frontiers in Communication

SPECIALTY GRAND CHALLENGE
published: 26 July 2016
doi: 10.3389/fcomm.2016.00005

Cultural Context, Structural Determinants, and Global Health Inequities: The Role of Communication

*Mohan J. Dutta**

Department of Communications and New Media, Center for Culture-Centered Approach to Research and Evaluation, National University of Singapore, Singapore

Keywords: structure, culture, health promotion, inequalities, globalization, health activism, health advocacy, culture-centered approach

The entrenched patterns of health inequities across the globe draw attention to the role of the global political economy in creating, reproducing, and sustaining these inequalities (Navarro, 2007; Dutta, 2015). The structural inequities in distribution of health resources and health opportunities manifest communicatively, with limited opportunities for individuals, families, and communities in the global margins to articulate their views, to be represented in policy making platforms, and to be counted in global political economy, in ways that matter (Dutta, 2008, 2015). Policies impacting human health are increasingly decided within restricted elite spaces that are opaque from public purview and public participation, while, at the same time, the dominant rhetoric of public health is rife with claims of participation (Dutta, 2015). Much of the prevailing practices and theorizing of health communication have unfortunately worked toward reproducing these inequities, typically operating within top-down expert-driven elite frameworks of diffusion of elite-driven innovations, where experts design health priorities, health policies, and health messages to be targeted toward recipient populations (Kreps, 2001; Dutta-Bergman, 2004; Dutta and Dutta, 2013). The erasure of the margins in health discourse is systematic and essential to the legitimacy of health communication knowledge, situating the "local" and "backward" beliefs of communities in opposition to the universal and scientific knowledge produced by health experts (Dutta-Bergman, 2005). Identities of communities at the margins and their knowledge systems are erased from discursive sites of knowledge production, having been depicted as "traditional," juxtaposed against the linear model of progress embodied in the rationality of modernization (Airhihenbuwa, 1995; Dutta, 2008, 2011, 2015). The ontological violence embodied in the erasure of local knowledge is carried out through the obfuscation of the cultural bases of scientific knowledge, instead marking culture as the "outside" of secular scientific processes and knowledge claims (Good, 1993).

The theorizing of communication, conceptualized as top-down persuasion, works at the sites of these erasures, turning these margins as passive recipients of health messages targeted through health campaigns (Lupton, 1994; Dutta-Bergman, 2005). For example, prevailing frameworks of public health communication, such as the diffusion of innovations model, theory of reasoned action, theory of planned behavior, and dual process theories, situate the belief of targeted communities against the innovations developed by experts in global centers of knowledge production (Dutta-Bergman, 2005). The erasure of the agentic capacity of communities and the treatment of communities as homogeneous aggregates are intrinsic to their symbolic and material marginalization, depicting the interplay of structural and communication inequalities (Dutta, 2008, 2015). An emerging body of critique of this top-down framework has led to the adaptation of the health communication processes to include audience data gathering through formative research and message dissemination strategies through community participation (Merzel and D'afflitti, 2003; Randolph and Viswanath, 2004). These modifications to the top-down framework make the argument that including the community in different phases of data gathering and message dissemination turns communication processes into more participatory forms, thus empowering communities and increasing the effectiveness of

OPEN ACCESS

Edited by:
Rukhsana Ahmed, University of Ottawa, Canada

Reviewed by:
Vinita Agarwal, Salisbury University, USA

***Correspondence:**
Mohan J. Dutta
cnmmohan@nus.edu.sg

Specialty section:
This article was submitted to Health Communication, a section of the journal Frontiers in Communication

Received: *13 May 2016*
Accepted: *11 July 2016*
Published: *26 July 2016*

Citation:
Dutta MJ (2016) Cultural Context, Structural Determinants, and Global Health Inequities: The Role of Communication. Front. Commun. 1:5. doi: 10.3389/fcomm.2016.00005

the health promotion effort in inducing behavior change. In these instances of more participatory health communication processes, however, the decision still remains in the hands of experts who have now developed appropriate data-gathering tools to inform more sophisticated message dissemination strategies, strengthening organizational intelligence in incorporating community participation into the preconfigured expert-led framework (Dutta and Basnyat, 2008). Having been co-opted into the dominant narratives of health, communities at the margins continue to remain erased from discursive spaces and discursive processes, with limited opportunities for impacting the agendas and policies that impact their health. Moreover, the conceptualization of communities as homogeneous aggregates (African-American community, Hispanic community, etc.) obfuscates the heterogeneities, differences, and layers of power that interplay within communities.

Health is shaped by a wide array of structural determinants that constitute the spaces and everyday contexts within which individuals, households, and communities live their lives (Marmot, 2005). Access to preventive care, including health screening and access to health care, are some of the most evident structural determinants of health. Moreover, the resources available in communities, such as schools, sources of fresh food, spaces for play and community gathering, and opportunities for employment, shape the health outcomes of community members. These structural features of the environment interact with cultural contexts in constituting health. Culture is intertwined with a wide array of health practices (Napier et al., 2014). Culture, referring to a dynamic web of meanings, interactions, values, and norms, constitutes health behaviors (Airhihenbuwa, 1995). Health behaviors are rendered meaningful within cultural contexts, being anchored in cultural values and beliefs (Dutta, 2008). The agentic capacities of individuals and communities to make sense of their everyday contexts of life and to enact practices are constituted at the intersections between structure and culture. Communities, as sites of decision-making, are heterogeneous spaces, constituted amid interplays of power. Thus, agentic capacities of communities are reflections of these negotiations of power and control. How then can health communication scholarship enable the co-creation of participatory and reflexive spaces that open up possibilities of diverse voices from communities to emerge, constituted in negotiations of power both within as well as with external stakeholders, measured in terms of their contributions to overall health of communities, and, particularly, in reference to contributing to the health of the most marginalized members within communities? Communities, thus, are conceptualized as constitutive and dynamic sites of participation, constituted within networks and layers of power and its negotiations. Another question for health communication scholars is in understanding the ways in which culture, structure, and agency intersect (Dutta, 2008, 2015), especially in communities that bear disproportionately greater levels of health risks, and the role of communication in these interactions, especially in the realm of enabling spaces for listening to the margins within community spaces that are often silenced and experience the greatest health threats.

