

Communiquer à propos de la culture et de la santé :

Élaboration d'une théorie liée à l'approche axée sur la culture et l'approche de la sensibilité culturelle

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Résumé

Cet article soumet que la communication sur la santé dans des contextes culturels peut être classée en deux ordres généraux : l'approche axée sur la culture et l'approche de la sensibilité culturelle. Alors que l'approche axée sur la culture est fondée sur la volonté d'élaborer des théories et des applications émanant de l'intérieur même de la culture, l'approche de la sensibilité culturelle travaille au maintien du statu quo et cherche à adapter les messages aux marqueurs culturels du public cible. Dans cet article, des questions théoriques sont présentées pour l'analyse de chaque approche et accompagnées d'un examen des façons par lesquelles le pouvoir, l'idéologie et l'hégémonie s'expriment dans ces approches. Finalement, cet essai théorique offre un cadre conceptuel permettant de comprendre les façons dont la culture est théorisée et appliquée en communication sur la santé.

**Communicating About Culture and Health:
Theorizing Culture-Centered and Cultural Sensitivity Approaches**

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Dieser Artikel geht der These nach, dass Gesundheitskommunikation in kulturellen Settings in zwei große Kategorien eingeteilt werden kann: der kulturzentrierte Ansatz und der kultursensible Ansatz. Während der kulturzentrierte Ansatz darauf basiert, dass Theoriebildung und -anwendung aus der jeweiligen Kultur heraus geschehen, strebt der kultursensible Ansatz die Aufrechterhaltung des Status quo an und versucht, die Botschaft den kulturellen Merkmalen eines Zielpublikums anzupassen. In diesem Artikel werden theoretische Argumente für beide Ansätze präsentiert und mit einer Analyse verbunden, welche Rolle Macht, Ideologie und Hegemonie in beiden Ansätze spielen. Letztendlich wird in diesem theoretischen Aufsatz ein konzeptuelles Bezugssystem erarbeitet, das verdeutlicht, wie Kultur in der Gesundheitskommunikation theoretisch modelliert ist und angewandt wird.

Comunicando sobre la Cultura y la Salud:

Aproximaciones Teóricas Centradas en la Cultura y la Sensibilidad Cultural

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Resumen

Este ensayo propone que la comunicación y la salud en espacios culturales puede ser categorizada en dos aproximaciones amplias: una centrada en la cultura y la otra en la sensibilidad cultural. Mientras que la aproximación centrada en la cultura está basada en el compromiso de creación de teorías y aplicaciones desde dentro de la cultura, la aproximación de la sensibilidad cultural empuja a la agenda del status quo y busca adaptar los mensajes a las marcas culturales de la audiencia meta. En este artículo, los asuntos teóricos son presentados para la discusión de estas dos aproximaciones, acompañados por la examinación de formas en la que el poder, la ideología, y la hegemonía juegan un rol en estas aproximaciones. En última instancia, este ensayo teórico provee de un marco conceptual para comprender las formas en las que la cultura es teorizada y aplicada en la comunicación y la salud.

有关文化和健康的传播：文化本位和文化敏感度方法之理论化

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摘要

本文提议不同文化环境下的健康传播可划分为两大分支：文化本位方法和文化敏感度方法。文化本位方法在文化内建立理论和实践。文化敏感度方法则不满足现状，而积极寻求适合目标受众文化标志的信息。本文讨论两者的理论问题，检验权力、意识形态和霸权对两者的影响。最终，本文为文化的理论化及其在健康传播中的应用提供理论框架。

문화와 보건에 관한 커뮤니케이션: 문화 중심적 그리고 문화적 감수성

접근들의 이론화에 관한 연구

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요약

본 에세이는 문화 설정에서 보건 커뮤니케이션은 두가지의 광범위한 틀로 범주화할 수 있을 것이라고 제안하고 있는바, 이는 문화 중심적 접근과 문화적 감수성 접근이다. 문화 중심적 접근이 문화내부로부터의 이론과 응용들을 설립하기 위한 노력에 기초한 반면, 문화적 감수성 접근은 현상의 아젠다를 추구하며 목표 대상층의 문화적 표준에 대한 메시지를 채택하는 것에 중점을 둔다. 본 논문에서는 각 접근법의 토론을 위한 이론적 이슈들을 제시하였으며, 어떻게 파워, 이념 그리고 패권 개념들이 이들 접근법들내에서 역할하고 있는지를 연구하였다. 궁극적으로, 본 이론적인 에세이는 어떻게 문화가 보건 커뮤니케이션내에서 이론화되고 응용되는가에 대한 이해를 돕기위해 개념적 프레임을 제공하는데 목적을 두고있다.

ORIGINAL ARTICLE

Communicating About Culture and Health: Theorizing Culture-Centered and Cultural Sensitivity Approaches

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This essay proposes that health communication in cultural settings may be categorized under 2 broad umbrellas: the culture-centered approach and the cultural sensitivity approach. Whereas the culture-centered approach is based upon the commitment to building theories and applications from within the culture, the cultural sensitivity approach pushes the agenda of the status quo and seeks to adapt the messages to the cultural markers of the target audience. In this article, theoretical issues are presented for the discussion of each approach, accompanied by examination of the ways in which power, ideology, and hegemony play out in these approaches. Ultimately, this theoretical essay provides a conceptual framework for understanding the ways in which culture is theorized and applied in health communication.

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With the increasing diversification of the United States, the growth in global interconnections among nation-states in the realm of health issues, and the increasing presence of health communication scholars from postcolonial contexts in the U.S. academy, the concept of culture has emerged as a key topic of interest to health communicators (Brislin, 1993; Resnicow, Braithwaite, Dilorio, & Glanz, 2002). There is a growing awareness that culture needs to be taken into account in the ways in which health communication is theorized and practiced. Two distinct yet inter-related approaches to health promotion efforts have developed in response to this call for examining the role of culture in health care settings: the cultural sensitivity approach (Brislin, 1993; Brislin & Yoshida, 1994; Bronner, 1994; Ulrey & Amason, 2001) and the culture-centered approach (Dutta-Bergman, 2004a, 2004b, 2005).¹ The culturally sensitive approach is labeled as such because it seeks to modify the existing health communication practices to suit the characteristics of the culture, as opposed to the culture-centered approach that puts culture at the core of health communication practices. Whereas the cultural sensitivity approach focuses on developing culturally appropriate health education efforts that would change individual

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attitudes, beliefs, and behaviors of cultural participants by tailoring messages to cultural characteristics of audience members, the culture-centered approach emphasizes attempts at changing social structures surrounding health through dialogues with cultural members that create spaces for marginalized cultural voices.

Based on a survey of the health communication literature that conceptualizes culture and responds to it in efforts of health promotion, this essay (a) provides a theoretical framework for categorizing the cultural sensitivity and culture-centered approaches, (b) develops systematic criteria for differentiation between the cultural sensitivity and culture-centered approaches, and (c) examines the underlying principles that drive the cultural sensitivity and culture-centered approaches. It contributes to current health communication theorizing by investigating the different ways in which culture is conceptualized in health communication applications, and how these different conceptualizations of culture result in different processes and outcomes of health promotion efforts. This essay responds to the call for developing a distinction between education-based and resistance-based approaches in health communication, and sets up criteria for examining the ways in which health promotion efforts incorporate culture (Lupton, 1994; Zoller, 2005). Ultimately, the analysis presented here draws upon critical theory to examine how the concepts of power, ideology, and hegemony play out in the development and implementation of health promotion efforts that have purposefully attended to culture (Lupton, 1994).

