

Communication for Health and Healthy Lifestyles: Food for Thought from a Collective Health Perspective¹.

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ABSTRACT

This study discusses the need for a complex perspective regarding health communication, in order to go beyond an instrumental view of its conception and implementation. In particular, through analyzing the focus of communication directed towards behavioral change that promotes healthy lifestyles, it was proposed to extend the way in which health communication is conceived, starting from setting the problem. This would integrate some analytical strands that would make it possible to account for the many aspects and contradictions of the health communication process.

Keywords: Health communication. Public health. Theoretical object. Problem area.

Introduction

In this work we put forward some issues to enrich the debate around Health Communication as a theoretical object. Our goal is to contribute to its theoretical (re)construction in the context of Latin American collective health.

¹This paper results from a preliminary reflection in the communication and health research line, in the context of the research project "Communication in Health: Towards a Reconstruction from the Collective Health Perspective. (Rojas-Rajs, 2013).

To such end, we propose that it is useful to conceive the boundary between communication and health as a problematic field in Zemelman's sense (1987), to broaden the multiplicity of problems deriving from a more complex onlook as well as the conceptual and methodological framework used in the approach to the construction of knowledge and actual experiences in communication and health.

Health communication or communication for health constitutes a field that is still being developed. Health communication is a relatively young field, only starting to have some momentum in the 80s. In recent years the field has been validated in the academic community (Silva, 2001; Alcalay, 1999). There is an increasing number of departmental areas, specialization programs and research projects dealing with communication and health in educational institutions, and there is a number of scientific publications on the subject. Nonetheless, one can see some consensus around the need to increase and go deeper into health communication knowledge. According to some authors, knowledge is still limited on the results of health communication strategies and their evaluation processes (Martínez, 2004; Salazar, Vélez, 2004; Silva, 2001; Alcalay, 1999). Other authors say that methodologies and approaches to the analysis of health communication phenomena constitute a field that needs further development (Conde, Pérez Andrés, 1995). The need has also been put forward to review more broadly the actual experiences in health communication, and also the various problems associated with its dialogic and participative character, as well as with the recuperation of the perspectives and walks of life of communication receivers, which –ideally– should be part of any effective communication process (Beltrán, 2010; Gumucio-Dagron, 2010; Tufté, 2007). Besides these considerations, focusing mainly on the instrumental level of interventions, it is possible to identify problematic knots on a more general level, concerning the analysis of health communication theoretical foundations (Tufté, 2007). The present study proposal is to analyze the foundations of the hegemonic² model in health communication: Health Communication (HC) from the United States, as described by Schiavo (2007), or what we could call health communication for behavior change, which informs today's institutional communication on healthy lifestyles in most countries of Latin America and the world at large. Since the mid 80s and especially since the 90s health communication has held an important role in the promotion of “risk behavior” change, being claimed to be effective in the promotion of healthy lifestyles (Coe, 1998). It was promoted and supported by the World Bank (1993), the Pan

² In the sense used by Breilh when he recovers this Gramscian category: a type of dominance not effected simply by force, but rather through moral and intellectual leadership, and characterized by establishing alliances where “the hegemonic and the subaltern contract each other's services” (2003, p.173). Thus, dominance can not be pictured as vertical relationships because it implies mutual exchanges and conditioning that are not one-way. Breilh notes that in hegemonic action, some needs of the dominated being provided for, they find some utility in it which strengthens its legitimation.

American Health Organization (OPS, 1997, 1996a), and the World Health Organization (OMS, 1998, 1996).

This study addresses two central questions: what are some of the debates around HC?; and from what theoretical categories and perspective is it possible to address health communication, with a view to consider its reconstruction as a theoretical object in the collective health context?

The interest of (re)constructing the health communication object in the collective health context stems from the recognition of communication as a field of knowledge and intervention (Jarillo, López, 2007) which can bring about transformations that improve public health. Yet, in the absence of an outlook recovering the complexity of social determination processes it can also reproduce the state of affairs, especially health inequalities. For instance, by constituting a sole intervention if it is considered that just possessing information people can make different decisions on health and lifestyle. Therefore, it is a matter of devising communication approaches from a health knowledge perspective that assumes its dependence on social determination processes and on social response to health issues in terms of practices and policies; and further to that, one that seeks other transformations and solutions than the hegemonic. This is why this study does not take a neutral stance, since it involves a certain concept of health, of its social determination processes, and of its social-historical character; thus we seek to enrich the debate around what health communication is today, and what it should be.

