Davenport Sypher, McKinley, Ventsam, & Valdeavellano, 2002), researchers found that radio listening appeared to have become a central part of community life, where listeners would share with each other information from the program, educational advice, real-life stories, and jokes. Further interrogation of such campaigns suggests the need for raising questions such as, (a) Whose agenda do such mediated public spheres serve? (b) Who has access to the public sphere and who does not? (c) What is the relationship of these media infrastructures with broader transnational agendas, as reflected in the agendas of USAID? For instance, in the case of *Tinkha Tinkha Sukh* it is important to note that the radio listener clubs were formed to discuss the program, and therefore the scope of participation was framed within the broader agenda of USAID, the campaign planners, and the national elite who participated in the development of the campaign.

### Question of Culture

The early modern paradigm asserted that cultural traditions had to be erased in order for the Southern nations to modernize (Escobar, 1995). A report published by the United Nations (as cited in Escobar, 1995) claimed that economic progress was impossible without painful adjustments: “ancient philosophies have to be scrapped; old social institutions have to disintegrate; bonds of cast, creed and race have to burst; and large number of persons who cannot keep up with progress have to have their expectations of a

comfortable life frustrated” (p. 5). Development scholars posited that modernization of the South was dependent on changing the character of individuals in the South such that they resembled more closely the attitudes and values of people in Western Europe and North America (Airhihenbuwa, 1995; Melkote, 2003).

Responding to this top-down approach to the dominant paradigm of development campaigns, the critical-cultural approach suggests that culture should be central to the planning, implementation, and evaluation of health communication programs; this not only affirms the cultural identity of the group but also empowers communities to institute change within the community (Airhihenbuwa, 1995). The critical-cultural approach also criticizes the modernist framework, stating that Western theories or models do not always translate well in other cultures; instead, they suggest the relevance of interjecting the discursive spaces of development campaigns with the voices of subaltern groups in determining the agendas of the campaigns (Dutta-Bergman, 2004). In this sense, the critical-cultural approach demonstrates reflexivity in its interrogation of the master narratives of campaigns and in disrupting the dominant framework by introducing subaltern voices.

According to Lupton (1994), although certain human bodily experiences may be recognized as universal (e.g., pain, death, sex, and childbirth), such experiences are interpreted and understood differently according to the historical and cultural settings in which they take place. For example, controlling one’s environment, a central theme in Western cultural life, does not ring true in some cultures where harmonizing with nature or adapting to one’s environment is more valued (Airhihenbuwa, 1995; Dutta-Bergman, 2003). Further, theories based on measuring individual attitudes to his or her health do not capture the health locus of control in some cultures (e.g., Asia, Africa, and Latin America) where family and community are more central to the construction of health and well being than the self (Airhihenbuwa & Obregon, 2000).

There is also the recognition that cultural beliefs or practices should be seen as strengths, and not barriers to healthy behavior (Airhihenbuwa & Obregon, 2000). Diop (2000), for example, found that sociocultural and religious factors were primary reasons why the rates of HIV/AIDS were low in Senegal. The universality of marriage, rapid remarriage of widowed and divorced persons, a severe moral condemnation of all forms of cohabitation not sanctioned by a religious act, and strong social networks served to control irresponsible sexuality in Senegal; furthermore, local religious leaders used their sermons to sensitize people to the reality of AIDS, thus keeping the HIV/AIDS crisis in check (Diop, 2000). In this context, the nature of the intervention constituted in the realm of the culture is vastly different from the traditional condom promotion efforts evident in the dominant paradigm of HIV/AIDS campaigns.