Culture and health communication studies

In her seminal critique of the dominant approach to health communication, Lupton (1994) pointed out that most health promotion efforts focus on individual behavior change and are based on the cognitive or behavioral logic that changing individual beliefs, attitudes, and behaviors would solve key health problems. In Lupton's critical reading, the dominant approach referred to the existing state of affairs, to the status quo, to the ways that things are typically done in efforts of health promotion, and is exemplified by health campaigns that seek to modify knowledge, attitudes, and behaviors of target populations. Lupton's critique argued that efforts of health promotion are typically based on the universal logic of scientific rationality, draw upon individualistic assumptions about the constitution of health risks and hence are ignorant of cultural contexts, and are unresponsive to the sociocultural-economic contexts within which health experiences are located. Similarly, lamenting the absence of culture in the dominant conceptualizations of health promotion efforts, Airhihenbuwa (1995) posited that these dominant health promotion efforts reflected Eurocentric biases of individualism and cognitively focused communication in how health was conceptualized and how health promotion efforts were deployed. In over a decade since Lupton's early call for critical interrogation of health promotion efforts and Airhihenbuwa's call for the introduction of culture in health promotion, two streams of research evolved with the goal of addressing the concept of culture: the cultural sensitivity approach and the culture-centered approach.

The cultural sensitivity approach is directed toward the goal of producing health interventions that incorporate the cultural characteristics, values, beliefs, experiences, and norms of the target population in the design, delivery, and evaluation phases of the intervention (Resnicow et al., 2002). In other words, the focus here is on creating effective health messages that are responsive to the values and beliefs of the culture. The call for culturally sensitive health communication is based on the notion that communication about health ought to adapt to the characteristics of a culture in order to be most effective (Dennis & Giangreco, 1996; Resnicow et al., 2002; Sue & Sue, 1999; Ulrey & Amason, 2001). Being culturally sensitive means offering communication solutions that fit the cultural characteristics that are considered relevant by the health communicator. This emphasis on culture is observed in the broader agendas of health care organizations and funding agencies that point out that the way we communicate about health to different communities ought to be informed by their cultures. For instance, Resnicow et al. suggest that when working with African Americans, emphasis should be placed on “social outcome expectations related to communal benefits, community versus individual efficacy, inter- rather than intrapersonal motivation, and collective rather than personal goals” (p. 501). In this case, the characteristics of the culture are used as inputs for developing culturally appropriate messages such as, “Do it for yourself, your family, and your people” and “Do it with a friend” (p. 501). The move toward tailoring messages to cultural characteristics is seen as the adaptation of the dominant paradigm to the criticism that health communication has traditionally been theorized and practiced in a top-down manner (Airhihenbuwa, 1995).

Keeping in line with Lupton’s critique of the dominant health communication interventions that privilege powerful social actors, the culture-centered approach is concerned with the ways in which conditions of subalternity are created, reiterated, and sustained by health promotion efforts, and seeks to interrupt the dominant paradigm of health promotion by introducing subaltern voices into the discursive space (Dutta & Basnyat, in press; Dutta-Bergman, 2004a, 2004b, 2005). Subalternity refers to the position of “being under” or “being erased” from the discursive space; therefore, the culture-centered approach is principally concerned with engaging with these absences and with articulating alternative constructions of health through dialogues with subaltern communities. In order to do so, it examines the ways in which political and economic interests are represented in health promotion efforts and the absences that accompany such efforts. For instance, Dutta-Bergman’s (2005) critique of health communication campaigns points out the campaigns typically serve the interests of transnational hegemony through the framing of health in the realm of individual behavior change, accompanied by the simultaneous absence of the social, cultural, and economic processes within which health is located. Similarly, Dutta and Basnyat’s culture-centered analysis of the participatory processes applied in the Radio Communication Project (RCP) in Nepal pointed out that the RCP served dominant social actors through the framing of economic resource problems as problems of population control rather than as problems of structural inequities. The critical stance of the culture-centered approach is accompanied by dialogical

projects that engage with subaltern communities in understanding the ways in which health meanings are constructed, the ways in which health risks and health issues are constructed, and the possible solutions to these health issues and health risks as dialogically constructed by community members.

The voice of the community is central to the articulation of health problems and corresponding solutions. For instance, the photovoice method engages with marginalized communities and equips such communities with communicative tools such as cameras to document their experiences of health, health issues, and needed solutions and subsequently creates communicative platforms for the voicing of these issues through public showings, public dialogues, and meetings with policy makers where community members have an opportunity to voice their concerns (Wang, 1999). Social and structural changes are achieved through these opportunities for dialogue and through the active participation of community members (additional details in the next section).

Both the cultural sensitivity and culture-centered approaches seek to respond to the call for incorporating culture in health communication efforts. However, these approaches differ in their conceptualization of what culture is, in their theoretical focus, and in the ways in which they apply the concept of culture in the practice of health communication. The next sections will outline the conceptualization of culture, the theoretical framework, and the applications of the cultural sensitivity and culture-centered approaches, thus providing criteria for distinguishing between the two approaches.

Cultural sensitivity approach

As documented in the introduction, cultural sensitivity is one of the focal areas of health communication research within the United States and refers to the development of health communication strategies that adapt to the characteristics of the culture in question (Brislin & Yoshida, 1994; Dennis & Giangreco, 1996; Jackson & Haynes, 1992; Ulrey & Amason, 2001). The increasing popularity of cultural sensitivity has primarily been a result of the large-scale immigration patterns into the United States, the growing number of critiques of the dominant paradigm in its inability to meet the needs of cultural communities, and the gaps in access to health care services and prevention measures that vary by culture. The notion driving the move toward cultural sensitivity is that crafting messages or training programs that respond to the cultural needs of communities would be more effective in communicating health as compared to messages that do not respond to the cultural characteristics of the community. By promoting individual behavior change in underserved communities, the cultural sensitivity approach seeks to reduce the disease burdens of these communities.

Conceptualization of culture

In the cultural sensitivity approach, culture is conceptualized as a collection of shared values, beliefs, and practices that are contained within a clearly defined community

(Brislin & Yoshida, 1994; Ulrey & Amason, 2001). These values, beliefs, and practices are conceptualized as variables, and the goal of the health communicator is to identify those underlying cultural dimensions that may be incorporated into the delivery of the health message. Examples of such cultural variables include individualism–collectivism, power distance, uncertainty avoidance, and masculinity–femininity, and they are used to guide the development of a health intervention. For instance, a culturally sensitive health campaign targeting Hispanic populations within the United States uses collectivistic appeals, given the collectivistic nature of Hispanic cultures. From a cultural sensitivity standpoint, an intervention is successful when it responds adequately to the variables that have been identified by the interventionists as relevant to the effectiveness of the message, resulting in effective behavioral change in the community. Therefore, in cultural sensitivity approaches, there seem to be two different and yet interrelated measures of effectiveness: (a) the responsiveness of the intervention to the cultural variables and (b) its ability to foster behavioral change in the target population. A successful culturally sensitive intervention utilizes messages that take the culture into account and hence is more likely to lead to behavioral change. Culture, in the cultural sensitivity approach, is considered static and is measured as a conglomerate of traits identified by the expert.