Health Communications for behavior change: some debates.

Nowadays communication is a component of health systems and part of prevention and health promotion actions. The World Health Organization (1998) regards communication as a key strategy to inform the population on health related issues and to keep relevant health issues on the public agenda. As a part of the health care services it is unthinkable that they would do without it (Alcalay, 1999) and communicators consider that no health program aimed at large sectors of society can be conceived without communication (Gumucio-Dagron, 2004).

Nonetheless, health communication or communication for health is a broad concept to allude to numerous communication practices at different social and relational levels. Thus, it can be used to refer to the use of mass communication media and other technologies to disseminate, propose and/or promote health contents and information, as well as refer to the various manners of communication carried out by health workers in their professional or training activities, or to communication about health of various social players. To talk about communication for health means to refer to a field that can not be simplified in its complexity. This is so because of interwoven issues and problems in different health visions and positions, intersecting problematized debates on communication characteristics, functions and effects on social life, as well as on its reach as an intervention.

The scope of this work can be narrowed down to health communication involved with behavior change of individuals, because of the impact it has had on overall health communication practices. Schiavo (2007) suggests to use the expression “Health Communication” as it refers to a conceptualization of communication and its practice differing from health promotion and Latin American “communication for social change” that appeared in the 70s, and recovering the “social communication” model initially promoted by WHO, PAHO, and other multinational organizations such as the World Bank, which focused on communication to influence individual behaviors, with an impact on health. We can consider that nowadays HC constitutes an hegemonic model of communication for health, with specific institutions and programs in the national health systems of the United States, Canada, and United Kingdom, among other countries. HC is also the basis of communication for health proposals for Latin America and one of its central goals is to promote healthy lifestyles.

There is not a sole HC definition and it is possible to find numerous technical and instrumental definitions³. PAHO defines it as “a process to present and assess persuasive educational information, interesting and attractive, that results in healthy individual and social behaviors” (Coe, 1998, p.26). Other authors describe it as the use of communication techniques and technologies to inform and influence positively individual and collective decisions affecting health (Mailbach, Holtgrave, 1995). These definitions are broad and not only do they include in “behavior change” actions such as an increased use of health services, the acceptance and compliance of treatments (like supervised antiretroviral), or social participation in early detection programs (e.g. cervical cancer); they also refer to modifying how people live their daily lives, including particularly the concept of healthy lifestyles, which dates back to 1974 with the Lalonde Report proposal in Canada, on the four determinants of health (Lalonde, 1996). This report contributed the notion of lifestyle as the most relevant factor in both preserving and damaging health (over biological, environmental and health care factors), asserting that lifestyles are out of health care control and depend on people’s choices. The idea of health depending mainly on individual decisions, therefore being an individual responsibility, became a dominant idea especially since the 90s, when it was backed by the World Bank (1993), PAHO (1997, 1996a, 1996b), and WHO (OMS, 1998, 1996). It is worth remarking that such an idea is consistent with the neoliberalization process of social life whereby individuals jump to the leading role in social events, while the responsibility of communities and the State to provide or steer social solutions gets diluted (López y Blanco, 2007).

³ A great deal of HC available texts in scientific databases for December 2010 are technical or instrumental, reviews of specific communication experiences, or communication actions assessments. Overall there is little explicit theoretical development compared with instrumental literature. (Review of scientific publications of 2010 in PubMed.)

The critical debate on healthy lifestyles has already received considerable input from collective health (see: Cerda, 2010; Benach, Muntaner, 2008; Carvalho, 2008; Possas y Testa, in De Almeida Filho, 2000; Menéndez, 1998) and the questions raised are many. For instance, there is a discussion as to whether a real capability exists to make a choice on any of those factors determining human health. It has also been claimed that social circumstances of individuals are overlooked, as if it all depended on personal options, not driven by cultural and social events. Or else, it has been argued that healthy lifestyles represent a limited perspective on health social determinants, as it reduces subjects to individuality and unitarity (De Almeida Filho, 2000), abstracted from their historical context and independent from life conditions and situations.