The location and constitution of culture in the realm of development campaigns is juxtaposed against the backdrop of the tensions between the modernist and critical-cultural tendencies of development campaigns. Responding to the growing body of literature that calls for valuing cultures of disenfranchised peoples in the development the health applications, the current discourse of health campaigns suggests an increased recognition that campaigns that start from a position of respect for local culture and recognition of community values may have more lasting impacts (Snyder, 2003). However, the inclusion of culture in the framework of campaigns continually exists in the realm of the dialectical tensions between the dominant and critical-cultural approaches. For instance, James Wolfensohn, president of the World Bank, stated, “we are starting to understand that development effectiveness depends in part, on solutions that resonate with a community’s sense of who it is” (as cited in Snyder, 2003, p. 182). Note, however, in Wolfensohn’s statement the deployment of culture as a variable that would further help in development effectiveness. In this context, the concept of culture is co-opted in the dominant framework as a fixed category that may be mobilized to reach the rational scientific goals of effectiveness of the modernist actors; this tension attests to the necessity of reflexivity as an entry point for theorizing about and engaging in the praxis of contemporary campaigns, and also points toward the relevance of continual dialogue between the different approaches as a way of understanding and impacting current social issues. Although in this case the attention paid to culture in the dominant approach to campaigns is a vital response to the critique of the top-down nature of campaigns, it is also important to reflexively evaluate the ways in which the concept of culture is conceptualized and practiced in such campaigns. With the increasing focus on cultural sensitivity in contemporary development campaigns, it is important to understand the ways in which cultural understanding gets co-opted to push the dominant paradigm of development based on modernist assumptions. The growing number of campaigns seeking to promote multicultural health suggests the importance of maintaining a critical stance in interpreting the role of culture in such campaigns (Dutta, 2007a, 2007b).

Another contemporary model that reflects the tensions between the dominant and critical-cultural tendencies of campaigns is the PEN-3 model (Airhihenbuwa & Obregon, 2000). This approach uses the process of appreciative inquiry to engage people in the process of trying to understand the behavior in question, and simultaneously seeks to promote a certain behavior or set of behaviors. Through dialogue the approach uncovers the positive cultural behaviors of the group and then increases consciousness among the participants about the positive nature of those beliefs that are internal to the culture. For example, in an intervention designed to increase healthy eating in an African American community, study participants soon

realized that not all African American food habits were unhealthy; in fact certain existing African food habits could be encouraged, such as the eating of boiled or steamed vegetables, salad greens, baked chicken and beef, one-pot meals, and “pot liquor” made from greens (Airhihenbuwa & Kumanyika, 1996). Culture-centeredness in this context placed value on understanding and highlighting the positive healthful behaviors within the culture rather than focusing on persuasion. In the example documented here, although the intervention engaged with the culture and the culturally situated meanings of health, it did so within the broader framework of promoting healthy eating.

### Question of Locus of Responsibility

The more modern approaches to health communication have often located health behavior within the individual, not taking into consideration the sociopolitical factors that impact an individual or community’s ability to engage in healthy behaviors. Melkote (2003) argues that external contextual constraints such as income inequality, politics, and the lack of democratic norms can impact health behaviors. Thus, the critical-cultural approach stresses the role that governments, employers, and international policies play in the production of health, and it recommends advocacy as a means of achieving health goals. In doing so, it questions the ideology of health communication campaigns that support the status quo by obfuscating the role of structures in the production of poor health. This ideology of the dominant paradigm of health campaigns focuses on individual health behaviors as solutions to health problems, suggesting that individual health outcomes would change only if the individual were to have the knowledge of healthful behaviors and then change his or her behaviors to align with the prescribed behaviors. It simultaneously omits a variety of other factors intrinsically related to health, such as poverty, inequality, access to medical services, access to food, community infrastructures, and so forth.

Challenging this individual-focused ideology that supports the status quo, the critical-cultural approach highlights the role of the government in promoting healthy behaviors, via policy level changes and legislation. It also foregrounds the role of global policies such as trade agreements and intellectual property rights in the realm of development. Diop (2000) for example found that the government in Senegal played an important role in keeping the AIDS crisis under control by passing legislation to regulate commercial sex activities; the policy also required that commercial sex workers made use of regular medical services. Not only do governments contribute to improving the health of people, but they can also aid and abet in the deterioration of health. Similarly, other studies document the ways in which free trade agreements promoted by transnational capitalism negatively influence the health of members of marginalized communities (Zoller & Dutta, 2008). The critical-cultural