Theoretical overview

According to the cultural sensitivity approach, health communication theories become culturally sensitive by extracting and incorporating certain aspects of cultures into the dominant theories and applications of health communication. The emphasis is on identifying stable characteristics from within the culture that might be used to categorize it and subsequently build health communication applications that are tailored to these characteristics. Models built upon this approach often identify certain cultural variables and use them to predict a variety of outcome variables. For instance, the research on health locus of control seeks to predict the role of health locus of control in the realm of a variety of health outcomes. Culture is conceptualized in terms of stable sets of values and beliefs that might be used to differentiate one community from another. Research using the culturally sensitive approach seeks to figure out the most important characteristics of a culture that would lead to the development of successful health messages.

In some health communication projects on the topic of cultural sensitivity, the emphasis is on conceptualizing and operationally defining the concept of cultural sensitivity, developing scales to measure it, and correlating it with outcome factors. In the area of physician–patient communication for instance, the cultural sensitivity approach seeks to develop training programs for physicians, measure physician effectiveness in cultural sensitivity, and correlate cultural sensitivity with a variety of outcome measures such as patient satisfaction and duration of visit. The emphasis is once again on configuring the already-existing communication processes, styles, and messages to fit the cultural characteristics. The expertise remains in the hands of the dominant external experts who determine the objectives, determine the relevant

cultural characteristics, configure the messages to fit these characteristics, and evaluate the messages based on externally defined criteria.

Application

Applications developed from the cultural sensitivity approach seek to provide targeted health solutions to cultural communities based on the most relevant cultural characteristics of the communities as identified by the researcher. Typically, the cultural sensitivity approach begins by setting up an agenda for the health communication program, by defining cultural variables of interest, by measuring the cultural variables in formative research, and finally by developing health communication solutions that respond to the cultural variables identified in formative research. The program is then evaluated based on the criteria developed by the experts and the pathway for the health communication program is defined by these experts. Therefore, to be considered culturally sensitive, a health communication program (a) has clearly defined health objectives determined by the outside experts, (b) identifies relevant cultural characteristics and measures them (this is also expert driven), (c) develops health messages that are tailored to the characteristics of the culture, and (d) evaluates the health communication program on the basis of the objectives defined at the onset of the program (once again, by the external experts).

Take for instance the use of the community-based participatory research (CBPR) approach to develop interviewer training manuals for the Messengers for Health (MFH) project directed at increasing the participation of Apsaalooke women in cervical cancer screening (Christopher, Burhansstipanov, & Gun-McCormick, 2005). The goal here was to develop reliable and valid instruments for gathering survey data such that effective efforts can be directed toward the goal of reducing the high rates of cervical cancer among Native American women in the northern plains in the United States. The MFH project developed through the collaborative meetings between members of the tribe who later became members of the project's advisory board, the project coordinator who was a member of the Apsaalooke tribe and the academic partner, and was funded by the Centers for Disease Control and Prevention (CDC). The task of developing a culturally, geographically, and scientifically relevant survey instrument was seen as essential to the development of a culturally competent, community-driven educational intervention. Based on the discussions, several key points emerged as critical for the interview manual: (a) communicating respect for the women interviewed and for the community; (b) ensuring the confidentiality of shared information; (c) ensuring that the information would be brought back to the community before being shared outside the community; (d) communicating that the shared information will be used to directly help improve Apsaalooke women's health; (e) approaching the study participants through respectful and open dialogue rather than attempting to persuade; (f) communicating sincerity and interest in the woman's feelings; (g) preceding the interview with a visit, a snack, and a cup of coffee or tea; (h) being patient and courteous with the interviewees; (i) alternating between English and Apsaalooke; and (j) continuously updating the community about the

progress of the project (Christopher et al., 2005). It is important to note that the interview manual developed through the involvement of the community members was responsive to certain cultural characteristics of the tribe. Although the involvement of community members is similar to the culture-centered approach, further examination suggests that the interview manual developed under the MHF project through the use of CBPR would fall under the cultural sensitivity approach because (a) it uses community involvement to push externally developed agendas (promoting cervical cancer screening), (b) does not involve community members in identifying key community problems and identifying corresponding solutions to these problems, and (c) does not address structural aspects surrounding health, instead focusing on individual behaviors. Furthermore, consistent with the conceptualization of culture in the cultural sensitivity approach, the development of the interview manual under the MHF project conceptualized culture as static and approached it on the basis of certain aggregated characteristics that could be extracted by the researchers to develop their interview manuals. The data gathered in the project are ultimately gathered with the objective of modifying the individual behaviors of community members to promote greater health rather than resisting unhealthy structures surrounding health (i.e., access to basic health care, access to health enhancing resources, structurally situated cancer risks, etc.).

Culture-centered approach

The culture-centered approach to health communication is concerned with the voices of subaltern groups in discussions of health. The origins of the culture-centered approach may be located in subaltern studies scholarship that explores the absence and presence of the subaltern position from dominant spaces of knowledge (Beverly, 2004; Escobar, 1995; Guha, 1982). Subaltern refers to the condition of "being under." The subaltern voice is marked by its absence, by not having been noticed. Therefore, subaltern studies scholarship interrogates the ellipses, absences, and silences that are marked in the dominant writings of knowledge. Through the articulation of these absences, subaltern studies seek to create alternative ways of knowing the world, opening up discursive spaces to marginalized voices. The centralization of voice is also located in the realm of context, suggesting that human experience is meaningful when articulated within the richness of the context in which it is experienced (Dutta-Bergman, 2004a, 2004b). The goal of the culture-centered approach is to offer an alternative entry point for theorizing and practicing health communication by highlighting the absences and/or silences in current health communication theory and practice, and by presenting voices of the marginalized sectors through engagement in dialogue (Airhihenbuwa, 1995; Dutta-Bergman, 2004a, 2004b, 2005).

Conceptualization of culture

In the culture-centered approach, culture is conceptualized as a complex and dynamic web of meanings that is continuously in flux, as it interacts with the

structural processes that surround the culture (Airhihenbuwa, 1995; Dutta-Bergman, 2004a, 2004b, 2005). Culture is articulated in the meanings coconstructed by the cultural participants, and these meanings are located within the local context of the culture. Culture includes a continuous component that flows through the history of the culture, and a dynamic component that continually shifts as the culture responds to statewide, national, and global shifts in politics, economics, and communication flow. The interactions between the continuous and dynamic elements of culture provide the context for cultural meanings that are in flux.