These and other criticisms regarding the real possibilities of individuals to make “healthy” decisions have not impacted much on the general view of health communication so it would focus on behavior change. Considering in what terms some debates take place around the health communication perspective, one can notice that criticisms revolve around the effectiveness of communication interventions. For instance, it has been remarked that conditions and behaviors identified as risky are not modified by merely having information or receiving attractive advice on the need of change and how to do it (Martínez, 2007). It is hard to see a direct and measurable relationship between the decrease of illness indicators and communication efforts to promote healthy lifestyles, and assessing results is one of the obscurest parts in health communication. Other remarks regard communication limitations, especially when impossible or unfeasible changes are advised in the face of actual life conditions of people, for cultural or ideological reasons (Beltrán, 2010). This author though, does not go deep into the structural factors giving rise to such “communication obstacles”, but rather puts forward alternatives to get around them (like avoiding certain messages, media, or formats) without attacking them.

In communication about healthy lifestyles, ambivalence at least can be noted: the WHO deems that in future there will be an increase of health problems such as chronic degenerative diseases and obesity, addictions, HIV-AIDS, and sexually transmitted diseases, independently of subjects behavior, and more related with present social evolution, while research and implementation experience in health communication for behavior change identifies behavior as a crucial factor in the development of those diseases. In last century’s 90s a good deal of textbooks on health communication stressed its potential to trigger behavior changes, but twenty years later positive results are not clear. In the last decade some authors tried to explain the “failure” of healthy lifestyles communication and the permanence of unhealthy behaviors. It has even been considered whether health communication as a discipline has gone into crisis (Tufté, 2007).

Nevertheless, although various authors point to problems in health communication practice, their solutions do not differ fundamentally in the

conceptualization of either communication models, neither health, but rather constitute instrumental views in connection with interventions effectiveness and focus on what to do and what not, but not on how to conceive health communication. Thus, they keep interpreting and perpetuating the notion of health communication as the promotion of behavioral changes in individuals. Most debates leave it at that. For example, relative to the problem of limited results of communication in areas such as prevention and lifestyles, Alcalay (1999) suggests that it could be solved if health professionals developed communication skills, since they may have scientific knowledge on healthy habits and conducts, but they do not know necessarily how to communicate effectively this information so it can be used by the society; i.e. communication is thought of as information. In the same vein, Martínez (2007) points to the need to adjust communication so it achieves a “bigger impact” and suggests a more aggressive communication of health risks and damages, more dissuasive than persuasive. Both authors consider that the problem lies more in methods, techniques, and ways of communication. Silva (2001), when characterizing the functions and goals of communication practices, reduces the problems to a matter of reach and dissemination, information transmittal, technical effectiveness of execution, and audience segmentation strategy or effectiveness of interventions. Thus, their interpretation of communication is more strategic than conceptual, more technical than theoretical, and it refers to instrumentation: messages, media, formats, channels, strategies, as if they were issues independent of health problematizations in its social dimension. As a general trait in the approach of authors such as those just mentioned, the problematization of social determination processes in health (Breilh, 2003; De Almeida Filho, 2000) or the social character of health-illness processes (Laurell, 1982) are absent from their analysis and their proposals of communication strategy improvements.

On the other hand, in the rich Latin American tradition of alternative communication models development and conceptualization (Cuberli, 2008), and particularly of participative communication, it is worth to highlight the value and the contribution of many experiences of health communication specific applications, which have produced definite changes in the health of social collectivities, such as various socially based projects in Bolivia (Gumucio-Dagron, 2010). In a great deal of participative experiences communication has achieved to mediate social action (Del Valle, 2007). From the development of communication in Latin American thought one must note the important theoretical contributions to the conception of the dialogic character of communication processes, the recognition of the capacity for action and change of subjects in communication, and the view that a permanent connection exists between society and communication given that it is impossible to exist or be transformed without communication (Beltrán, 2010). This has allowed the development of more conceptual proposals concerning the acknowledgement of addressees in communication and the identification of problems in the source-message-receiver model, an old problematic knot in

communication theories. The interest in a greater and better understanding of culture (interculturality), identity, interests, perspectives, and affective questions of the “publics”, has been pointed out as a possible way to improve health communication effectiveness.