perspective also interrogates the role of employers and organizations to look after the health of workers. For example, positive results were seen in an HIV/AIDS campaign in Thailand that focused on promoting cooperation between sex workers, brothel owners, and clients (Visrutaratna, Lindan, Sirhorachai, & Mandel, 1995). The intervention included free condom supply to the sex establishments; small group training sessions by peer educators for sex workers, and most important, the encouragement of brothel owners to insist on mandatory use of condoms. To evaluate the program, specially trained volunteers posing as clients tested a subsample of sex workers both before and after the intervention to see whether they insisted on condom use; before the intervention only 42% refused to have sex without a condom, whereas after the intervention 92% refused sex without a condom (Visrutaratna et al., 1995). In this realm, application of some of the principles of the critical-cultural perspective suggests the need for organizational reflexivity, interrogating unhealthy workplaces and their practices. Worth noting here is the incompleteness of the critical stance in the project, as it leaves in place the political circumstances of sex work. Reflexivity opens up avenues for engaging with these tensions, ironies, and contradictions brought about by the critical engagement of campaigns. Although multiple workplace-based campaigns have been initiated, it is critical to examine the ideology of these campaigns. For instance, employee assistance programs are often driven by the ideology of increasing worker efficiency in the workplace; health-promoting behaviors are encouraged for the purposes of generating healthy and productive employees. In doing so, such programs omit factors such as job-related stress, job safety, organizational structures, and marginalizing management practices. The modernist ideology of employee efficiency, rather than the development of healthy workplace environments, becomes the driving force for monitoring employee health.

Critical scholars further illuminate the negative impact that factors such as international blacklisting and economic globalization have on health—factors that are complicitly, coercively, or punitively imposed on nation states. Moodie, Borthwich, Phongphit, Galbally, & Hsu-Hage (2000) argue that the state of health of the peoples of the Southeast Asian nations of North Korea, Thailand, Indonesia, and Myanmar depends as much or more on extranational forces beyond their control as it does on their own policies and practices. Myanmar and North Korea have been severely affected by sanctions from countries and individuals opposing their governments and Thailand and Indonesia have been battered by capricious policies of countries and individuals investing in their economies (Moodie et al., 2000). Furthermore, the sustained campaign conducted since the early 1980s by U.S. trade officials to open markets for American tobacco in Japan, South Korea, Taiwan, and Thailand has resulted in the explosion of smoking rates across the region (Moodie

et al., 2000). In this realm, the critical-cultural approach opens up the discursive space to interrogations of transnational hegemony in areas of health policy.

Acknowledging the role governments, employers, and international policies play in shaping health behaviors, the critical-cultural approach encourages advocacy as a means to improve health conditions. According to Lupton (1994),

Advocacy activities seek to change the political agenda, to direct the spotlight of public accountability away from individuals and toward vested interests in industry and government, to influence public policy, and to encourage the initiation and enforcement of regulation of industrial activities that perpetuate unhealthy environments and manufacture unhealthy products. (p. 63)

Advocacy attempts to shift the focus of health research from blaming victims to identifying those factors in the environment that are collectively responsible for conditions of ill health.

### Question of Structural Conditions

As suggested in the previous section, modernist approaches to health campaigns have typically focused more on the individual's attitude toward the health behavior and have tended to neglect the impact of structural conditions on the production of those health behaviors (Dutta-Bergman, 2004). According to Dutta-Bergman (2005), the location of health behavior in the individual is problematic because it ignores the role of context and structure in the enactment of health behaviors, thus reflecting the conservative ideology of the dominant paradigm. Baer, Singer, and Johnsen (as cited in Lupton, 1994) argue that a critical approach must define health "not only as a state of physical or emotional well being, but as access to and control over the basic material and non material resources that sustain and promote life at a high level of satisfaction" (p. 60). Such an alternative understanding of health in terms of structural resources alters the taken-for-granted assumption that individual behaviors provide the panacea to global health problems. It also creates opportunities for understanding the role of transnational hegemony in promoting a behavioral approach to health that maintains the privilege of national and international elites. In multiple instances, campaigns advocating health behavior change have supported conditions for further marginalization by shifting attention away from the need to make structural adjustments.