Theoretical overview

The culture-centered approach to health communication is built on the notion of centralizing cultural voices in the articulation of health problems and solutions (Airhihenbuwa, 1995; Dutta-Bergman, 2004a, 2004b, 2005). The commitment here is to writing theory from below and defining praxis through the engagement with subaltern classes who have traditionally been silenced by the dominant theories and models of health communication. Therefore, the culture-centered approach uses culture as a theoretical lens to interrogate the dominant paradigm for its absences and silences. As a result, alternative theories of health are generated by engaging in meaning-making with cultural participants. These theories provide alternative paradigms for understanding health, healing, and curing, and they rupture the dominant discourse of the medicalizing ideology that is currently in circulation in much of health communication scholarship. For instance, Dutta-Bergman's journey with the Santalis in Bengal suggests that health is constituted in the realm of natural processes and in the harmony in these natural processes, which are typically threatened by the modernization projects in India; thus, this experience offers an alternative to the dominant conceptualization of health as constituted in the realm of individual lifestyles. Similarly, the Sonagachi HIV/AIDS Intervention Program (SHIP) developed through the active participation of the sex workers of Sonagachi in India foregrounded the voices of sex workers in articulating the problems around HIV/AIDS in the realms of structural inequities, structural violence, and economic capacity-building, thus shifting the individual-level emphasis of dominant approaches to HIV/AIDS to the structural inequities surrounding sex work and HIV/AIDS (Jana, Basu, Rotherum-Borus, & Newman, 2004).

Application

Applications that draw upon the culture-centered approach begin by working from within the culture to identify the health problems that are critical to the community. The locus of change, therefore, is the culture. Cultural participants actively participate in what would be considered a meaningful problem for the community. Therefore, in this approach, the community lies at the core of the definition of the problem and at the development of solutions to the problem. Fundamentally, the culture-centered approach centralizes the active role of the cultural community in developing health applications.

One example of the culture-centered approach is the photovoice method that draws upon the life experiences of local community members to impact health policy

(Wang & Burris, 1994). Photovoice is a participatory action research method that involves placing cameras in the hands of community members so they may visually represent and communicate their lived experiences to internal and external stakeholders. With its emphasis on providing venues for voices that are typically silenced in the mainstream discourse, the photovoice method enables participants to share their emotions, feelings, and insights about issues that are important to them through photographs. In doing so, the method (a) records the key issues faced by the community and community strengths as constructed by community members, (b) promotes critical dialogue and builds new knowledge through the discussion of the photographs, and (c) influences positive social change by reaching policy makers and decision makers through public forums and showings of the photographs. The photovoice method was originally applied by Caroline Wang and her colleagues in China's Yunnan province to create a platform for rural women who had minimal access to the policy makers who made decisions that affected their lives (Wang & Burris, 1994). Through the showings of the photographs and their interpretations by the women in public forums, a discursive space was created for social change through the enactment of agency of the women. The women were able to share their stories and identify the issues that were most important to them and hence to have control over "the ways in which their perspectives and life situations were depicted, discussed, and communicated to others" (Wang, 1999, p. 327). The photographs coupled with the critical discussions they generated led to structural changes in the communities such as the construction of day-care facilities and water tanks in villages and the establishment of educational scholarships for rural girls (Wang & Burris, 1994).

Similar applications of the photovoice method have involved residents of homeless shelters in Ann Arbor, MI, who countered stereotypes and stigmas about homeless people by documenting their everyday life, work, and health conditions through photographs (Wang, Cash, & Powers, 2000), and Latino adolescents in North Carolina who examined their lives in the context of immigration (Streng et al., 2004). The Inspirational Images Project engaged African American breast cancer survivors in rural eastern North Carolina to create a discursive space for identifying the needs of the women and for developing an action plan for addressing these needs based on a public showing of the photographs and a public forum that brought the women and policy makers together (Wang, 1999). The photovoice method meets the criteria of the culture-centered approach: (a) it engages culture through the articulation of the local contexts within which the lived experiences of the cultural members are enacted; (b) it addresses structural issues through the emphasis on policy and decision-making processes that influence the health of the local communities; (c) it creates a space for the enactment of agency by shifting the discursive control over the narratives, representations, identification of issues, and respective solutions in the hands of local community members; and (d) resists the dominant structures through the voices of community members. Ultimately, through the application of photovoice, the health needs and corresponding solutions are developed from within the community through dialogue with policy makers and other decision makers

rather than emerging from outside the realm of the community. The photovoice method resists the dominant discourses of health interventions by displacing the expert voices of health communicators with the voices of cultural members represented through the photographs and their interpretations by community members. The locus of knowledge production shifts from the outside expert to the community.

Given the roots of the culturally based approaches in critical scholarship and the early criticisms of the dominant paradigm of health communication, it is relevant to take stock of the current landscape of these approaches from a critical standpoint (Lupton, 1994). How do these culture-based approaches stack up against the backdrop of the questions of power, ideology, and hegemony raised by Lupton? The next section presents a critical examination of the cultural sensitivity and culture-centered approaches.

Critical interrogation: Power, ideology, and hegemony

Critical theorists discuss the relationship between power, hegemony, and ideology in maintaining dominance over the discursive and material spaces of capitalist societies (Dutta-Bergman, 2005; Lupton, 1994). Power reflects the ways in which access to social structures creates positions of domination and subordination. It essentially captures the ways in which those with access determine the outcomes of those without access, thus circulating the economic logic of the system and sustaining it. Ideology encompasses the taken-for-granted assumptions that are essential to the propagation of the dominant logic. These taken-for-granted assumptions ensure that the status quo stays in place. Hegemony refers to the control held by a dominant group on other groups without the use of force.

In the area of health communication, Lupton (1994) strongly made the important point about the need to interrogate the ways in which the dominant paradigm of health communication conceptualizes core elements of praxis and puts them into action. In her essay, Lupton suggested the relevance of taking a critical stance in health communication where much of the practice of health goes unchallenged. Furthermore, she articulated the relevance of examining the ways in which hegemony, ideology, and power interplay in the way that health is communicated. This interplay of power, hegemony, and ideology are central to the critique of the cultural sensitivity approach and the development of the culture-centered approach. The next section builds the argument that whereas the cultural sensitivity approach serves the status quo by pushing a preconfigured problem articulation determined on the basis of external producers of knowledge, the culture-centered approach interrogates the status quo with its focus on engaging with the voices of subaltern participants.

Cultural sensitivity

The cultural sensitivity approach maintains power by “othering” cultural participants based on the expertise of external actors. Furthermore, the critical perspective suggests that the cultural sensitivity approach coopts the participatory engagement

of cultural members by pushing the status quo agenda while simultaneously marginalizing the agendas of subaltern groups. This is exemplified in the RCP where the agendas of United States Agency for International Development (USAID) and the local elite are foregrounded and the resource problems in Nepal are framed as problems of population control and participatory platforms are utilized to push this dominant agenda (Dutta & Basnyat, in press).

Maintaining power

Power refers to the unquestioned access of dominant social actors to the discursive space and to their ability to control theory building and application that are typically deployed in those spaces that remain the subjects of dominant operation (Escobar, 1995). Therefore, power is enacted through the one-way flow of communication from spaces with power to those spaces that remain the subjects of knowledge and praxis. The approaches to cultural sensitivity evident in the dominant health care system seek to make the health care system more effective and efficient based on the argument that culturally sensitive communication would be more effective in carrying out the organizational agenda by meeting the key cultural needs (Ulrey & Amason, 2001; Voelker, 1995).