Some of the grand challenges for health communication scholars and practitioners are guided by the questions: How do we develop communicative infrastructures of listening to and/or witnessing community participation that generate greater opportunities for health and well-being (Wilkin, 2013; Dutta, 2015)? What role can communication play toward creating equitable infrastructures for the participation of communities of the global margins in the realm of health policies and health programs? In the midst of global health inequalities that depict the inequalities in distribution of global power and the consolidation of decision-making in the hands of a narrow coterie of global elites, how can communication work toward bringing health inequalities on the global, national, and local agendas, and push for policy and program solutions that address these inequalities?

STRUCTURAL DETERMINANTS OF HEALTH: ROLE OF COMMUNICATION

The prevailing ideology of global health is anchored in a free-market framework that individualizes health and locates the solutions to health as individual-level beliefs, attitudes, and behaviors (Lupton, 1994; Dutta, 2015). This self-help ideology highlighting individual-level responses place the responsibility on the individual actor instead of looking at the broader structural forces that constitute health. For instance, health communication interventions are developed to promote fruit and vegetable consumption in target populations, often in marginalized communities, without attending to the structural forces that shape the access to fruits and vegetables, the inequities in distribution of food resources, the large-scale commoditization of food, and the corporatization of global agriculture. Similarly, health communication solutions directed at addressing obesity target the individual by encouraging behavior changes, such as healthy eating, exercising, and an active life, without attending to the broader structural determinants, such as the powerful advertising machinery of the sugary sweet drink industry, availability of spaces to exercise, opportunities for leisure amid work in multiple shifts to simply afford a living, and the role of stressors in the broader neighborhood environment on the desire to exercise.

Structural patterns of organizing of global, national, and local economies shape the broad meanings of health care and the ways in which health care is constructed. The commoditization of health, accompanied by the narrow framing of health as a profitable resource results in the disenfranchisement of individuals, households, and communities from access to health care. As a private commodity, health has to be purchased, with the rhetoric of personal choice and individual responsibility inundating the neoliberal propaganda (Dutta, 2015). Particularly salient is the deployment of "free market" ideology to transform health care into a privatized site of corporate profiteering. In this backdrop of the privatization and corporatization of health, socioeconomic status (SES) and health outcomes have become increasingly intertwined. The globalization of neoliberal ideology has resulted in the weakening of labor unions and the minimization of the collective bargaining powers of poor workers, rendering them vulnerable to being fired, low wages, lack of health insurance, and lack of protections. The transnational movement of capital and labor without accompanying global regulations has resulted in the proliferation of sweatshop economies, with extremely low

wages, long working hours, and health-threatening working conditions as evident in the Rana plaza collapse in Bangladesh. In many contexts across the globe, poor health can result in bankruptcy. A chronic illness can result in the inability to work, resulting in poverty. Moreover, access to health care is contingent upon access to work and access to economic resources, depicting the interplay between economics and health. The structural determinants of health literature attends to the ways in which the social class influences access to health resources, such as healthy food and physical activity, preventive services, and health care. Yet, in other contexts, poor communities experience inaccess to health care, unable to get to a provider or to health services. Lack of transportation infrastructure to health services can play a pivotal role in the ability to access these health services. What are the roles of health information and health communication in these contexts of structural inaccess to health resources? How can health communication be theorized to offer an explanatory framework for conceptualizing the relationship between social class and access to health resources? How can communication solutions be developed to address the health needs of the global poor? and what is the role of communication as an organizing resource for the working classes in addressing the communication and material inequalities they experience?

Environmentally constituted threats to health are distributed unequally in society, with the poorer communities in the global South often bearing the largest burdens of threats to health from climate change, and yet being predominantly erased from discursive spaces of policy making and often forced to pay the price of environmental damages (McMichael et al., 2007). Solutions to problems of the environment are put forth by elite experts situated within the global power structures, offering solutions that are often disconnected from the lived experiences of communities. For instance, whereas disproportionate burdens of human-induced climate change are borne by the poor in the global South, they are often missing from sites of articulation and policy formation. Similarly, the risks of pollution, chemical exposure, and poisoning are often disproportionately borne by the poor (Brulle and Pellow, 2006), while the poor are simultaneously erased from discursive sites where policies are discussed and decisions are made. Moreover, the global poor often have limited access to the transnational sites of justice, where claims may be made for reparations within the context of exposure to pollution and health risks constituted by production chains in transnational capital. For instance, factory workers in China are often disconnected from sites of claims making in the context of their exposure to harmful chemicals; factory workers in the Maquiladoras in Mexico have limited access to global sites of legal recourse from which they are disconnected both spatially and communicatively. Communities and activists in Bhopal, India, exposed to the harmful carbide at the Union Carbide factory, are disconnected from sites of legal decision-making located in transnational networks. Opportunities of articulation to claim for access to treatment and reparation for the global poor are often removed in far removed transnational networks that enable the free flow of transnational capital and labor with limited regulation.