Responding to the critical-cultural analysis, multiple public health campaigns in marginalized populations have developed poverty- and food-based components as the first step to creating healthy communities. For example, the microcredit program of the Bangladeshi Rural Advancement Committee in Bangladesh successfully improved health knowledge among poor women in rural Bangladesh by integrating it with a grassroots poverty reduction program

that gave collateral free credit to rural poor women and other support services such as group meeting, skills training, basic literacy, and primary health care services (Dutta-Bergman, 2005b). Even as microcredit lending responds to the social structures, it leaves intact the broader political economy of the neoliberal interpretations of health and development. The SWEAT (Sex Worker Education and Advocacy Task Force) project in South Africa fostered the development of exit programs, support programs, job-creation schemes, and skills-training programs for sex workers (Synergy Project, 2002). Research conducted by Shane Petzer and Ilse Pauw led to the formation of SWEAT based on a harms-reduction model, and the project sought to decrease the incidence of HIV infection and sexually transmitted diseases among the sex workers of Cape Town through advocacy, education, counseling, and support (see <http://www.walnet.org/csis/groups/sweat/97sweat.html>). SWEAT focuses on a range of social issues surrounding HIV that affect the ability of sex workers to access structural resources. Reflexive engagement with the project suggests that although the project does address the sociostructural context, it does so within the broader domain of HIV/AIDS prevention. Similarly, projects such as SWEAT that take structure into account also need to be further questioned for the structural changes brought about by them because the ways in which they take structure into account are situated within their broader agendas (such as HIV/AIDS prevention). Taking a reflexive stance suggests that the processes and outcomes associated with structurally responsive campaigns need to be further examined for the actors and objectives being served by them.

### Question of Knowledge

There is a realization that the information content of knowledge cannot be separated from questions of who produces it and who controls it (Panos Institute, 2001). Specifically in the realm of health communication, Western knowledge has informed much research and praxis in the Third World—a reason attributed for the failure of development projects (Escobar, 1995). Scholars claim that the spread of information from the West to the East ate into traditional knowledge bases and indigenous processes that were best equipped to deal with local conditions (Panos Institute, 2001). According to Escobar (1995), "the dominance of this knowledge system dictated the marginalization and disqualification of non-western knowledge systems" (p. 13). The very campaigns that were produced to generate development have contributed toward the disenfranchisement of cultural members by pushing an alien set of values, by undermining local cultural values, and by seeking to erase local knowledge with the goals of replacing such knowledge with Western knowledge that qualified as universal scientific knowledge. In doing so, health campaigns pushed a seemingly secular universal framework, but in reality this framework was embedded in the values and practices of the West. The critical-cultural

stance suggests the relevance of interrogating the very privileging of a particular knowledge system that fundamentally underlies the conceptualization and implementation of health campaigns. Such an interrogation opens up the space for understanding alternative ways of knowing that might direct health communication scholars to different sets of answers.

Therefore, critical-cultural scholars argue that knowledge systems other than the dominant paradigm need to be recognized; moreover, they need to be recognized not just as knowledge systems, but as circumstances pivotal to the preservation of the environment and to ensuring a means of existence for people living there (Panos Institute, 2001). For instance, Dutta-Bergman's engagement with Santalis in West Bengal, India points out that the ability to be healthy is intrinsically intertwined with nature and that the disruption of nature creates conditions of poor health. Therefore, according to the knowledge articulated by the Santalis, health campaigns need to focus on changing rapid urbanizations, further industrialization, consumer lifestyles that contribute to environmental degradation, and commercial-industrial-scientific practices that pollute the environment. Privileging alternative ways of knowing suggests fundamental shifts in what we come to know as campaigns, and exposes the ways in which power shapes our understandings. Although the Santali knowledge of health perhaps seems more meaningful in a world that has been deeply challenged by the threats of environmental degradation brought on by modernist projects, it would be absurd to envision a campaign developed by Santalis on developing an understanding of nature directed at the largest oil producers in the United States. Similarly, it would be absurd to imagine a campaign created by Santalis and directed at the U.S. public that seeks to reduce the use of cars. Inherent in this absurdity is the distribution of power in the modernist landscape of health care.

There is also the realization that knowledge is not the same as information but rather is the sense people make of information (Panos Institute, 2001). The critical-cultural approach stresses the need to allow people to interpret, evaluate, and reach their own understanding of information (Freire, 1970). Critical models of health communication are wary of the imperialistic tendencies of campaigns to speak for the "other." The idea that all groups have a right to speak for themselves in their own voices and have those voices accepted and legitimated is essential to the approach.