Here is an example of bias toward maintaining power evident in the *CDC Pink Book*:

To develop effective health communications, you must understand key aspects of the cultures influencing the intended audience and build that understanding into communication strategy. Messages must take into account cultural norms in terms of what is asked (e.g., don't ask people to make a behavior change that would violate cultural norms), what benefit is promised in exchange (in some cultures, community is more important; in others, individual benefit is), and what image is portrayed. The symbols (including clothing, jewelry, and hairstyles), types of actors, language, and music used in materials all convey culture (p. 58).

In the above example, culture is used as a concept in order to create more effective messages based on the assumed expertise of the health communicator. In other words, the knowledge of cultures may be deployed toward the goals of enabling behavior changes in the population as seen fit by the message developer (thus making health communications effective). The understanding of norms, benefits, images, and symbols is harnessed toward the creation of a more effective health message as determined by the organization (CDC in this case). The *Pink Book* embodies the power structure of dominant social actors by maintaining the points of knowledge creation in the hands of these actors (suggesting how they might create effective health communication messages by incorporating their knowledge of the culture) and by simultaneously negating the opportunities for engaging with the voices of local communities in the definition of problems and the articulation of solutions. The emphasis is on the health communicator who would create appropriate

messages based on his or her expertise and knowledge of the culture, and not on creating communicative processes and spaces through which the local knowledge of these communities might be presented, as outlined by the culture-centered approach.

In the area of physician–patient relationship, culture is similarly used as a category to develop cultural sensitivity training for physicians (Brislin & Yoshida, 1994; Dennis & Giangreco, 1996; Jackson & Haynes, 1992). Once again, culture gets applied as a concept for the purposes of developing greater effectiveness of existing programs. For instance, an article written by Ulrey and Amason (2001) juxtaposes the importance of intercultural communication in health care against the backdrop of increased business and profits. Taken for granted in the intercultural competency programs are questions regarding the medicalizing ideology of the dominant approach and how this ideology fits with the cultural community. Also, outcome measures reported in such programs often include concepts such as patient satisfaction, patient behaviors, and the duration of the visit, outcomes that fit into the capitalist organization of the medical system (Waitzkin, 1981, 1984). Culture enters the bureaucratic machinery of the hospital to maximize efficiency and to increase consumer satisfaction, which in turn would feed into the economic logic of the health care system. Absent from the literature on cultural sensitivity in the area of physician–patient communication are discussions of alternative healing systems, alternative ways of knowing, alternative systems of organizing health care, or alternative ways of approaching relationships between providers and patients.

Culture, therefore, is used as a device to serve the status quo, to help the status quo figure out the best strategies for enacting change based on the persuasive tools that would adapt to the cultural variables. By utilizing cultural knowledge for the purposes of effective message design, such culturally sensitive communication interventions open up discursive spaces in underserved communities to the dominant agendas of the core actors at the center. Power over the culture is maintained through the panopticon that keeps an eye on the culture and its unhealthy practices, and designs persuasive strategies to alter these unhealthy practices identified at the individual level (Foucault, 1995). This is exemplified in the CBPR approach to develop interviewer training manuals for the MFH project discussed earlier where the participation of the Apsaalooke women is utilized for the predetermined purpose of developing effective messages that would encourage the women to engage in cancer screening.

Othering

Although the theorists and scholars practicing the cultural sensitivity approach suggest that the adoption of the concept of culture is invaluable to the development of effective health communication interventions in multicultural communities, it is important to note that essential to the deployment of an intervention is the identification of a category that must distinctly serve the needs of the communicator. The

definition of culture as a category focuses on identifying key variables within the culture that might be addressed in multicultural programs. The metaphor of culture is that of a box that contains a set of characteristics. Culture here is a composite of underlying beliefs and values that constitute the community. To the extent that these values and beliefs can be recovered, health communicators can design effective interventions to target them.

Central to the conceptualization of the “other” is the creation of a system of categorization. This system of categorization serves as the basis for the intervention, as a justification of the presence of the health communication scholar, the social marketing agencies, and nongovernmental organizations that must carry out the project. For instance, in an article written by Witte and Morrison (1995), East Asians are described as a God-fearing people who like colored pills and like to chaperone their women to local hospitals and clinics. The portrayal of the cultural participants in child-like terms, without acknowledging their agency, serves as the basis for health care interventions that are imposed on the community, with the goal of injecting self-efficacy into the population.

Culture in this context is elsewhere, somewhere exotic. It is a “thing” that can be captured in the lens imposed by the ubiquitous knower from outside. This act of objectifying culture fossilizes it, locating it in a stable frame of stable constructs accessible to health communicators. For instance, the concepts of individualism and collectivism are often used to distinguish cultures and to subsequently develop messages based on a culture’s level of individualism or collectivism. In such an approach, the external lens of the health communicator fixes the culture in a stable, unchanging frame.

The othering that drives the conceptualization and implementation of health communication interventions does violence to the culture by fixing it in terms of static characteristics as perceived and defined by the intervener. This categorical system then drives the ways in which identities are constructed in discourse and policy, as well as the implementation of policy. The political violence of the dominant representation of the other is articulated by Escobar (1995) in his discussion of the colonizing power of First World constructions in constructing the realities of the Third World:

To be blunt, one could say that the body of the malnourished—the starving “African” portrayed on so many covers of Western magazines, or the lethargic South American child to be “adopted” for \$16 a month portrayed in the advertisements of the same magazines—is the most striking symbol of the First World over the Third. A whole economy of discourse and unequal power relations is encoded in that body ... it all becomes, for Western science and media, helpless and formless (dark) masses, items to be counted and measured by demographers and nutritionists (pp. 103–104).

What Escobar depicts here is the deployment of the primitive–modern categorization scheme in the context of praxis. It is, after all, the depiction of the malnourished

that supports the economic enterprise of the knowledge producers who seek to develop culturally sensitive materials targeting the population. In other words, the act of othering is essential to the economic logic of culturally sensitive health communication. It is only through the identification of fixed categories that a systematic body of knowledge can be developed that addresses these categories and produces communication materials to induce behavior change. The economics of knowledge production in this context is predicated upon the ability to identify fixed categories that clearly delineate the culture and its practices.

Expertise located outside

The cultural sensitivity approach conceptualizes expertise in the knower located in the academy, the funding agency, the provider, or the social marketing agency; these actors are typically removed from the setting of the culture on which the health communication intervention is imposed. The basic assumption here is that the expert is going to figure out what is best for the culture; the desire is to maintain an objective distance on the part of the social scientist. This objective distance gives the expert the objective knowledge about the culture, which he or she can use for the health communication intervention. Studies conducted within this paradigm often report on “lay” theories of health in cultures, which might be used to develop the interventions. Note that the culturally based theories are labeled as lay theories so that they can be differentiated from the so-called objective and systematic theories of the outside expert.