Migration offers yet another structural context that brings forth new challenges, such as language and translation, cross-cultural interaction, and inaccess for health communicators to address (Dutta and Jamil, 2013). Migrants are often excluded from spaces of access to health care, with citizenship emerging as a site of exclusion. More recently, environmental changes, changes in economic opportunities, and wars have constituted the contexts for large-scale forced human migrations. Forced migration, as evident in the trans-border movement of refugees, such as in the cases of Syrians and Rohingyas, constitute vulnerabilities and health risks associated with movement, acculturation in the new environment, and adaptation. What then are the health consequences of these migrations, and how can the needs of migrant communities be addressed through communication? Communities living in spaces that are targets of the global extractive industries (mining, oil, etc.) experience tremendous health risks brought about by these industries, with communication playing a key role as legitimating tools through corporate social responsibility, corporate development, community engagement, and community relations. In addition to the health risks brought about by the extractive industries, the livelihoods of local communities are often threatened through uses of state-corporate instruments of violence (Dutta, 2015). Displacement of poorer communities through large-scale land grab is another site of health risks, globally. Communication, often framed as development and articulated as an enabler of growth and community well-being, is strategically positioned to justify the displacement as necessary for economic growth and progress. Poor health outcomes of displacement, exposure to health risks at sites of mining operations, and physical threats to health are obfuscated from the discursive space.

Moreover, structural features of societies, such as institutional racism, have significant effects on human health, producing inequities in health outcomes (Williams, 1999; Smedley et al., 2002). These structural inequities are often rendered acceptable through cultural norms (to be discussed in the next section). For instance, the disproportionate burdens of poor health borne by African-Americans in the U.S. are intertwined with the racist social structures of U.S. society, manifesting in inaccess to a plethora of health resources as well as in experiences of everyday racism that directly threaten the health of African-Americans (Black et al., 2015; Ellis et al., 2015). The disproportionate burden of police violence and incarceration experienced by African-Americans in the U.S., for instance, are fundamental threats to health (Krieger et al., 2015). The apartheid experienced by Palestinians, accompanied by the atrocities of the Israeli occupation significantly impact human health, constituting experiences of stress and trauma (Qouta et al., 2008; Hobfoll et al., 2011; Dugard and Reynolds, 2013; Antze and Lambek, 2016). Caste oppression in India is another form of culturally constituted racism that significantly impacts the health of *dalits* (considered the downtrodden castes) by limiting access to economic resources; limiting access to resources of health, such as food, water, shelter, and health care; stigmatization; and direct threats of violence (Nayar, 2007). Ethnic and religious minorities in China (Pan and Spittal, 2013) and the Rohingyas in Burma (Toole and Waldman, 1993) experience stigmatization, bullying, as well as direct threats to health through violence, often performed by the instruments of the state. In India, the health of Muslim minorities is similarly

threatened through micro and macro forms of violence whereas in neighboring Bangladesh, the health of Hindu minorities is threatened by forms of violence.

Similarly, structural patterns of violence, including wars and incarceration, significantly impact human health adversely (Qouta et al., 2008; Dutta, 2016). What for instance are the health burdens on individuals, families, and communities in Iraq and Afghanistan that are direct products of the U.S. war on terror? What are the health consequences of the U.S. drone program on families in Pakistan that have been targeted through the program? What are the health effects of colonial occupations and apartheid, such as the Israeli occupation of Gaza and the West Bank? What role then can health communication play in narrating these adverse health effects and in shifting national–global pubic policies toward nurturing greater health and well-being? Within nation states, forms of state-sponsored violence directly threaten the health of communities that have been marked as "threats" through strategic communication. For instance, the genocide in Indonesia carried out by the military of individuals, families, and communities suspected of having links with PKI (Indonesian Communist Party), supported and equipped by U.S. and Dutch governments, was constituted through communication as Cold War propaganda that constructed the "Communist threat." In India, state-sponsored military and para-military attacks on India's indigenous communities to strategically displace them from their spaces of livelihoods are carried out through the framing of indigenous communities as "Maoist threats." The role of health communication in putting forth alternative meanings are particularly salient today as airstrikes have hit sites of health care, such as hospitals and infrastructures of *Medicins Sans Frontieres* in Gaza, not only placing at jeopardy the health of community members but also placing at risk the health of health providers (Dutta, 2016). As communication is strategically deployed as propaganda in building public support for war and use of state-sponsored violence, health communication theorists and practitioners ought to systematically interrogate communication as propaganda and examine the ways in which affected communities might access communication infrastructures to voice their lived experiences of health.

Yet another salient site of health disparities is in the realm of gender. What are the disparities in the health burdens and access to preventive and health services, constituted along the lines of gender? The question of gender and health attends to the tension between the macro/micro-structures of work hours, women working in unorganized sectors of labor, women working as farmers across the globe, child care, such as in instances even where state supported assistance is available (such as through county health centers in the U.S. or health social workers in India), unpaid labor of household work, children/women walking long distances to the village well or in unsafe areas for their daily toilet needs (in developing countries), and women's exposure to various culturally constituted forms of gendered violence globally. Depicting the interplays of gender and health, women's access to reproductive health services renders visible the complex webs of patriarchy within which health experiences are constituted globally (Inhorn, 2006). Within sites of access to health care in the global North, inequities continue to play out along gender lines, especially in the context of women's access to reproductive health, including access to abortion, and their ability to navigate the processes of decision-making on reproductive health issues. In contrast, for women in the global South, abortion often becomes an instrument of patriarchal sociocultural control, situated in the context of female feticide; thus, picking up completely different meaning frames in contrast to the widely adopted frames of women's health in the global North (Inhorn, 2006). Across these globally dispersed sites of patriarchal threats to women's health, opportunities of participation of women are systematically erased. Particularly salient in local, national, and global contexts are the differential pathways through which gender influences health, and the intersections of gender with class, race, and nationality (Airhihenbuwa and Liburd, 2006).