The critical-cultural perspective thus advocates participatory research, in which local knowledge or local wisdom is privileged (Davenport-Sypher et al., 2002). The community is given a platform to present its problems, as well as the power to design and implement campaigns that most speak to its needs (Airhihenbuwa & Obregon, 2000, Dutta-Bergman, 2005). The two promises of participatory approaches are that they empower the audience and they are more democratic (Snyder, 2003). According to Freire

(1970), the goal of participation efforts should be to facilitate conscientization of marginalized people globally; it is through conscientization and collective action that they perceive their needs, identify constraints to addressing their needs, and plan to overcome problems. As Dutta-Bergman (2005) states, "explanations of phenomena and articulations of pragmatic solutions based on the nature of the phenomena emerge from within the culture or subculture being studied . . . the culture-centered approach becomes the conduit through which members of indigenous communities find ways to articulate their voices and participate in social change" (p. 116). However, as stated earlier, it is important to not take the participatory claims of a health campaign at face value but rather to question the uses of participation; it is also important to attend to the ironies and paradoxes that emerge in the realm of local participation. Participation, after all, may be used to deceive the local cultural participants and to give a sense of involvement in the change initiative while pushing the agenda of those in power.

An example of a participatory approach that has focused both on local knowledge and collective responsibility is the Sonagachi project on HIV/AIDS prevention started in Calcutta in 1992 (Jana et al., 1998). The Sonagachi project sought to alter the sociocultural conditions leading to 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 (Jana et al., 1998). In this case of the Sonagachi project, the local community of sex workers was central to the definition of the problem and to the development of strategies for addressing the problem. Involvement, in this instance, was directed toward changing structural conditions surrounding the life experiences of sex workers.

## CONCLUSION

Global health disparities continue to increase in spite of concerted efforts at changing individual health behaviors via health campaigns (Zoller & Dutta, 2008). The dominant paradigm of campaigns based on the monolithic identification of problems and the deployment of universal solutions based on secular rational appeals has been fractured by the articulation of the latent consequences of this paradigm brought about by critical-cultural scholarship; the dominant paradigm has been self-confronted with increasing health disparities, questions of power and ideology, questions of culture and structure, and has responded to some of these issues by adjusting its programs. Such adjustments perhaps suggest the broader location of campaigns in a period of reflexive modernity in which the universal logic of biomedicine is being challenged from various quarters and the practitioners of this logic cannot remain insulated to the widespread criticism being offered from a variety of fields. Reflexive modernity in health

campaigns suggests the confrontation of such campaigns with their side effects and unintended consequences. In this era of reflexive modernity, the critical-cultural approach exists in dialectical tension with the dominant paradigm. The very theorization, conceptualization, and application of health campaigns are intrinsically linked to the criticism of campaigns and to the articulation of their failures. The critical-cultural approach, therefore, is not merely an academic exercise but is integral to the practice of health communication campaigns, providing an alternative approach that is responsive to the problematics of the dominant paradigm, suggesting entry points for conceptualizing health, and continuously interrogating the dominant paradigm. In doing so, it keeps the dominant paradigm in check, offers a framework for evaluating its claims, and continuously suggests ways for improvement.

The critical-cultural approach suggests that the complexity of our current situation begs for a reconsideration of terms such as *health* and *development* in our practices. *Health*, as suggested in the critical-cultural approach, is no longer the mere absence of disease, and *development* is no longer synonymous with modernization. The critical-cultural approach to health campaigns attempts to foreground tensions inherent in contemporary society through a process of reflexively engaging modernist assumptions that are typically taken for granted. Reflexive modernization implies the coming to terms with the limits and contradictions of the modern order brought about by an increased consciousness. This awareness is stimulated by insights garnered from the past and new information that comes to us in the present and guides us toward the future; the development of application draws centrally from criticisms that provide new directions for growth, and these applications are further open to critical interrogation. The reflexive approach inherent in critical health communication scholarship attempts to reconcile the past and present by interrogating assumptions of the past with regard to the present condition and by providing guidelines for praxis.

