Chapter 13

Participatory and cultural challenges for research and practice in health communication

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Arguably, health communication is one of the most dynamic areas in the field of development communication. In fact, it is one of those areas that often seem to receive greater attention from communication researchers and practitioners, a perception that may have been fueled by the emergence of HIV/AIDS and the critical role of communications to combat the epidemic. By the same token, Latin America has made very important contributions to the field of development communications over the years. The indigenous practice of development and health communication in the region often has taken some distance from dominant approaches to the field, primarily those arising out of the developed world. This is especially true when it comes to the emphasis on participatory approaches in development and health communication in Latin America, which often clashes with the more positivistic, strategic approaches developed by researchers and practitioners in the developed world.

In this chapter we attempt to highlight some of the methodological and research challenges that the practice of health communication brings to the field of development communication. We do so by providing an overview of development communication research and practice and the centrality of participatory approaches to health and development communication with a stronger focus in Latin America, followed by a discussion of the evolution of health communication approaches, and the challenges that researchers and practitioners may want take into account in the near future.

The chapter is divided into three sections. Section one will focus on the participatory, critical and cultural roots of communications in Latin America.

This section seeks to provide readers with a historical and conceptual context of the key transformations that have taken place in the region. It discusses the Latin American response to dominant paradigms in development communications and the movement toward participatory, critical and cultural approaches in the study and practice of communications, which have permeated most of the work in development communication in the region.

Section two deals with the emergence and evolution of health communication including a brief discussion about the main approaches that have influenced the practice of health communication. Drawing from key ideas developed in the previous section, the final section of the chapter focuses on some of the immediate and future challenges that development and health communication practitioners and academics must bring into their practice and analysis. In doing so, there is an attempt to connect the main aspects of the development of health communication in Latin America with some of the broader issues discussed in this book on research and methodological issues in development communication.

Participatory, critical and cultural roots of development communication in Latin America

The 1960s brought several social and political developments in Latin America, which had a profound impact on its socioeconomic landscape. In this volatile context the "revolutionary" and liberating work of Paulo Freire in Brazil provided a new and fresh approach to the implementation of adult education programs which, inadvertently, set many of the principles of communication for development and social change. One of Freire's vital assumptions was the critical capacity of the illiterate. He argued that every human being, no matter how uneducated, is capable of looking at his/her world in a critical manner leading to a dialogical encounter with others (Freire, 1986). This led to the notion of "dialogue of knowledge", in which both teacher and student engage in an exchange of knowledge based upon their realities. In Freire's view, literacy programs would not only teach people how to read and write, but also would help people *conscientizize* (consciousness-raising) of and transform their realities.

Also in the 1960s, the U.S. launched several efforts to modernize Latin America and other regions of the world. A great number of U.S. researchers traveled to Latin America to share their developmental model, which had worked very well in the U.S., but eventually failed to produce similar results in Latin America (Beltran, 1976; Diaz-Bordenave, 1976). Television became the dominant medium, which led to the implementation of several media development programs based on Wilbur Schramm's (1964) ideas on *Mass media and national development*. For instance, with underlying notions of powerful media effects, media development programs were carried out in El Salvador to support formal education initiatives. Similar projects were implemented in Africa, and throughout Latin America. However, many of these projects failed due to a lack of understanding of local conditions and cultural practices (Rogers, 1976; 1987).

The concept of dependency theory emerged and quickly gained serious support. First stated by Andre Gunder Frank (1966), dependency theory viewed development and underdevelopment as necessarily inter-connected (Cardoso and Faletto, 1979). One essential idea was that underdevelopment in the Third World was, to a large extent, caused by unequal trade relations necessary for the development of the First World. Theorists aligned with the dependency paradigm argued that "Latin American economic and political development is structured according to the needs of developed industrialized capitalist states" (Fejes, 1986, p. 247; Cardoso and Faletto, 1979).