Nonetheless, assimilating the concepts of “interculturality” and “dialogue” without surpassing the instrumental approach can also be limited. For instance, when one only seeks to speak the same language of the addressees to be persuasive (Tufté, 2007; Martínez, 2004), without an in-depth consideration of the various social factors that influence health problems. Latin American communicators such as Beltrán (2010) or Del Valle (2007) have brought up the need to comprehend audiences, their psychology and life conditions, but rather in the sense of optimizing persuasion and conviction, not as a critical formulation of communication models applied in the field of health or life conditions themselves. For example, there are few critiques of models such as social marketing, which specifically propose that health (healthy behavior) is a product that needs to be sold, thus reducing the exercise of communication to a set of persuasion and sales technical skills without even considering that in the market logic most people of the world do not have a free choice as consumers⁴. It is not that the notion does not exist among communicators that health is also a social affair, but this situation is not considered an issue relating to communication, which is why there is a tendency to think of determinants as immutable conditions or something whose transformation is independent of health communication exercise. Now, if such social determination is historical and therefore may be transformed, health communication can play a role in said transformation. This is why it is considered that approaching health communication as a theoretical object from the perspectives of Latin American collective health and social medicine contributes to enrich its development and to its reinforcing.

The Health Communication object from a collective health perspective: a preliminary proposal of problematic axes and analytical categories

⁴ The same way as one can question individuals’ autonomy and capacity for choice to adopt healthy lifestyles, it is also possible to question whether communication practice aiming at behavior change is a matter of choice for Latin America and the Caribbean. Coe (1998) remarks that during the 90s, 80% of World Bank loans in the health sphere included funds for health communication. Or else, that health and nutrition financial help from the United States Agency for International Development (USAID) to Latin America and the Caribbean earmarked for communication was estimated to amount to roughly 20 million dollars towards the end of the 90s. If health communication for behavior change is an appraisal element to attract resources and financial support, it can be considered to influence the type of communication used by health institutions, i.e. the social response in health care in that domain.

To start from the notion that human health is socially determined implies an acknowledgement of its sociohistorical character. That is to say, an understanding of the social and historical context as inherent to any conception of reality and human problems (Zemelman, 1987). Zemelman holds that the construction of a problematic field, such as health communication theory and praxis, involves epistemological and ontological problems: the point is not **what** to think about some particular issue, but rather **how** to think of the reality that said issue belongs to. Thus, to make a theoretical proposal on health communication from a collective health perspective requires a different approach than the analytical categories that underlie current debates on HC. Four discussion axes and some categories have been identified as point of departure, which need further discussion or even be reconsidered. The first two axes are relative to the conception of health. The third is relative to the conception of communication. And the last tackles the conception of health communication subjects (Table 1).

Table 1. Matrix for Health Communication analysis

	Problematic axis	Analytical categories
Conception of Health	Individual/Social	Conduct Equity
Conception of communication	Direct causality/Social determination processes Causal functionality/Functionality relationships	Risk Complex totality Health needs Function Effectiveness Disciplinary function (normalization, power)
Conception of communication addressees	Subject perspective	Individual/Collective Clients and consumers Passive/active receivers Audiences and publics Healthy lifestyles

The first analytical axis refers to the conception of health and “healthy” lifestyles, in their individual and social dimensions. Some authors such as Schiavo (2007) and Mosquera (2002), who review the theories that have contributed to the conformation of HC, underline the contribution to the definition of communication praxis of theories such as reasoned action, social cognitive or social learning action, the foundations of social marketing and

innovation dissemination models, persuasive communication, health beliefs, the theory of world conception, and various contributions from behavioral sciences, health education, anthropology and sociology. In this theoretical group that underlies HC one can identify at least the first five as having a point of departure in the conception of people's action in its individual dimension, above any collective or social considerations, and stressing the possibility to make decisions out of free will, as if free will were a preexisting natural condition of individuals. In contrast, from the collective health perspective, the social context is an analysis level with more explanatory power of phenomena, subordinating the individual dimension, though not ignoring it. It is in this sense that the conduct category and its conception as an individual or social result ask for rethinking. As well as the concept of equity, questioning the notion of free will in conduct, since in inequitable societies individual decisions are influenced by differing degrees of freedom (Breilh, 2003).