There is a movement in the theorizing and practice of health communication campaigns that seems to attend to the criticisms presented by the critical-cultural approach. For instance, an increasing number of campaigns are reconceptualizing the role of media; in these campaigns, people are seen as being actively engaged in the sense-making process. The media are seen as a catalyst for the development of a public sphere—a space where marginalized voices can be heard. Although the response of such campaigns to cultural criticisms is noteworthy, further critical interrogation suggests that we ask questions such as (a) What are the ways in which audience participation is encouraged in such campaigns? (b) For what purposes is audience participation used? (c) Whom does audience participation serve? The reflexivity in the critical-cultural approach perhaps suggests that the act of criticism be a continuous process, and that there is a continuous need for interrogating the interplay of

power, ideology, and hegemony in the theory and practice of campaigns. Reflexivity in this sense is a continual presence throughout the life cycle of the campaign.

The articulation of the critical-cultural stance and its engagement with the dominant paradigm has drawn attention to the role of culture in health campaigns. In a growing number of health campaigns, there is a sense that culture is integral to the development of the campaign. However, once again, the reflexive stance suggests the importance of asking questions such as (a) How is culture conceptualized in such culturally sensitive campaigns? (b) Whom do these campaigns serve? (c) For what purposes does culture get used in the campaign? Such questions provide a backdrop against which cultural interpretations of campaigns can be drawn (Dutta, 2007a). The critical-cultural approach takes issue with the superficial use of cultural markers to push the dominant agenda. Whereas cultural sensitivity often implies simply inviting cultural members to provide input regarding campaign materials in formative research and in generating messages using symbols and artifacts familiar to cultural members, the critical-cultural approach calls for a deeper understanding of culture in articulating what health is and the health problems faced by communities, and in figuring out solutions that are meaningful to cultural members and not dictated by external entities (Dutta-Bergman, 2004).

The critical-cultural approach also guides us toward the understanding that the locus of responsibility for healthy behaviors does not rest solely with the individual but with sociopolitical and structural factors that impact his or her health behaviors. In pointing out the role of structure, it suggests the importance of developing praxis that seeks to change this structure. The dominant approach to health campaigns continues to maintain its behavioral focus, although some campaigns have started addressing structural factors. However, even in such campaigns, structures are addressed to the extent that they are seen as barriers to individual behavior modification. Finally, the critical-cultural approach questions the ways in which knowledge is privileged in health communication campaigns and critiques the taken-for-granted assumptions embedded in the positions of the campaign planner and the target audience. It suggests the relevance of praxis that is guided by alternative ways of knowing. To be able to achieve this fundamental transformation in praxis, it foregrounds the relevance of health advocacy.

The critical-cultural paradigm does not just interrogate the modernist principles of health campaigns but reflexively engages them in the institution of health campaigns; it offers an alternative paradigm for theorizing, practicing, and interrogating health campaigns. This is done with the realization that contemporary society is a web of sociocultural-political complexity, one that is best understood in terms of a complex tension and linkage between the global and local, the past and present, the modern and postmodern; these tensions exist simultaneously. The very interrogation

of health campaigns coexists with the application of campaigns; these applications of campaigns open up possibilities for interrogation. In other words, as long as health campaigns are going to be implemented, there is going to be a critical-cultural paradigm that reflexively engages with these campaigns; the task of criticism is never complete. There is a sense that health conditions cannot be improved via the application of modernist principles based on Western values that are secularized, but that modernity cannot be abandoned either, as we are situated within it and its practices (such as health communication campaigns). There is also a sense that meanings and interpretations of campaigns as cultural texts are fragmented, but that fragmentation exists alongside the dominant ideologies of health campaigns that threaten cultural values, mores, and customs in the Third World. The possibility of multiple understandings coexists with the top-down flow of messages based on access to power in the global landscape.

The culture-centered approach advocates the use of participatory culture-centered research, political advocacy, the development of a public sphere, the increased responsibility of governments and employers, the alleviation of structural deficiencies, and the engagement with local knowledge as first steps toward improving health conditions in other worlds (Dutta, 2007a, 2007b); it also suggests that efforts that are responsive to these elements be interrogated for the ways in which they serve positions of power and push the dominant ideology. Herein lies the emancipatory potential of reflexivity; it is through the constant criticism of practice that social change can be achieved. Social change, rather than “ivory tower” criticism, is the goal of critical health communication scholarship achieved through reflexivity. This reflexivity, we have argued in this project, is essential to health communication so the field can engage with the rapidly changing global order and respond to questions of power, ideology, and hegemony such that cultural members can achieve health as they see it. Through our essay, we hope to create a space for greater critical dialogue in the field of health communication.

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