Communications research in Latin America quickly developed a strong critical approach (Schwarz and Jaramillo, 1986). Luis Ramiro Beltran, a Bolivian communication scholar, became a strong critic of modernization and diffusion of innovation programs. In his seminal article "Alien premises, objects and methods in Latin American communication research", Beltran (1978) discussed the weaknesses of modernization programs. These programs were based on what Everett Rogers (1976), perhaps the most influential scholar on diffusion of innovations, later defined as the old dominant paradigm: top-down approach, big scale projects, focus on economic growth, capital intensive technology, and centralized planning. Efforts were made to use communication as a development tool in the region, which led to the consolidation of a critical stance to external development models. CIESPAL, a training institution created with UNESCO's support, emerged as an alternative to train media and communication professionals increasingly aware of the social needs of the region. However, by 1973 CIESPAL was gradually forced to reshape its orientation. Political developments in the region (i.e., the establishment of military dictatorships in Peru and Chile, and soon in other nations) led to the adoption of new working frameworks.

The non-democratic context emerging in the region and the increasing power garnered by media organizations in Latin American countries became fertile ground for critical approaches to communications, fueled by the thinking of educators (i.e. Freire), social developers (i.e. Diaz Bordenave), and communicators (i.e., Beltran, Mario Kaplun), amongst others. Development communicators throughout the region played a key role in promoting dialogical and participatory approaches to communications and development. Yet, in many cases this type of work was perceived as too critical or even revolutionary at times, given the current sociopolitical situation in most countries. Hence, they often operated from the margins.

The '80s brought new critical elements into the study of Latin American communication research, particularly in the area of cultural studies. Unlike previous approaches, the most distinctive feature of this line of research in Latin America was its less political character. O'Connor (1991: 60) argued that:

> The cultural studies that has emerged from Latin America during the last decade is theoretically sophisticated and subtle. But it seems to lack the explicit Marxism and Feminism of the researchers and activists that emerged in the 1970s.

Two of the most relevant figures are Jesus Martin-Barbero and Nestor Garcia-Canclini. Martin-Barbero's major contribution is his analysis of media, mediation, and popular culture, and how media have transformed concepts of culture in Latin America. He argued that "cultures of urban and rural masses are increasingly products of the mass media" (1993: 18). However, by no means is this viewed as a passive relationship. Rather, in Martin-Barbero's view, people constantly re-elaborate, reinterpret, and transform messages offered by the media. Schlessinger (1993: xii) summarizes Martin-Barbero's thinking:

> What Martin-Barbero contends is that we should shift our attention from forms of analysis concerned with the ownership and control of media structures and with messages conceived as hegemonic ideology to modes of reception in the context of wider social relations.

At the root of Martin-Barbero's reasoning is his definition and understanding of popular culture. Martin-Barbero holds that although common wisdom characterizes popular culture as "a homogeneous subject defined either in positive terms as a pole of resistance, or in negative terms as a product of manipulation, a corrupted version of elite culture" (1993: 18), this dichotomy fails to recognize the social, economic and symbolic dimensions of popular culture. Rather, the relationship between popular culture and media brings with it the concept of mediations, in which culture is constantly resisted, negotiated and contextualized, and yet it is provisional.

Similarly, Nestor Garcia-Canclini's contributions are rooted in the analysis of media and culture. One of his fundamental premises is the concept of culture and subcultures created by the media. Media produce new cultural communities without territories that are difficult to define in conventional cultural terms (1992). Garcia-Canclini criticizes the deductivistic and inductivistic approaches in the analysis of popular culture. Deductivistic approaches impose cultural definitions in structural, macroscopic terms from the outside. By contrast, inductivistic notions view individuals as units of a group or community who are culturally labeled with no options for redefining their world (1988). In both cases, Garcia-Canclini argues, the conflictual interaction that takes place between dominant and dominated groups is ignored. He implies that it is this interaction and the interpretation of it what gives meaning to culture. Also central to Garcia-Canclini's thought are the ideas of everyday life, meaning, and cultural mediations.

