

Why health communication is important in public health

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For the first time, health communication was allocated a chapter in the United States of America (USA)'s Healthy People 2010 objectives, illustrating its growing importance, according to Parrott.¹ In these objectives, set by the United States Department of Health and Human Services, health communication is seen to have relevance for virtually every aspect of health and well-being, including disease prevention, health promotion and quality of life. This increase in the prominence of the field, externally, is happening contemporaneously with important developments taking place, internally, one of which is the focus on the study of environmental, social and psychological influences on behaviour and health. Given the global challenges posed by major threats, health communication scholars and practitioners recognize the importance of prevention and, with it, the need to understand human behaviour through the prism of theory. This has given rise to theorizing about the role of risk perceptions,^{2,3} social norms,^{4,5} emotions^{6,7} and uncertainty⁸ in health behaviours.

Communication is at the heart of who we are as human beings. It is our way of exchanging information; it also signifies our symbolic capability. These two functions reflect what James Carey characterized as the *transmission* and *ritual* views of communication, respectively.⁹ Carey recognized that communication serves an instrumental role (e.g. it helps one acquire knowledge) but it also fulfils a ritualistic function, one that reflects humans as members of a social community. Thus, communication can be defined as the symbolic exchange of shared meaning, and all communicative acts have both a transmission and a ritualistic component.

Intervention efforts to change behaviours are communicative acts. By focusing mostly on the transmission function of information exchange, such efforts often neglect ritualistic processes that are automatically engaged through communication. In adopting the transmission view of communication, it is reasonable to think carefully about the

channels through which intervention messages are disseminated, to whom the message is attributed, how audience members respond and the features of messages that have the greatest impact. These considerations reflect the essential components of the communication process: channel, source, receiver and message, respectively. In the ritual view, however, target audiences are conceptualized as members of social networks who interact with one another, engage in social ceremony and derive meaning from the enactment of habitual behaviours.

Three important intervention considerations emerge from this dual view of communication. First is the realization that communication interventions do not fall into a social vacuum. Rather, information is received and processed through individual and social prisms that not only determine what people encounter (through processes of selective exposure), but also the meaning that they derive from the communication (known as selective perception), depending upon factors at both the individual (prior experience, efficacy beliefs, knowledge, etc.) and the macro-social (interpersonal relationships, cultural patterns, social norms) levels.

Second, it is reasonable to expect discrepancies between messages disseminated and received. They arise not only due to differential exposure to the intervention but also because of the differences in interpretation in decoding information. A careful study of the correspondence between messages as they are sent and received is thus of great importance to avoid unintended (and worse, counterproductive) effects.¹⁰

Third, communication is a dynamic process in which sources and receivers of information continuously interchange their roles. One of the central tenets of health communication interventions – the need to conduct extensive formative evaluation, audience needs assessment and message pretesting – is the direct offshoot of this understanding.

Use of these health communication principles in public health presents

challenges. First, the evaluation of communication interventions, especially those using national mass media (e.g. radio), does not usually lend itself to randomized trials. Hence, innovative methodological and statistical techniques are required for attributing observed outcomes to intervention efforts. The responsive and transactional nature of health communication interventions also means that modification in intervention content may occur, adding an additional challenge to the evaluation process. Second, the recognition among behavioural scientists – that causes of human behaviour reside at multiple levels that reinforce each other – poses difficulties in designing and testing multilevel interventions. This complexity of health behaviour determinants also requires a multidisciplinary approach for effectively promoting change, which further means that interventions need to incorporate expertise from a variety of professional backgrounds. Finally, because of the rapidly changing communication channels, health communication interventions need to make extra efforts to meet their audiences at their level of technology use.

Health communication has much to celebrate and contribute. The field is gaining recognition in part because of its emphasis on combining theory and practice in understanding communication processes and changing human behaviour. This approach is pertinent at a time when many of the threats to global public health (through diseases and environmental calamities) are rooted in human behaviour. By bringing together researchers and practitioners from diverse disciplines and adopting multilevel theoretical approaches, health communicators have a unique opportunity to provide meaningful input in improving and saving lives. We are optimistic.

[Editor's note: Read more about health communication in the upcoming special theme issue of the *Bulletin* in August 2009.] ■

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