Also salient are the uses of gender narratives framed as emancipation (such as the "Lifting of the veil" of the oppressed woman) that are used to justify patriarchal imperial invasions such as the U.S. invasions of Iraq and Afghanistan that threaten human health (Jabbra, 2013). Worth noting in these narratives is the portrayal of the body of the brown man as the subject of colonial intervention, propped up as the justification for imperial state-sponsored military violence. Moreover, a large percentage of women in the global South, displaced from their sources of livelihood that resulted from a plethora of shifts ranging from climate change to the structural adjustment programs imposed by the international financial institutions (IFIs), have been forced to participate in various forms of precarious labor, working in conditions that significantly challenge their health and well-being (Dutta, 2015). Whereas many of these women have been forced to work as casual laborers in sweatshops without union representation and worker rights, other have been forced to informal feminized labor such as sex work and domestic work, forms of work that are often not recognized within the ambits of worker acts and are subject to exploitation and oppression. In addition, interplays of gender and health are significant in the health and illness experiences of sexual minorities, such as lesbian, gay, bisexual, and transgender communities (Boehmer, 2002; Mayer et al., 2008). Heteronormative structures of health in the dominant framework for instance disenfranchise transgender individuals and communities, stigmatizing community members, threatening health through patriarchal violence, reproducing social and economic exclusion, and limiting access to quality health resources. Health communication scholarship, here, can play two key roles: first, health communication scholars ought to examine closely the ways in which discourses are deployed by patriarchal structures in constituting the gendered experiences of health, in carrying out erasures, and in specifically manipulating gender as a construct to carry out violence on the bodies of women at the margins? Second, health communication scholars ought to examine the communicative practices through which women at the margins negotiate structures, articulating their agency, and participating in micro and macro practices of resistance in negotiating and transforming patriarchal structures of health.

Given the growing inequalities in health outcomes that are constituted amid broader economic inequalities, health communication scholarship stands in an important space for theoretically and empirically delineating the role of communication

advocacy directed at transforming the unhealthy structures (policies, programs, interventions) we are witnessing across the globe. Particular attention needs to be paid to theorizing the role of health communication in addressing communication inequalities, interrogating the taken-for-granted assumptions that constitute the fundamentals of health communication (Dutta, 2015). Addressing issues of communication inequality calls for layered and complex approaches to health communication that simultaneously interrogate global neoliberal/neo-imperial structures, national structures, and local community structures, within the broader framework of health. Privatization of health resources and the transformation of human health as a site of capitalist profiteering need to be interrogated. For instance, the networks of biocapital that turn bodies in the global South into sites of profiteering through randomized controlled trials and clinical experiments, often with minimal regulation and scrutiny, and in multiple occasions without appropriate consent or through manipulation/coercion, need to be closely interrogated (Rajan, 2006; Petryna, 2009). Health communication scholars ought to pay close attention to the ways in which communication is deployed toward generating new markets and new bodies/genes/matter as harvestable resources for transnational capital. Yes, another site of profiteering through extraction is in the realm of biopiracy, where indigenous plant forms, crops, and livelihood are co-opted as patentable property by transnational capital through patenting laws pushed by the World Trade Organization (WTO) (Mies and Shiva, 1993). Also in the realm of patenting, powerful nation states, transnational pharmaceutical corporations often housed in these nation states, and the WTO push patent laws to continue creating new markets for pharmaceuticals, often allowing pharmaceutical monopolies through the provision of new uses of existing drugs, thus, limiting the manufacturing of generics, and preventing the access of poor communities, especially in the global South to generic drugs. What then are the roles of health communicators in collaborating with subaltern communities in the global South to resist their exploitation by transnational biocapital?

Whereas, on the one hand, structures mostly remain absent from mainstream theorizing of health and communication, problems of health instead get framed in the narrative of technology. For any health problem, a technological solution is proposed as a miracle. The monolithic emphasis on such techno-deterministic solutions needs to be interrogated in the backdrop of empirical evidence and lived experiences of communities rather than being ideologically adopted as solutions. Take for instance, the solution to health disparities that gets framed as one of digital divide, thus, proposing solutions of equipping communities at the margins with internet access, oblivious to the sustainability of such solutions, the lived experiences of marginalized communities with technology, and the community knowledge of the health enabling uses of technologies. Moreover, the techno-deterministic ideology, simultaneously, erases articulations of structural inequalities that call for communication as organizing directed at structural transformation. The expert-driven bias of building information superhighways or cyber-infrastructures to addressing these communication inequalities are at best limited, and at worst, complicit in the perpetuation of the inequities by proposing a techno-deterministic framework of solutions that erases the inequities in distribution of power underlying communicative and health inequalities. For instance, the question of digital divide in marginalized communities can't simply be solved with the premise of building computers in these communities, without also addressing broader structural issues of economic inequality, literacy, digital literacy, and structurally constituted patterns of usage. What role can communication play in shifting the broader power inequities and structural inequalities in the unequal distribution of resources? What is the role of communication in shifting the techno-deterministic discourse? Similarly, within communities, what role can communication play in co-creating spaces for the margins, in foregrounding and reproducing health promoting practices, and in collectively addressing health threatening practices? The locus of decision-making, located in community life and constituted in relationship to the materiality of health, is achieved through community participation, negotiations of power, and expressions of agency.