While taking somewhat different paths, both Garcia-Canclini and Martin-Barbero incorporated notions of resistance, a permanent construction of popular culture removed from the negative connotations of the past, and the constant process of negotiation and transaction in which groups, regardless of their position in society, engage in everyday life. At the root of Martin-Barbero and Garcia-Canclini's work is the role of media, particularly television. A great deal of these negotiations and resistance take place in the world of mass communications, especially with television, which is seen by many as a homogenizing

tool that attempts to construct a fixed model of culture. Further, both authors have found *telenovelas* to be a critical genre through which audiences engage in a daily struggle of cultural negotiation.

Despite its less political connotations, Martin-Barbero and Garcia-Canclini's work still conveys a critical flavor. Martin-Barbero's and Garcia-Canclini's views have shaped Latin American communication research, and their thinking is often brought into development communication approaches. Their influences are reflected in the value accorded to culture as an entry point in development communication as well as through a number of audience reception studies of telenovelas and other media genres (see Fadul, 1993; McAnany, 1993; Allen, 1995; Tufte, 1995).

In short, the appearance of critical research and cultural studies in Latin America was the result of the convergence of several social and cultural events, coupled with the failure of developmental models that were transferred to Latin America in several areas, including communications. In retrospect, not only do we see a strong critical and culture-based orientation but also a thrust toward participatory communication, a fundamental assumption in Rogers' new development communication paradigm (1976), a concept that was already present in the works of Paulo Freire back in the '50s and '60s. Thus, a critical view, the role of culture, and participatory communication became central to the theory and practice of development communication in the region.

Conceptual approaches to health communication: from information to social change?

Although health communication has been present in the region since the 1960s and '70s, primarily through family planning programs, it only developed as a field at the beginning of the '80s. Hence, only recently have many of these elements rooted in the communication tradition of Latin America been incorporated into the practice of health communication. The Declaration of Alma Ata (1978) was an important conceptual shift from previous visions of health care and prevention –largely dominated by high technology, hospital-based concepts of health care– towards the search for innovative and flexible approaches that paid greater attention to knowledge already possessed by local people. This was a meaningful shift in the power relationship from what was termed "scientific management" (Pfeffer and Coote, 1991) toward health interventions controlled by lay people. According to MacDonald (1992), the spirit of the Alma Ata declaration was mainly underpinned by communitarian values, which aimed to enhance the democratic distribution of power in decision-making in health.

The community development movement emphasized the importance of involving people in their own development, while the state and its welfare institutions and professionals sought to transfer their responsibilities for health care provision to individuals and families (Sanchez, 1994). This strategy of individual responsibility for self-care assumes that the basic cause of an individual's illness or lack of health is the individual him/herself, not the state or the existing social structures.

Therefore the solution must come primarily from the individual and not from structural changes of the economic or social system (Navarro, 1986). Communication strategies in this context have centered not only in exclusively achieving change in behavior but also in achieving effective communication by producing adequate, persuasive messages that respond to the symbolic universe of the target groups without attempting to create a dialogue for change nor a participatory process.

According to the World Health Organization, health communication is the study and use of communication strategies to inform and influence individual and community decisions to improve people's health. This type of communication is recognized as a necessary element in the efforts to improve personal and public health. Similarly, health communication may contribute in all aspects of disease prevention including physician-patient communication, adherence to treatment, and the design, implementation and evaluation of public health communication campaigns.

Health communication is generally conceived as a strategic process aimed at achieving a rational use of health services, and improving the efficiency and effectiveness of programs directed at disease prevention and health promotion. Research has shown that health communication programs based on solid theory may bring health to the forefront of the public agenda, reinforce sanitary messages, stimulate people to seek more and better information, and in some cases lead towards healthier lifestyles. Four key elements of the communication process are typically used in health communication: source, message, channel, and audience, increasingly coupled with social mobilization and participation components and with rigorous research. It is generally agreed that effective programs in health communication identify and prioritize key behaviors, segment audiences, design messages based on scientific evidence and research, and reach audiences through key channels, while mobilizing communities to become involved in this processes (Piotrow et al, 1997; Freimuth, 1992).