The second axis lies in the problem of linear or direct causality versus the multicausal and multidimensional conception of health issues. In collective health the perspective of social health determination processes is proposed, or what could be named a complex and holistic comprehension of these phenomena, where a suitable approach is that of a dialectical vision of health (Samaja, 2004; Minayo, 2003). The first perspective, in which HC is rooted, conforms to the hegemonic biomedical vision⁵, which identifies the direct causes or etiology of diseases, disconnected from their social dimension. This approach can be recognized in the current contents of health communication on healthy lifestyles, built on the idea that health depends on the avoidance of destructive factors (risks) and the adherence to protective factors. But if we understand health as a social process (Laurell, 1982) resulting from complex interactions between biology, economy, culture, politics, and history, the notion of direct causality is then limited and the concept of risk asks for some thinking that links these dimensions together⁶. In view of this, an alternative that aims at the reconstruction of the health-disease object is to understand health communication processes and shape their exercise and practice as interventions, in a broader, more comprehensive perspective. To this end, the dialectical concept of complex totality discussed by Samaja (2004) comes in useful, when the author mentions the importance of understanding health phenomena and

⁵ Menéndez (2004) synthesizes the characteristics of his hegemonic biomedical model proposal: biologicism, ahistoricity, individualism, pragmatic efficacy, curative orientation, asymmetric and subordinate patient-physician relationship, patient knowledge exclusion, tendency to medicalization of problems, and ideological identification with hegemonic scientific rationality.

⁶ The limitations of the risk concept are also dealt with in a rich discussion from a collective health standpoint, which debates the shortcomings of its linear conception as cause-effect, among other aspects (De Almeida Filho, Castiel, Ayres, 2009; De Almeida Filho, 2000; Menéndez, 1998).

thinking in terms of “complex totalities with a history” and “complex adaptive systems”, which are not immobile and transform themselves. In accordance with this, Zemelman (1987) also holds that problematizing the totality, the reconstruction of research problems does not start from objects completely theorized (or preformed, as would happen in a disciplinary perspective within the positivist paradigm), but rather rests on the problematization of reality, always richer and more complex than any theory. Thus, the theoretical reconstruction based on dialectical reasoning allows a reciprocal relationship between material reality and theory, which imposes a broadening and an experience of subjectivity on the investigative subject. Let us add that understanding the concept of health as a process of historical and social character means essentially to base and explain it as a function of the reality that determines it: that is to say, the structure and dynamics of society, the degree of development of its productive forces, the type of relationships it establishes, the economic model, how the State is organized and its policies, in what ways are the distribution and access to resources, goods and services dealt with. All these structural and relational levels can be approached from the dialectical perspective of the totality⁷, which is in opposition to the Cartesian notion of the impossible knowledge of the whole and therefore, its successive segmentation to know it. Such a fragmentation is compatible with, and underlies epistemologically the notion of risk as a gnosiological value in the conception of health and in intervention strategies, as occurs in epidemiology. From this analytical axis, the health needs category takes on great importance, since their definition depends on how health problems and intervention strategies are conceived (Breilh, 2003).

The third problematic axis lies in the analysis of models of health communication for behavior change towards healthy lifestyles, which implies a certain conception of communication. Although the latter is generally considered as a technical issue, it definitely has theoretical implications. In HC the potential of communication revolves around its function to produce effects, proposing that information and persuasion allow conduct change. Regarding the function of communication a broad spectrum of problems arises, of different kinds and at different levels. On one hand, seen from the various theories of communication, this vision would correspond more to a linear conception of communication processes well surpassed in the debates of the second half of last century (Maigret, 2005; Mattelart, 1997), than to the recognition of the various sociocultural conditions which partly determine the way people live, or to a conception of communication as a mediated process. On the other hand, seen from collective health, the function category takes on a different meaning

⁷ The concept of totality does not mean that, to get an historical perspective, one needs to study all planes of social reality of all times, but it does require to take into account said totality in any particular study of its various fragments or constitutive parts (empirical and material samples), which, to be known, understood, and explained require an analysis of their previous relationships in multiple dimensions.

to the extent it can be apprehended from the totality and it is not limited to stimuli that elicit responses in a causal relationship. The terms functionality relationships or Samaja (2004) functional ligature (of Kantian orientation) describe his way to conceive functions, not as isolated circumstances, but rather as part of a complex whole, contributing to its conservation and reproduction. From the symbolic dimension the function category on health communication and its relationship with effectiveness also asks for a review of the disciplinary function in Foucault's (1999) sense, which leads to the normalization and power categories, given that through healthy lifestyles communication an imaginary is built of what is normal and accepted, while at the same time positions are instituted on what is pathological and blamable. Under this perspective, of great importance in the Latin American context –although outside the discussion on models of health communication for behavior change–, this allows to tackle as well the political use of health messages, a topic that deserves to be included in a reconstruction of health communication, to the extent that it is part of a power exchange strategy to support hegemonic positions in the field of politics and in the sphere of health.