CULTURAL HEALTH RESOURCES

Culture, a dynamic web of shared values, practices, meanings, and symbolic expressions, is an invaluable health resource, often containing health-promoting practices within culturally held community norms and values (Good, 1993; Airhihenbuwa, 1995; Dutta, 2008; Napier et al., 2014). For instance, cultural practices, such as songs and dances, contribute to health and well-being of local communities. Communities across the globe have culturally situated games and physical activities that contribute to health and well-being. Similarly, many culturally situated eating practices contribute to human health and well-being. Cultural practices of using herbs for everyday health form key elements of health and well-being. Forms of knowing such as Yoga, Ayurveda, and Traditional Chinese Medicine offer pathways for healing, constituted within systematic knowledge traditions. These cultural contexts, cultural meanings, and forms of knowledge need to be foregrounded in the backdrop of the global circulation of monolithic health-depleting Western lifestyles of fast food, snacks, processed food, and sugary sweet drinks. The global hegemony of the communication industry (advertising and public relations) often directly threatens human health through its dissemination of an unhealthy Western lifestyle, simultaneously threatening the wide diversity of health practices across the globe (Dutta, 2015). The logic of the free market is deployed to open up nation states to fast food and sugary sweet drinks as well as to limit regulations of these industries (Navarro, 2007; Dutta, 2015).

In contrast to the organic and socially constructed concept of culture, it is conceptualized in dominant health communication discourses as the realm of the "other," located elsewhere, as a barrier to health that needs to be addressed through a culturally sensitive health communication intervention. Along similar lines, the depiction of culture as backward and health threatening in the global discursive constructions of infectious disease result in the militarization and privatization of health solutions (Sastry and Dutta, 2012). Health communication scholars, therefore, have key roles to play in addressing these power imbalances, interrogating the conceptualization of culture in mainstream

health communication, developing community-based advocacy frameworks that push for regulations of unhealthy products, and advertising/PR for these products, enabling local community participation in addressing health risks, such as infectious diseases, as well as circulating health-enhancing local cultural practices through community ties and networks of community organizations, activists, and academics. The challenge for health communicators is to co-construct ground-up community-driven theories of health that are based on culturally situated meanings and practices.

Extending further the notion of community agency (to be discussed in the next section), local community participation emerges as an anchor for addressing health-threatening cultural practices. For instance, practices of feticide and child marriage in rural communities in India are addressed through the participation of local women in community-driven collectives of change, performances, theater, and art (Mangai, 1998). Similarly, in various countries in Africa, community-driven collectives of women have worked together to address the health consequences of genital mutilation and to bring about change (Lewis, 1995). Cultural change thus, located within the networks of community life, is brought about through the realignment of meanings and values through local participation of community members, especially those at the margins of community life. For health communication scholars, critical analyses of cultural practices in postcolonial contexts ought to be located amid analyses of complex layers of colonial constructions, colonial tropes, and imperial desires, juxtaposed in the backdrop of local expressions of agentic sites of transformations through participation and solidarity. For instance, critical analyses of agency-robbing Eurocentric colonial discourses of female genital mutilation superimposed on the image of Africa need to be juxtaposed in the backdrop of gender-based movements and locally driven social change efforts in communities that stand as exemplars of cultural transformation through local participation (Gruenbaum, 2001; Nnaemeka, 2005). The role of health communication is shifted to one of listening in solidarity, attending carefully to the practices and processes of cultural transformation ongoing within communities with humility, and lending support through research and advocacy, as opposed to participating in fashionable "academic tourism" driven by Eurocentric arrogance and lack of cultural understanding. Simultaneously, by rendering culture as the site of the everyday, attention is drawn to practices such as plastic surgery and male circumcision in global commodity flows that are naturalized as secular, universal, and scientific, thus opening up spaces for cultural transformations of health-depleting practices within the institutional structures of biomedical capitalism.

Culture is salient in health interactions (Flores, 2000). Cultural studies of health and communication ought to attend to how the "patient" is constructed – sustaining empowering relationships between providers or health practitioners (local/alternative or biomedical) – embedded in community interactions. Within a dominant framework of communicating health, the hegemony of biomedicine as universal science is juxtaposed against culture as a repository of practices that are primitive. The inequalities between the culture of biomedicine and healing cultures of communities at the margins results in the devaluing of cultures in health-care interactions and within health-care settings. Established health communication approaches respond to these challenges of interactions in cross-cultural settings with prescriptions for assimilation for subcultural communities (minorities, immigrants, and refugees for instance) and cultural sensitivity training for providers. Although these approaches of health communication work toward acknowledging culture, they also often continue to perpetuate the stigmatization by defining culture as the "other," as outside of the realm of biomedicine. Similarly, culturally sensitive health communication campaigns and culturally tailored campaigns identify characteristics of the local culture and then develop messaging strategies that are directed at speaking to these characteristics (Dutta-Bergman, 2005). The agenda of health communication is defined by the experts located outside the culture, and often with lip service paid to cultural insiders.

Moreover, as posited in the previous section, cultural narratives reflect and render as commonplace structural inequities. Inequalities in distribution of power are given meaning through cultural scripts. For instance, in India, scripts of caste are rendered as normative, built into everyday cultural practices, playing out structural inequities in access to resources. Similarly, indigenous communities in India experience dramatic structural violence, legitimized through culturally accepted norms. In extreme examples, these culturally accepted normative ideas result in physical violence and in the loss of human life. As discussed earlier, certain cultural norms in communities threaten the health of members in gendered ways, and, therefore, need to be critically interrogated through community participation, conversations, and dialogs. Health communication scholars also ought to critically interrogate the appropriation of culture into the terrains of global capital – whether by local cultural forces or corporate/dominant "othering" interests. Take for instance, the Baba Ramdev health products in India, which have become in some ways a bigger "mass corporatization," force marketing local knowledge than Colgate and other Western corporate interests. Similarly, consider the ways in which Yoga has been taken up in transnational capitalist networks as a site of profiteering, birthing Yoga industries and industries of paraphernalia including apparel, accessories, etc. Similarly, sustainability-driven global brands have systematically co-opted indigenous knowledge systems to create new global markets, simultaneously obfuscating indigenous communities from their sources of livelihood. Cultural knowledge as an economic resource of profiteering needs to be interrogated and resisted through health communication efforts that explore meaningful forms of healing that are rooted in the cultural context and respectful of local cultural norms of knowledge preservation and circulation.