Nevertheless, other authors differ in their approach to the role of communication in health, particularly when it comes to issues of target populations and audience needs. Gumucio-Dagron (2001) argues that communication has often been conceived erroneously either as propaganda or as simple diffusion of information. Accordingly, he adds, many governments, international agencies, and NGOs view communication as an opportunity to gain visibility concentrating their work in the use of mass media and in other activities that, for instance, may impact urban areas, but not necessarily those areas most in need.

Health communication has undergone important conceptual changes over the past decades. Table 1 is an attempt to summarize these changes through the identification of the main approaches that have characterized the implementation of health communication and some key characteristics of each approach. While this table is by no means exhaustive nor does it provide the fullness of how health communication has evolved, it does illustrate some of the key transformations that health communication has experienced over the years.

Table 1. Evolution of health communication approaches

Approach	Strategies	Characteristics	Centrality of…
Information and education	Counseling; health education	Extensionist model, top-down communication	Messages, recommendation of behaviors
Information, education, communication (IEC)	Increasing use of mass and interpersonal communication	Greater articulation of interventions and more strategic character; limitations with complex behaviors (i.e. HIV/AIDS)	Media messages and products, educational materials, planning methodologies, KAP research, focus on changing behaviors
Communication for behavior change (CBC)	Increasing use of multiple communication strategies,linkages with social mobilization interventions and health services	Strong use of social and behavioral psychology and communication theories; more research-driven processes	Focus on behaviors (ideal and attainable), barriers and enablers, focus on behavior change at the individual level, efforts to reach measurable impact
Context-based approaches (UNAIDS's HIV/AIDS Framework)	Integration of various communication strategies and media interventions; use of local media	Contextual domains as areas subject to change through communications (government & policy, socio-economic status, culture, gender, spirituality)	Focus on changing context to facilitate individual and collective behavior change
Communication for social change	Social mobilization, community participation, dialogue-based, alternative media	Greater emphasis on empowerment and local ownership	Focus on changing structural dimensions through communication processes, impact at the individual and collective levels, social norms, rights

Three central themes emerge from this table. First, it may be argued that participatory and dialogical elements were, for the most part, absent in the initial approaches to health communication, while the latter two approaches are certainly characterized by issues of culture and participation. Second, while behavior change –whether individual and/or collective– remains the primary goal in the first three approaches and it is certainly present in the latter two approaches, the way to reach this type of change is what distances each of these approaches as it is explained in the next paragraphs.

Third, IEC and CBC approaches are characterized by two central features: they aim directly at the notion of generating behavior change on individuals, and lately on collectivities; and they are essentially message-centered and rely on the critical role played by carefully designed messages and communication strategies that will eventually lead to behavior change. For instance, IEC focuses on communication activities aimed at preventing disease and at promot-

ing health by strengthening people's capacity to act on their own health and development. Thus, IEC seeks to improve people's knowledge about health issues and to stimulate attitudinal and behavior change through a set of integrated communication strategies. IEC starts with the assessment of people's needs followed by the identification of key communication mechanisms and messages that may lead to changes in behavior and to improvements in the health of the population.

In Communication for Behavior Change (CBC), multiple theories and concepts have been taken from other disciplines (i.e. social psychology) or elaborated to understand why individuals behave in a certain manner with respect to their health, how and when they may use health services, their acquisition of health-related habits, modification of knowledge and attitudes, and ultimately health behaviors. Most variables considered in CBC are derived from a set of widely used psychological theories that have had a strong influence in health communication research such as the health belief model, the theory of reasoned action, and social learning theory. However, there is increasing consensus on the number of contextual variables that need to be considered when predicting or understanding human behaviors.

On the other hand, contextual approaches and communication for social change frameworks take a different route. In essence, both approaches recognize the need to generate change in the contextual and social dimensions of health through communication and other elements as changes on these variables will eventually facilitate and lead to changes in people's behaviors. The UNAIDS' HIV/AIDS communication framework developed out of the growing concern for the perceived lack of effectiveness of existing strategies in containing and/or curbing the HIV/AIDS epidemic. It is stated:

> Seeking to influence behavior alone is insufficient if the underlying social factors that shape the behavior remain unchallenged. Many communications and health promotion programs proceed on the assumption that behavior, alone, needs to be changed, when, in reality, such change is unlikely to be sustainable without incurring in some minimum social change. This necessitates attention to social environmental contexts (UNAIDS, 1999: 15).