Finally, a fourth analytical axis lies in the subject's perspective which is built from the hegemonic health communication model and which is directly related with the conceptions of health and communication. In this respect, the review of Del Valle (2007) propounds that models associated with healthy lifestyles communication, such as social marketing and dissemination of innovations, are based on modernization theories, that is to say on the promotion of behavior changes through communication which should lead us to a better condition or place, thus starting from a depreciation or even a negation of the subjects' lifestyles. As remarked by Del Valle, these models, besides supporting the logics of consumerism, commodification and technologization, they also entail vertical and hierarchical designs which reproduce the pattern of a message being sent by active emitters that monopolize the appropriateness of a conduct to passive receivers, bereft of accurate notions as to their health. Therefore, they imply reductionist conceptions of social subjects and the dialogic character of communication. Paradoxically, in contrast with this critical view of communication models, Del Valle (2003) had developed in previous years a complete manual "to communicate health" from an instrumental point of view, describing subjects as "clients" and "consumers", remarking that "consumers must be the centerpiece of any communicative endeavor". The construction of subjects that are receivers in health communication as clients and consumers is in line with the World Bank (1993) and WHO (2000) proposals on advice to health care clients and satisfaction of the latter as a key variable in health care appraisals. Another category which is used is that of an audience or public, again denoting and connoting particular conceptions of subjects in their mercantile relationship as expecting details on a material or symbolic product to be consumed in market conditions, but above all, expressing the emitter power. In the analysis of the subject perspective, some categories from other analytical axes intersect. The remark can be made that an understanding of subjects as

clients and/or consumers, to stress their responsibility as individuals, and to define them as receivers, audience or public, involves respectively a commodifying vision of health, a conception of attention social responsibilities limited to the subjects, and an understanding of communication as an essentially one-way process

Lastly, along this axis, the healthy lifestyles concept needs to be reviewed, in its normalizing character, its reduction to what is individual, and its disconnection from objective life conditions. For Chapela (2007) the subject matter invisibilizes the multiplicity of conditions on which “the possibility of a healthy subject” depends. It fragments health actions and reinforces (reproduces) the conception of health situations as the result and responsibility of individual actions, without giving a real chance of change and transformation. Cerda (2010) notes that interventions constructed based on the healthy lifestyles discourse do limit, if not definitely exclude, the capacity of agency and social change of subjects, and ignore the social rights perspective, all of which undermines the original groundwork of Health Promotion.

Synthesis

To think of health communication differently, in a way that surmounts the limits set by the notion of healthy lifestyles, it is necessary to get out of the space circumscribed by the technical and instrumental debate on health communication and stand on a more general theoretical level, where it can be conceptualized with technical and instrumental implications ensuing from that. Thus, the heart of the problem will not be what to do and how, but rather to comprehend health communication, its practical possibilities in certain contexts where subjects, institutions, and the various forces and powers of participants converge. To this end, the reconstruction of the theoretical object from the collective health standpoint is valuable; starting for instance from the four analytical axes proposed which allow to compare the hegemonic HC model with conceptually different categories. To locate the four analytical axes allows to make a critique of that model, where its cornerstones are questioned and their weaknesses revealed, while solutions can be suggested that, without displacing or attacking a different object, endow with a different sense the theoretical categories required to transform the object. The linkage of the theoretical and instrumental levels, which is left for the future, is an indispensable step that cannot be made without initially problematizing our conception of health, of communication, and of the people for whom health communication is intended.

Collaboration

Soledad Rojas-Rajs is responsible for the general conception and development of the text.

Edgar C. Jarillo Soto is responsible for the reviewal, corrections and contribution of references.

Both authors took part in the conceptual discussion in this work overall.

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Translated by Artur Sixto.

Translation from **Interface - Comunicação, Saúde, Educação**, Botucatu, v.17, n. 46, p. 587 - 99, 2013.

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