Recognizing the role of culture calls for a fundamental shift in how health communication scholarship is conducted because culture has been traditionally treated as a barrier to health solutions typically developed by Western experts and local elites, drawing from Western understandings of health (Dutta-Bergman, 2005). Moreover, the theorization of power in community contexts attends to the layers of inequality and power within community structures, thus suggesting entry points for health communication scholars to explore the ways in which reflexivity in community contexts can be nurtured through community–civil

society–activist–academic partnerships and through a cultivated habit of interrogating privilege. The framework of health communication scholarship needs to move beyond its persuasion-driven model to one of communication as dialog, seeking to understand the ways in which dialogs in spaces of health can offer entry points for acknowledging and co-constructing knowledge with cultures at the global margins. Health communication scholars ought to be responding to challenging questions such as: How to develop descriptions of culturally situated health meanings that are health promoting? How to communicate health promoting meanings in communication spaces such that these meanings are supported structurally?

The culture-centered approach outlines the role of listening as an entry point for foregrounding community voices in co-creating locally situated cultural ideas of health and well-being (Basu and Dutta, 2008; Dutta, 2008). How then can the next generation of culture-centered health communication scholarship develop global infrastructures for promoting culturally situated practices of health and well-being? Moreover, what are the limits of such forms of dialog and participation? Alternatively and complementarily, what is the role of adversarial politics in transforming structures that constrain health? These questions are particularly salient amid the global onslaught of an economic model that pushes for markets for unhealthy products and lifestyles.

AGENTIC OPPORTUNITIES FOR COMMUNITY PARTICIPATION AND ADVOCACY

Agency is conceptualized in the active processes of meaning making community members participate in, the ways in which they negotiate health, the changes they articulate in their interpretations of health, and the individual and collective processes they participate in to enable greater health (Dutta, 2008). For instance, Pitaloka (2014) depicts the ways in which Javanese women make sense of Type 2 diabetes and negotiate locally constituted health solutions to diabetes. Similarly, Dillon and Basu (2014) depict the ways in which HIV/AIDS negotiations of minority men are rooted in meanings, which in turn are situated amid the interplays of culture and structure. Sastry (2016) depicts the ways in which meanings of condom use among long distance truck drivers in India, mapped as a high-risk group, are situated amid the interplays of cultural norms and structures of work.

Communities are vital resources of health-based decision-making, participating in a plethora of ways in negotiating structures and securing resources. Recognizing the agentic capacity of communities creates entry points for developing health solutions that are grounded in everyday community life. It is particularly salient to recognize the capacity of local communities to identify problems within their locally situated interpretive frames and to collaboratively work toward developing solutions to these problems. Particularly salient for health communication scholarship is to recognize the structural challenges that communities experience as they come to construct solutions to health problems, thus creating anchors for structural transformation. The acknowledgment of the structurally situated nature of health, well-being, and illness creates openings for collaboration that are directed toward bringing about changes to these structures. For instance, in the backdrop of the racism and state-sponsored racist police violence experienced by African-Americans in the U.S., the #BlackLivesMatter movement emerges as a space for trans-boundary community organizing, drawing attention to the racist police violence across communities and states targeting African-Americans, and calling for policy change (Jee-Lyn García and Sharif, 2015).

The challenge for health communication scholarship, therefore, is to identify the role of communication in the pathways of solidarity with local communities that work toward transforming the structural impediments to health and well-being. The nature of health communication scholarship, therefore, is guided by an emphasis on health activism and health advocacy that is directed at holding the state accountable, securing public resources of health and well-being, and developing community-based frameworks for health that challenge the large-scale corporatization of health. Also of salience is the recognition of differences within communities, inequalities within community spaces, and the interplays of power in community networks, thus offering entry points for conceptualizing communication in community participation that addresses the inequalities within, enables critical engagement with the layers of power within communities, and through the cultivation of reflexivity, enables community members to continually open up spaces for the most disenfranchised within-community spaces. In contrast to community participatory approaches that often co-opt community voices to serve the dominant agendas developed by elite experts, the challenge for health communication scholars and practitioners is one of developing radically transformative spaces grounded in local community knowledge and democratic community participation. Moreover, in the backdrop of the global consolidation of power in the hands of the power elite, the challenge for health communication scholars is to nurture and cultivate communicative networks of solidarity that bring forth local concepts of health to global spaces and enable knowledge production rooted in the global South (Dutta, 2014). What national–global network structures enable possibilities of local–local solidarities among marginalized communities in the global South? How can communication cultivate health politics of solidarity among communities at the margins?

CONCLUSION

In conclusion, the challenge for the next generation of health communication scholarship is to interrogate some of the fundamental taken-for-granted assumptions of the discipline, examining the ways in which these assumptions have perpetuated inequities in opportunities for health, and for communicating for health. Who is present and who is absent from discursive spaces of health policy making, program development, and knowledge production? What does it mean to participate in networks of knowledge production about communication and health, and how are these sites of knowledge production intertwined with power? Who does not have the opportunity to be recognized and represented in dominant discursive spaces where health is talked about and in global–national structures where knowledge is produced and

practiced? Close interrogations of the taken-for-granted assumptions and values in these mainstream health communication frameworks/structures offer new entry points for the theorizing of health communication that is attentive to the inequities in health outcomes that we witness across the globe, as well as inviting to knowledge claims about health and well-being embedded within local cultural contexts, lived experiences of communities, and community desires for health.