The framework called for greater attention to five contextual domains (policy, government, gender, culture, socio-economic, spirituality) that play a central role in determining people's behaviors. Thus, it was argued, there was a need for a greater focus of communication strategies on these domains as a way to generate change in people's behaviors in the context of HIV/AIDS (Airhihenbuwa, Makinwa and Obregon, 2000). For instance, it is generally agreed that condom promotion alone is not sufficient to curb the epidemic and that a shift in the balance of power relations in gender relations is critical to ensure women's empowerment to negotiate condom use.

Lastly, Communication for Social Change (CFSC) focuses on the larger notion of social development and on the role that communication may play in generating change. It calls for greater participation and control of communities over communication processes and it highlights the need to allow community voices to be heard and become the leading voices of processes of change (Rockefeller Foundation, 1999). The CFSC model describes a process in which "community dialogue" and "collective action" come together to produce social change in a particular social environment to improve the well being, i.e., health, of its members. Social change implies the participation of the community in all processes concerned with the planning, implementation and evaluation of development and health programs[1].

In short, from a historical perspective, there has been a significant shift in health communication thinking, at least conceptually, from approaches mainly centered on effects, individual behavior change, and biomedical thinking, towards an approach in which active participation of people directly affected by the problems as well as culture and social relations are now key references for the design, implementation and evaluation of health communication programs. While IEC and CBC-based projects and initiatives have been implemented widely throughout the world yielding mixed results –depending on the type of health issue at hand (i.e., vaccination and family planning, very successful; HIV/AIDS, little success), the UNAIDS' communication framework and the CFSC model still are in the process of being further operationalized and implemented on different scales in order to provide specific examples and evidence of their application.

However, given their focus on issues of participation, empowerment, dialogue, and culture, these two approaches, the UNAIDS' framework and CFSC, clearly resonate with the background of development communication in Latin America. Similarly, given the increasing attention to issues of culture and participation, models focused on CBC have moved toward hybrid models (Sood, Menard and Witte, 2004). As these approaches are progressively used in health communication with an increasingly central role being played by issues of participation and culture, they bring up a host of methodological and research challenges that are addressed below.

Challenges for the research and practice of health communication

Never before had the work of Paulo Freire been given so much attention in the Western development communication literature as it has been the case over the past five years (i.e., Tufte, 2004; Tufte, 2004a; Singhal, 2004; Richards, Thomas, and Nain, 2001; Servaes, 2001). By the same token, the focus on participation and culture brings up important questions related to issues of planning, evidence, meas-

1 See Gumucio, A. (2001), *Making Waves: Stories of Participatory Communication*, for an anthology of community-based, participatory communication projects around the world.

urements, impact, and indicators amongst other issues. For instance, as Nancy Morris, whose full article appears on this volume, puts it referring to outcomes and evaluation of processes, "the task is complex, in part because of the lack of accepted definitions of community, empowerment, or participation" (2003: 232).

Arguably, the practice of health communication in the region has reflected some sort of co-existence of different models and approaches –IEC, CBC, participatory approaches–, and there is certainly a long way to be covered with regards to the role of participation and culture in health communication. Below we briefly discuss some of the issues that health and development communication practitioners and researchers should consider in the context of participation and culture in health communication.

Issues of participatory planning and evaluation

According to Gumucio (2001), to speak of *planning* in health communication one may compare health programs and communication programs. Assessment, planning, and implementation tend to be vertical, one-way processes. On one side are the organizations and systems that generate preventive or corrective actions, while on the other extreme are the recipients, receptors of these actions. In health communication planning one may frequently find very vertical approaches wherein there is a primary source of decision-making or message-generation, with a receiver who appears to be quite passive. Yet, participatory approaches are increasingly gaining terrain in a new pluralistic socio-economic paradigm, wherein communities must be active protagonists of the changes that affect them directly. If this is so, Gumucio affirms, they should also be responsible for their health, hence their own communication and planning. This participatory planning approach facilitates the process of problem identification, search for solutions, commitment to reach the defined goals, and, more importantly, to assume a monitoring role. As health communication planning incorporates more and more participation and culture as central elements, communities will demand greater control of processes or greater efforts for consensus building, an aspect health communicators must be prepared to deal with.