The location of expertise outside the culture also creates the condition of minimal involvement. Studies utilizing a cultural sensitivity framework are often based on minimal interactions between the community and the researchers. In many instances, cross-sectional surveys are reported. In other instances, summaries of focus group data or survey data are used as inputs for developing culturally sensitive health communication programs. Note that in many of these instances, though, the focus groups and surveys are implemented by local actors; the data are then supplied to the health communicators at the center who might not have visited the culture, might not have spent more than a few short days in the culture to oversee the data gathering, might not know the language spoken in the culture, or might not even be familiar with the local cultural context. The expert position of the outsider is based upon his or her knowledge of communication phenomena and research methodology and, therefore, does not need to be informed by the knowledge of the culture or extensive amounts of time spent within the culture.

The expert position of the outsider dictates the development of theories and applications for cultural participants. These applications are then deployed in the culture with the goal of being culturally sensitive. Sensitivity is ensured through the process of doing the formative research. Accordingly, the theoretical insights and applications developed in this approach are based on the ability of the expert outsider to develop suitable strategies for the culture and to develop targeted messages that match up with the relevant cultural markers identified by the outside expert.

Although cultural inputs might be taken, these inputs are usually crafted as formative research in order to make the message cultural such that it would be more effective in the target population.

Cooptation of participation

As articulated earlier, the dominant paradigm of health communication incorporates culture in order to serve the agendas of the status quo. In addition to maintaining the power structure by supplying cultural knowledge for purposes of control, the dominant paradigm of health communication also coopts the participatory platforms of cultural members by foregrounding the medicalizing ideology. In other words, by its similar appearances to the culture-centered approach, it fundamentally diffuses the participatory emphasis of the culture-centered approach, while at the same time it pushes the agendas of key dominant actors. Dutta and Basnyat (in press) demonstrate this in their analysis of the RCP in Nepal, documenting the ways in which local participatory platforms are utilized by USAID (1999) and the national elite to push the externally configured solution of population control as a panacea to resource inaccessibility.

Individual-level solutions are proposed while at the same time backgrounding structural and contextual factors that are central to the experience of health (Zoller, 2005). For instance, the RCP claimed that it was culturally sensitive by conducting focus groups with community members and giving them an opportunity to provide inputs to the types of messages that were developed in the radio serial drama (Storey & Jacobson, 2004). What was not mentioned in the reports of the RCP was that the RCP was systematically used to diffuse the population control agendas of USAID and Johns Hopkins University/Center for Communication Programs, and not to enable communicative platforms for the articulation of health problems from the perspectives of the subaltern Nepalese participants. Similarly, the CBPR approach for developing training manuals for the MFH project incorporated the participation of the Apsaalooke women in order to develop more effective messages rather than to give the women a platform for voicing their needs and suggesting solution configurations.

Culture-centered approach: Theorizing alternatives

The culture-centered approach suggests some alternatives to the dominant paradigm of culturally sensitive health communication by pointing out the very gaps and silences in the ways in which health communication is studied, theorized, and practiced in the culturally sensitive approach (Airhihenbuwa, 1995; Dutta-Bergman, 2004a, 2004b, 2005). These gaps and silences become the entry points for enacting resistance to the dominant paradigm and provide an alternative to the dominant paradigm. The concepts that drive the culture-centered approach are the links between culture and structure, the notion of multiple and shifting contexts, as well as agency and voice, and spaces of resistance.

Culture and structure

Structure refers to the organization of social systems, the patterns of distribution of resources, and the patterns of control of these resources that are inherent in the production and reinforcement of social inequities. Structures are embodied in the organization of the state, of civil society organizations, and of for-profit organizations that are embedded in a social system and are complicit in the creation of life experiences at the margins. Cultures are intrinsically linked to the social structures that surround them because the way resources are allocated and controlled significantly influences how meanings are created in the context of the life experiences of cultural participants. In fact, cultures continually interact with these structures; on one hand, they shape structures and, on the other hand, cultures are shaped by structures.

The location of the structure at the center of culture-centered theorizing and praxis is evident in the example of the SHIP. Since its launch in 1992, the SHIP has increased the rate of condom usage among sex workers in Sonagachi, changing the percentage usage of condoms among commercial sex workers (CSWs) from 3% in 1992 to 90% in 1999. Located in the Eastern part of India in the city of Kolkata, Sonagachi is Kolkata's largest red light area. According to the campaign planners of the SHIP (Jana et al., 2004), the principle underlying the SHIP was the belief that CSWs ought to take the lead role in a campaign seeking to improve their health. It acknowledged the ability of the sex workers to resist and act within the constraints of their marginalized spaces and to fundamentally shape the course of action of the health promotion effort. In line with the goals of the culture-centered approach, steps were taken to ensure that the structural factors surrounding HIV/AIDS were addressed such that there was adequate access to condoms, STD treatment, HIV testing, and information on the diseases, as well as financial opportunities for the CSWs so that they were not constrained by their economic situation to engage in unsafe practices. As the campaign progressed, the participation of the CSWs on the programming committee led to the emergence of economic programs as a vital component of the campaign. Prior to the program, when sex workers were in need of money, banks or wealthy individuals would typically charge the CSWs 50% interest, fostering circumstances where the CSWs would be constrained to forego condom use in an attempt to earn a living. To combat this situation, a cooperative loan service (Usha) was established for sex workers, where a cooperative bank granted small loans at 15% interest with feasible payment arrangements. This program provided the CSWs a security measure they could call their own and could trust, and meant that they could resist clients who insisted on not using condoms. The SHIP also organized the CSWs into a quasi-trade union. The Durbar Mahila Samnwaya Committee was born in 1995 to help the sex workers exercise collective power and articulate their demands (Jana et al., 2004). The case of the SHIP elucidates how structures surrounding health are engaged by the culture-centered approach. Here, health (negotiating safe sex) was located within the societal structure and it was by mobilizing to create a cooperative that the sex workers were able to

create an alternative structure that would be more accessible for securing better health within the community, thereby giving the CSWs greater leeway in negotiating condom use with clients.

The culture-centered approach opens up possibilities for exploring the ways in which structure influences the health choices of cultural members. It constrains, limits, and defines what is available to cultural members and what is not. Especially in marginalized sectors of the globe where the culture-centered approach is applied, structure is central to the health experiences of the participants, limiting their access to health care services and supplies, limiting access to food, and lending to the experiences of pain of cultural members. Therefore, structure continues to hold a theoretically critical position for the culture-centered approach to health communication. As elucidated by the example of the SHIP, communication interventions that respond to structure include efforts of redistributive justice, microcredit programs, and participation in political processes to impact local, national, and global agendas.

Multiple and shifting contexts

Context refers to the rich web of intertwined local environments within which health meanings are constantly negotiated. It refers to the local setting within which life is lived. According to the culture-centered approach, multiple contexts are continually in flux within the structural constraints, and it is within these contexts that cultural participants live their lives. Contexts are both static and dynamic such that the meaning of health is both continuous and transformative, shifting through interactions with these contexts. In other words, contexts connect local cultural systems with broader social structures and provide a culturally nuanced basis for the coconstruction of meanings.