Moreover, creatively working through the interplays of culture, structure, and agency serve as a framework for developing health communication solutions that are grounded in local cultures, inviting to dialogs, both in foregrounding positive cultural resources and in transforming health depleting cultural practices. Health communication scholars studying power in community contexts can offer insights into frameworks for cultivating reflexivity within communities and within academic–community partnerships that seek out continual possibilities for addressing community inequalities by opening up spaces for the margins within communities. The co-creation of space, thus, becomes a continual process of interrogating the privileges written into existing spaces and simultaneously inviting the margins to these spaces, thus continually transforming the rules and codes of community participation. Ultimately, the challenge for health communication grounded in an acknowledgment of culture and structure is to fundamentally invert the nature of communication from top-down information delivery or persuasion to one of creating infrastructures for listening to the plurality of voices of the global margins (Dutta, 2014, 2015).

AUTHOR CONTRIBUTIONS

Prof. MD has conceptualized and written the article.

REFERENCES

Airhihenbuwa, C. O. (1995). *Health and Culture: Beyond the Western Paradigm*. New York: SAGE.

Airhihenbuwa, C. O., and Liburd, L. (2006). Eliminating health disparities in the African American population: the interface of culture, gender, and power. *Health Educ. Behav.* 33, 488–501. doi:10.1177/1090198106287731

Antze, P., and Lambek, M. (eds). (2016). *Tense Past: Cultural Essays in Trauma and Memory*. New York: Routledge.

Basu, A., and Dutta, M. J. (2008). Participatory change in a campaign led by sex workers: connecting resistance to action-oriented agency. *Qual. Health Res.* 18, 106–119. doi:10.1177/1049732307309373

Black, L. L., Johnson, R., and VanHoose, L. (2015). The relationship between perceived racism/discrimination and health among Black American women: a review of the literature from 2003 to 2013. *J. Racial Ethn. Health Disparities* 2, 11–20. doi:10.1007/s40615-014-0043-1

Boehmer, U. (2002). Twenty years of public health research: inclusion of lesbian, gay, bisexual, and transgender populations. *Am. J. Public Health* 92, 1125–1130. doi:10.2105/AJPH.92.7.1125

Brulle, R. J., and Pellow, D. N. (2006). Environmental justice: human health and environmental inequalities. *Annu. Rev. Public Health* 27, 103–124. doi:10.1146/annurev.publhealth.27.021405.102124

Dillon, P. J., and Basu, A. (2014). HIV/AIDS and minority men who have sex with men: a meta-ethnographic synthesis of qualitative research. *Health Commun.* 29, 182–192. doi:10.1080/10410236.2012.732911

Dugard, J., and Reynolds, J. (2013). Apartheid, international law, and the occupied Palestinian territory. *Eur. J. Int. Law* 24, 867–913. doi:10.1093/ejil/cht045

Dutta, M. J. (2008). *Communicating Social Change: A Culture-Centered Approach*. London: Polity.

Dutta, M. J. (2011). *Communicating Social Change: Structure, Culture, Agency*. New York: Routledge.

Dutta, M. J. (2014). A culture-centered approach to listening: voices of social change. *Int. J. Listening* 28, 67–81. doi:10.1080/10904018.2014.876266

Dutta, M. J. (2015). *Neoliberal Health Organizing: Communication, Meaning, and Politics*. New York, NY: Left Coast Press.

Dutta, M. J. (2016). Violence in Gaza: an academic-activist agenda for health communication. *Health Commun.* 1–3. doi:10.1080/10410236.2015.1089455

Dutta, M. J., and Basnyat, I. (2008). The radio communication project in Nepal: a culture-centered approach to participation. *Health Educ. Behav.* 35, 442–454. doi:10.1177/1090198106287450

Dutta, M. J., and Dutta, U. (2013). Voices of the poor from the margins of Bengal: structural inequities and health. *Qual. Health Res.* 23, 14–25. doi:10.1177/10497323124622411

Dutta, M. J., and Jamil, R. (2013). Health at the margins of migration: culture-centered co-constructions among Bangladeshi immigrants. *Health Commun.* 28, 170–182. doi:10.1080/10410236.2012.666956

Dutta-Bergman, M. J. (2004). The unheard voices of Santalis: communicating about health from the margins of India. *Commun. Theory* 14, 237–263. doi:10.1111/j.1468-2885.2004.tb00313.x

Dutta-Bergman, M. J. (2005). Theory and practice in health communication campaigns: a critical interrogation. *Health Commun.* 18, 103–122. doi:10.1207/s15327027hc1802_1

Ellis, K. R., Griffith, D. M., Allen, J. O., Thorpe, R. J., and Bruce, M. A. (2015). "If you do nothing about stress, the next thing you know, you're shattered": perspectives on African American men's stress, coping and health from African American men and key women in their lives. *Soc. Sci. Med.* 139, 107–114. doi:10.1016/j.socscimed.2015.06.036

Flores, G. (2000). Culture and the patient-physician relationship: achieving cultural competency in health care. *J. Pediatr.* 136, 14–23. doi:10.1016/S0022-3476(00)90043-X

Good, B. J. (1993). *Medicine, Rationality and Experience: an Anthropological Perspective*. New York, NY: Cambridge University Press.

Gruenbaum, E. (2001). *The Female Circumcision Controversy: An Anthropological Perspective*. New York, NY: University of Pennsylvania Press.