A second challenge that requires careful analysis is the integration of heavily participatory processes with the required evidence-based data in the health sector. How could evaluation of participatory communication processes contribute to the identification of specific contributions of communication to changes in society and health? The importance of *evidence* in health communication practice and research should be seen in the larger context of discussions on evidence-based medicine taking place throughout the world[2]. Evidence-based approaches in health can be described as health policy and health care delivery driven by systematically collected proof on the effects of health-related interven-

2 For a more detailed discussion see Brownson, R.C., Baker, E.A., Leet, T.L., Gillespie, K.N. (2003) *Evidence-based public health*, Oxford University Press.

tions from the social and health sciences (Speller et al, 1997). During the 1990s, debates on evidence-based medicine have influenced the national and international agendas for health policy and health research. While the debate stems from a fundamental concern with medical and public health practice, it cannot be dismissed as pertinent only to medicine. Health communication is also challenged by this debate. In the industrialized world, health communication practitioners and researchers are urged to base their work on evidence, typically using a full range of quantitative methodologies.

Over the past two decades the focus on reducing disease and behavioural risk factors has placed an overemphasis on the role of health communication in addressing lifestyles, focusing its attention on assessing individual health outcomes in connection with behavioural impact. In attempting to support evidence-based health communication, it is important to understand the underlying values, ideas and interests that are behind how evidence is produced, defined, operationalised, and measured. Therefore, the analysis of evaluation processes has great relevance, starting from the selection process to define the nature of indicators that evaluate the success of an intervention.

In public health and medical practice, wherein the concept of evidence-based is borrowed, evidence is usually produced through highly quantitative randomized trials. Evaluation criteria usually include the use of controls and measurements before and after the intervention. One of the fundamental problems in using randomised controlled trials in health communication research is that where interventions aim to influence populations it may be difficult to randomly allocate units of analysis in social settings, thus quasi-experimental control designs are commonly used. According to Speller et al (1997), one of the major problems with studies employing quasi-experimental design is the "contamination" of the control group. This poses a serious dilemma as the practice of public health relies on that data. The issue here is to assert whether or not the intervention produces a health gain in the experimental group or whether that health gain is produced by cultural factors. This cannot be determined by looking at outcome measures alone. Qualitative research can make significant contributions to assessing the effectiveness of interventions by revealing processes, exploring cultural and social diversity, and developing new approaches. It includes a broad range of methods such as case study, ethnography, participatory action research, participant observation and grounded theory.

Therefore, it is important to ask about the scope and purpose of health communication: is it to change lifestyles, as in the case of communication for behaviour change? Or is it to help people overcome social conditions that affect their health, as posed by the UNAIDS framework and CFSC? The implicit value in each of these questions will guide the type of evidence that may be gathered. A health communication process strongly influenced by a biomedical focus is guided to change high risk attitudes and behaviours on individuals; a health communication focus on social change promotes the participation of people,

organisations, and communities towards the goals of increased individual and community control over the determinants of health and disease. The central question of evaluation, therefore, is not simply *does it work?*, but *how does it work, for whom, and in what circumstances?* According to Fetterman (2001), the purpose of the evaluation for empowerment is to understand what is happening in a certain situation, from the perspective of the participants, so much as from the perspective of health personnel and policy makers.

The increasing *integration of qualitative and quantitative methods* to assess impact of interventions constitutes another challenge in health communication. However, social scientists that rely on qualitative approaches face issues of external validity and replicability as international organizations tend to privilege quantitative over qualitative research as a the primary data to assess impact. While qualitative research plays an important role in formative research to inform project design and implementation, the same qualitative methods do not have equal weight when it comes to research for impact evaluation. Health communication practitioners and academics need to explore ways to bring qualitative research into the mix of methods to evaluate impact of interventions. For instance, the Soul City Project, an entertainment-education based health communication intervention in South Africa, has developed a methodological approach that integrates qualitative and quantitative data to assess impact.