Take, for instance, the context of hunger and how this shapes health meanings. In a study conducted in West Bengal, Dutta-Bergman (2004a) demonstrates that the local context of lack of food (going to bed hungry without having had the share of *panta*, rice soaked in water) is played out in its relationship to the broader structure of poverty surrounding the community. Discussions of health that are presented within this context of hunger articulate that meanings of health are intrinsically tied to food. The context is also shifting depending on the season: In the monsoon season when men in rural Bengal have difficulty finding jobs, the context of hunger becomes salient; however, it is easier for them to find jobs in the winter season, and the context of hunger—which is otherwise central to the discourse of health—becomes backgrounded. Meanings are articulated within contexts. Therefore, participants in the example above discuss “pain,” experienced within the context of hunger. The inability to feed one’s children further adds to this pain.

Multiple contexts are simultaneously intertwined in the constitution of culture. These contexts are embedded in each other and continually influence each other. For instance, the dynamic context of food shortage is deeply embedded within the broader realm of corruption, another contextual element articulated in the interviews

with rural men in Bengal. Although the state government in the above example has announced multiple schemes of basic food supply for the community, participants articulate their inability to receive such rations because of the corruption in the system. Once again, meanings of pain then are articulated within the intertwined contexts of hunger and corruption. As suggested earlier, the local contexts provide the cultural frameworks within which structural inequities play out. Therefore, the broader inequities of global food supply, national food policies, and state food policies are played out within the local contexts of corruption and food shortage. In other words, contexts are the conduits that connect the local and the global, and that provide the reference in the backdrop of which meanings are articulated and negotiated.

Agency and voice

The culture-centered approach is committed to the notion that humans have the capacity to understand their environments, to understand the contexts within which their health is enacted, and to act within and with these contexts to create and recreate their health experiences. Agency refers to the capacity of cultural participants to participate in day-to-day actions in response to their contexts based on a deeper level of understanding of these contexts and the structures surrounding them. Studies applying the culture-centered approach demonstrate that agency is enacted in working with the existing social structures to find avenues for solving health problems and also in working toward changing those structural forces that constrain the life experiences of marginalized groups (Dutta-Bergman, 2004a, 2004b, 2005). For instance, the SHIP brings to our attention the ways in which CSWs participate in their day-to-day practices of resistance and mobilize collectively in order to challenge the dominant social structures surrounding their lives. The active participation of the CSWs in defining the problem and the relevant health solutions is based on the notion that community members know best the nature of the problems facing the community and are therefore best equipped to participate in developing solution configurations that address these problems.

Rather than accepting the logic that members of cultures are passive receivers of messages directed at them, the culture-centered approach is committed to the articulation of an agency that is richly complex in its negotiation of structures. The expression of human agency is typically carried out through the voices of cultural participants engaged in dialogue. In other words, cultural participants articulate their health problems and coconstruct the solutions to these health problems through engagement in dialogue. The culture-centered project is committed to recovering those voices that have typically been erased from the epistemic structures, and that have typically been conceptualized as subjects of the dominant project and thus rendered invisible. The recovery of voices is a political act and is always articulated at the margins of the dominant epistemic structures. Literature on the culture-centered approach addresses questions regarding the accessibility of subaltern voices, the reflexive role of the scholar, and the overall nature of the culture-centered

project. This once again is evident in the photovoice method where the goal is to create communicative spaces for articulating the voices of members of marginalized communities and for ensuring that these voices are heard by key stakeholders such as academic experts, policy makers, and opinion leaders (Wang & Burris, 1994).

Expertise located within

The expertise in the culture-centered framework is located within the culture instead of fundamentally being attributed to the external actors who have the so-called tools to decipher knowledge. Therefore, knowledge is articulated through grassroots networks and through the involvement of cultural members in identifying major structural issues facing the community. The change initiative originates within the community and is driven by the community's understanding of what its major problems are, the ways in which these problems ought to be resolved, and the steps that ought to be taken. The role of the academic becomes one of a coparticipant rather than one of the omniscient outsider who intervenes from his or her position at the center. Once again, this is exemplified with the SHIP, where the emphasis was on creating avenues through which CSWs could participate in identifying problems and developing solutions facing the CSW community (Jana et al., 2004). Similarly, the photovoice method embodies the culture-centered approach in its emphasis on creating alternative communicative structures for listening to the stories of marginalized communities and for bringing about change through the voicing of these stories (Wang & Burris, 1994).

Much of the knowledge development of the culture-centered approach is built on the dialogue between the researcher and the cultural members. The location of expertise in the culture suggests a shift in communicative stance in terms of how health is communicated and the ways in which culture is used as a variable in health communication projects. It suggests a move away from the traditional top-down approach that emphasizes message production to a more egalitarian approach that privileges dialogue and listening. It also highlights the importance of respecting the values of local culture and of fostering an open communicative stance. The dialogical stance is open to mutually coconstructed problem definitions and ways of looking at the world. It also calls for the immersion of the scholar within the community and the articulation of knowledge through networks of solidarity. To sum up, the emphasis, therefore, is on solidarity and dialogue that are built upon the communicative act of listening as opposed to more top-down notions of sending out messages directed at the local communities based on the expertise of the outsider.

The culture-centered approach questions the inherent expertise of the outside scholar and criticizes the dominant approach to health communication for its decontextualized treatment of culture and for its arrogant assumption of expertise. The culture-centered critique of health communication demonstrates how the assumption made by the bourgeoisie academic located at the center is based on a faulty understanding of culture. This understanding of culture is often misguided because of faulty priorities that have been predetermined, and it runs the risk of

marginalizing and stigmatizing cultural members by pushing messages that undermine the agency of cultural participants (demonstrated earlier in the section on “Othering”). In summary, locating expertise in the culture not only provides a space for articulating alternative knowledge but also a space for questioning the dominant ways of knowing the world. It is this space for alternative knowledge that fosters spaces of resistance.

Spaces of resistance

The presence of the subaltern voice in the discursive space becomes a resistive act. Therefore, the culture-centered approach opens up the discursive space of health communication to resistance by engaging in dialogue with subaltern participants. Through the stories of health told by the participants, alternative pictures emerge. For instance, in Dutta-Bergman’s (2005) dialogical engagement with Santalis of Bengal, India, resistance is enacted by locating health in the realm of nature. For Santalis, ill health is caused by the disruption of nature. This theorization, which links the destruction of trees and natural resources as the root of the health problem for the Santali community, challenges the very basis of the modernization projects that seek to bring about development in marginalized sectors of the world. Resistance is enacted through the rupturing of the dominant discourse presented by proponents of the dominant paradigm who see modernization as the solution and not the problem. The very articulation of epistemologies that challenge the dominant epistemic worldview is fundamentally a resistive act as it attempts to shift the centers of power where knowledge is articulated and subsequently used for the purposes of developing praxis.

Similarly Shiva’s (1988) work on the global ecosystem demonstrates how health resources are depleted under the auspices of the dominant modernization paradigm that seeks to control, manipulate, and predict natural processes rather than trying to develop a sense of understanding of these natural processes and to live in harmony with them. Shiva’s work also outlines the violence perpetrated by so-called projects of science that health communicators so often blindly emulate. Also, the writings of Shiva question the dominant ideology of the medical system, pointing out the ways in which the medicalizing ideology privileges global pharmaceutical corporations.