Hobfoll, S. E., Mancini, A. D., Hall, B. J., Canetti, D., and Bonanno, G. A. (2011). The limits of resilience: distress following chronic political violence among Palestinians. *Soc. Sci. Med.* 72, 1400–1408. doi:10.1016/j.socscimed.2011.02.022

Inhorn, M. C. (2006). Defining women's health: a dozen messages from more than 150 ethnographies. *Med. Anthropol. Q.* 20, 345–378. doi:10.1525/maq.2006.20.3.345

Jabbra, N. W. (2013). Women, words and war: explaining 9/11 and justifying US military action in Afghanistan and Iraq. *J. Int. Womens Stud.* 8, 236–255.

Jee-Lyn García, J., and Sharif, M. Z. (2015). Black lives matter: a commentary on racism and public health. *Am. J. Public Health* 105, e27–e30. doi:10.2105/AJPH.2015.302706

Kreps, G. L. (2001). The evolution and advancement of health communication inquiry. *Ann. Int. Commun. Assoc.* 24, 231–253. doi:10.1080/23808985.2001.11678988

Krieger, N., Chen, J. T., Waterman, P. D., Kiang, M. V., and Feldman, J. (2015). Police killings and police deaths are public health data and can be counted. *PLoS Med.* 12:e1001915. doi:10.1371/journal.pmed.1001915

Lewis, H. (1995). Between Irua and 'female genital mutilation': feminist human rights discourse and the cultural divide. *Harv. Hum. Rights J.* 8, 1–55.

Lupton, D. (1994). Toward the development of critical health communication praxis. *Health Commun.* 6, 55–67. doi:10.1207/s15327027hc0601_4

Mangai, A. (1998). Cultural intervention through theatre: case study of a play on female infanticide/foeticide. *Econ. Polit. Wkly.* 33, WS70–WS72.

Marmot, M. (2005). Social determinants of health inequalities. *Lancet* 365, 1099–1104. doi:10.1016/S0140-6736(05)74234-3

Mayer, K. H., Bradford, J. B., Makadon, H. J., Stall, R., Goldhammer, H., and Landers, S. (2008). Sexual and gender minority health: what we know and what

needs to be done. *Am. J. Public Health* 98, 989–995. doi:10.2105/AJPH.2007.127811

McMichael, A. J., Powles, J. W., Butler, C. D., and Uauy, R. (2007). Food, livestock production, energy, climate change, and health. *Lancet* 370, 1253–1263. doi:10.1016/S0140-6736(07)61256-2

Merzel, C., and D'afflitti, J. (2003). Reconsidering community-based health promotion: promise, performance, and potential. *Am. J. Public Health* 93, 557–574. doi:10.2105/AJPH.93.4.557

Mies, M., and Shiva, V. (1993). *Ecofeminism*. New Delhi: Zed Books.

Napier, A. D., Ancarno, C., Butler, B., Calabrese, J., Chater, A., Chatterjee, H., et al. (2014). Culture and health. *Lancet* 384, 1607–1639. doi:10.1016/S0140-6736(14)61603-2

Navarro, V. (ed.) (2007). *Neoliberalism, Globalization, and Inequalities: Consequences for Health and Quality of Life*. Amityville, NY: Baywood Pub.

Nayar, K. R. (2007). Social exclusion, caste & health: a review based on the social determinants framework. *Indian J. Med. Res.* 126, 355.

Nnaemeka, O. (2005). *Female Circumcision and the Politics of Knowledge: African Women in Imperialist Discourses*. Westport, CT: Greenwood Publishing Group.

Pan, S. W., and Spittal, P. M. (2013). Health effects of perceived racial and religious bullying among urban adolescents in China: a cross-sectional national study. *Glob. Public Health* 8, 685–697. doi:10.1080/17441692.2013.799218

Petryna, A. (2009). *When Experiments Travel*. Princeton, NJ: Princeton University Press.

Pitaloka, D. (2014). *The (Passive) Violence of Harmony and Balance: Lived Experienced of Javanese Women with Type 2 Diabetes*. Ph.D. thesis, University of Oklahoma, Norman.

Qouta, S., Punamäki, R. L., and El Sarraj, E. (2008). Child development and family mental health in war and military violence: the Palestinian experience. *Int. J. Behav. Dev.* 32, 310–321. doi:10.1177/0165025408090973

Rajan, K. S. (2006). *Biocapital: The Constitution of Postgenomic Life*. Durham, NC: Duke University Press.

Randolph, W., and Viswanath, K. (2004). Lessons learned from public health mass media campaigns: marketing health in a crowded media world. *Annu. Rev. Public Health* 25, 419–437. doi:10.1146/annurev.publhealth.25.101802.123046

Sastry, S. (2016). Long distance truck drivers and the structural context of health: a culture-centered investigation of Indian truckers' health narratives. *Health Commun.* 31, 230–241. doi:10.1080/10410236.2014.947466

Sastry, S., and Dutta, M. J. (2012). Public health, global surveillance, and the "emerging disease" worldview: a postcolonial appraisal of PEPFAR. *Health Commun.* 27, 519–532. doi:10.1080/10410236.2011.616626

Smedley, B. D., Stith, A. Y., and Nelson, A. R. (eds) (2002). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (Full Printed Version)*. Washington, DC: National Academies Press.

Toole, M. J., and Waldman, R. J. (1993). Refugees and displaced persons: war, hunger, and public health. *JAMA* 270, 600–605. doi:10.1001/jama.270.5.600

Wilkin, H. A. (2013). Exploring the potential of communication infrastructure theory for informing efforts to reduce health disparities. *J. Commun.* 63, 181–200. doi:10.1111/jcom.12006

Williams, D. R. (1999). Race, socioeconomic status, and health the added effects of racism and discrimination. *Ann. N. Y. Acad. Sci.* 896, 173–188. doi:10.1111/j.1749-6632.1999.tb08114.x

Conflict of Interest Statement: The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.