Cultural issues

> *"The concept of culture highlights the general potential for human beings to learn through social means, such as interaction with others and through the products of culture"*

Challenges related to culture may be wide-ranging. However, two issues stand up, particularly in connection with the importance ascribed to culture in the communication context and tradition of Latin America. First, the possibility of looking at culture as an entry point for health communication interventions as opposed to exclusively relying on epidemiological and behavioral objectives as points of departure. This aspect is discussed below as interculturality. Second, the need to look at reception studies as an option for the evaluation of media components of health communication interventions, particularly interventions that use entertainment-education vehicles such as drama.

Interculturality starts with the acknowledgement that diverse belief systems related to health, healing and wellness exist, and that the perception of illness and disease and their causes varies by culture. Interculturality implies work on a set of community practices in which meanings relating to habits, behaviours and attitudes are produced, including those that intervene in the social production of health and disease. This approach to communications processes begins with the recognition of the multiple mediations, actors and discourses that take part in the construction of meaning and are built and developed in each community.

Thus, culture becomes the essential element to work with in the context of health. An example of this approach is found in a participatory health communication project undertaken in Malambo, a suburban community in Colombia's Atlantic Coast. Instead of focusing immediately on the epidemiological indicators related to youth and sexual and reproductive health, using elements from Martin-Barbero's thinking, the project has focused on the relationship between sexuality and culture, working on three areas: ways and spaces of socialization and construction of a sexuality environment, language and symbolic codes through which sexuality is expressed, and how youth approach their sexual health. Through a participatory process, youth have defined their own goals and communication strategies, and through a heavily reflective process that has been facilitated by the use of various communication strategies –radio shows, radio dramas, community activities, interaction with other community members– it is expected that important changes in gender and sexual practices will take place (Vega and Suarez, 2003; Suarez, Mendivil and Vega, 2004).

Dramas –whether radio, TV, theater– have turned into a fundamental component of many health communication interventions. The entertainment-education strategy, which makes systematic use of entertainment media to educate and generate behavior change is based on various theories, particularly on Albert Bandura's social learning theory and the power of role modeling to help people see themselves through the content of drama and reflect upon their own lives to eventually adopt certain healthy behaviors. However, the development of cultural studies in Latin America has led to a very rich body of knowledge, particularly through reception studies of television that have analyzed how people make sense of the content of TV dramas often negotiating, resisting, and reassigning meaning to media content.

Although the various audience's readings of media texts in the context of entertainment-education have been noted in the past (Singhal, 1999), health communication research has, for the most part, ignored the potential of reception studies as an alternative to analyze how audiences make sense of health communication messages (Tufte, 2004). Most evaluations are fixed on determining whether a particular message has led to a change in attitude or to a self-reported behavior. Reception studies pay special attention to how people relate to messages and to how they incorporate those messages to their daily life, a process that does not follow a linear pattern. Thus, health communication may benefit tremendously from the possibilities of analysis that reception studies offer. Thomas Tufte has made one of the few efforts that attempt to analyze young people's experiences in the context of health communication interventions from an audience perspective. In his preliminary analysis about his ethnographic work in South Africa, Tufte begins to uncover various issues such as identity, stigma, and denial, which may not come to light using a behavior change perspective.

Filling these gaps in health communication research and practice will require a rich and ongoing dialogue of practitioners and academics over the next

 years. Some of the steps that may be taken in that direction may include: to build a joint basis for the collection of data about successful experiences with a focus on communication, participation and culture; advance processes of training in search of technical excellence in participatory planning in health communication; identify key elements for the sustainability of health communication programs and their institutionalization; and galvanize greater dialogue and exchange of experiences between South and North through various scenarios with the participation of health communication professionals. In fairness, this closing discussion has raised more questions and challenges than answers or alternatives. However, it is our hope that by raising them we may contribute to further analysis that will eventually lead to new responses and a more robust field of development and health communication.