Furthermore, resistance is enacted in the act of returning the gaze; the subaltern articulation of problems becomes the evaluative criterion against which the so-called value-free, secular knowledge of health communication is contested. The dominant knower is located in the subject position and his or her practices are brought under scrutiny. By juxtaposing the knowing subject against the backdrop of the subaltern voices, and by applying the criteria developed through subaltern engagement to evaluate the taken-for-granted projects of modernization, the culture-centered approach privileges the subaltern. As demonstrated by the SHIP and the photovoice methods, this privileging is critical as it brings the dominant way of knowing under the scrutiny of an alternative lens that has hitherto been silenced. The privileged positions of the funding agency, campaign planner, and evaluator are thus brought

under scrutiny, rendered as subjects of study, and opened up to critical interrogation. The gaze is returned.

Although the subject articulated here is categorized as the European knower in the context of issues of global development and the First–Third, North–South divides, there are multiple other possibilities for articulating this privileged subject position that is brought under scrutiny. In the context of gender, it is the patriarchal subject that has typically enacted policies and applications in the realm of women’s health. In the area of class, the subject is the bourgeoisie in the metropolitan academy that dictates that agendas, policies, and interventions directed toward the working classes, rural participants, Blacks, Hispanics, and Native Americans in the United States who are subjects of dominant health communication interventions.

Ultimately, resistance is possible through the engagement of the culture-centered approach in political processes that seek to alter the structures surrounding the conditions of poor health. In this realm, political activism becomes an avenue for participating in structure change, as evident in the example of the SHIP (Jana et al., 2004). The CSWs mobilized under the umbrella of the SHIP to resist the marginalizing practices of the clients, local goons, pimps, police, and politicians, thus bringing about change in the social structures surrounding the lives of the CSWs. Also, the culture-centered approach seeks to respond to the call of Conquergood (1991) for critical ethnography, the type of culture work that opens up avenues for social change. The critical ethnographer’s stance is one of resistance to the dominant paradigm, and this resistance is enacted through performance. Performance offers the avenue for coparticipating with members of marginalized communities in sharing stories of oppression, stories of negotiating structural impediments, and stories of resistance. Ultimately, the culture-centered approach offers a space for social change by presenting the dialogues of cultural members through this performance, by enacting the stories of oppression that lead to poor health, and by opening up possibilities of change through performance.

Discussion: Communicating culture for health

This article illustrates the relevance of developing a theoretical framework for conceptualizing the culture-centered and culturally sensitive approaches to health communication. Given the growing interest in culture as a concept in health communication, it is critical to develop a categorizing scheme to understand the conceptualization of culture under different frameworks, the theoretical underpinnings of these frameworks, and the practical applications that might arise out of them. The purpose of this project is ultimately to encourage additional debates about the concept of culture, what it is, how it is conceptualized, and how it gets used.

It may be argued that the theoretical conceptualization of culture guides the development of applications and the ways in which these applications are then evaluated, thus fundamentally shaping what it means to communicate about health in the realm of culture. Also, the nature of theory building and the treatment of

culture are vastly different in the two approaches, suggesting the need for delineation such that the health communication scholar would know: What is culture as conceptualized in the culture-centered approach vis-à-vis the culturally sensitive approach? What practical ramifications are involved in being culture centered? What does it mean to be culturally sensitive in the development of health communication theories and applications?

The comparison of the culture-centered and culturally sensitive approaches was based on the concepts of power, ideology, and hegemony in order to demonstrate how the two approaches get taken up differently and result in different types of applications. Whereas the culturally sensitive approach is primarily education oriented and attempts to develop culturally relevant materials that would be persuasive for the community, the culture-centered approach is resistive in its stance and interrogates the distribution of power and its interplay in how the status quo is pushed on subaltern spaces. In some instances, culture-centered engagement with local communities might suggest the necessity of developing culturally appropriate health information resources that might be utilized by community members and that is typically unavailable to them. In such situations, the creation of culturally appropriate health information texts helps build the health capacity of the community, addresses health information structures by making available community-appropriate health information and, therefore, is constitutive of the culture-centered approach.

Whereas the culture-centered approach emphasizes culture as a shifting, contextually embedded, complex web of meanings, the cultural sensitivity approach seeks to fine-tune communication materials to specific cultural needs such that these communication materials and programs are more effective. Also, whereas the culturally sensitive approach typically serves the dominant hegemonic configurations by focusing on individual-level health behaviors and seeking to transform them, the culture-centered approach interrogates these hegemonic configurations by drawing attention to the unhealthy structures. In this realm, however, it is also worth pointing out that in spite of the culture-centered approach's emphasis on interrogating hegemonic configurations, the approach itself is constituted in the realm of the privileged health communicator who has access to the mainstream communicative platforms and to the discursive spaces of knowledge. The meaningfulness of the culture-centered approach lies in its ability to continuously turn this reflexive gaze upon itself, embedded in the knowledge that the privileged position of the health communicator needs to be continually theorized. Therefore, the culture-centered approach provides an entry point for reflexivity about the complex interplay of hegemonic forces within which it becomes constituted.

This essay is particularly timely because it guides a theoretical framework for understanding these two different approaches to health communication at a time where more and more funding agencies are turning to the concept of culture, accompanied by the growing number of applications addressing culture issues. Also, this is timely because it is becoming fashionable for culturally sensitive health interventions to use the arguments of the culture-centered approach, hence coopting the

resistive potential of the culture-centered approach. As is demonstrated in the essay, the two approaches serve very different agendas, use different tools, and ultimately produce different outcomes. Their political involvements are also sharply different, serving different stakeholder groups and being deployed toward different interests. Whereas the culturally sensitive approach supports the status quo through its emphasis on education and individual behavior change, the culture-centered approach resists the status quo by asking culture-based questions about how we typically communicate about health (how we silence those at the margins based on dominant values) and by pointing out that health can be conceptualized within alternative paradigms. In essence, the culture-centered approach challenges the very notion of culture that is used in the cultural sensitivity approach to develop effective health communication solutions. This essay also lays out the foundation for future scholarship that explores the intersections of the cultural sensitivity and culture-centered approach. Although the foundation offered here provides a framework for understanding the theoretical and practical differences between the two approaches, this foundation also opens up opportunities for exploring how these two approaches inform each other and how health programs might embody strands from both of these approaches.

Conclusions

In conclusion, the delineation of the culture-centered and cultural sensitivity approaches equips the health communication scholar with the understanding that these two different approaches have different theoretical and pragmatic commitments. Whereas one approach pushes the agenda of the status quo through the development of culturally sensitive materials, in the other approach, the status quo is resisted and interrogated. Understanding the roots of each approach is advantageous for the purposes of application development and for further discussion of theory. Ultimately, the study of culture provides a fertile ground for developing health communication theories and practices that respond to the cultural needs of communities. The increasing emphasis on culture within and outside the United States suggests the relevance for developing meaningful fusion of theory and practice in order to best understand the ways in which culture may be mobilized for health applications.

Note

- 1 Although current health communication efforts often switch back and forth between these two labels without invoking a systematic set of criteria, this manuscript sets out the parameters for classifying the cultural sensitivity and culture-centered approaches. Based on these criteria, it becomes evident that some current campaigns that label themselves culture centered are actually culturally sensitive and vice versa. In other words, the criteria suggested here provide a framework for differentiating between the approaches as opposed to the flexible use of the labels in current literature.

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