Abstract

The development of the health communication field has been paralleled with the appreciation of the importance of the social and cultural context in understanding health, health behaviour and health communication. This argues both for a shift in methods and a shift in the theoretical and philosophical approaches underpinning these methods. A lack of understanding of Muslims and their cultural and religious tradition contributes to potential conflicts in health promotion. Thus, this paper suggests the use of Islamic values and elements in developing a communication strategy for promoting health behavioural change. This paper has three objectives: (1) to briefly review the research on cultural sensitivity factors with specific focus on religious factors in health communication; (2) to identify the most promising explanatory mechanism for faith-based (Islamic) communication persuasion in health promotion, with particular attention to the relationship between religious factors and health behaviour; and (3) to critique previous work on Islamic communication and health, pointing out potential and promising new research directions in health promotion. These insights may contribute to further development of health promotion strategies for Muslims in Islamic nations as well as Muslim communities in non-Islamic nations through the inter-culturalisation process.

1. Introduction

As globalisation seems to have eliminated geographical nation state boundaries, it has also led people to be more literate in so many aspects across culture and values. Although scenarios in global health are witnessing benefits from new medicines and technologies, nonetheless there are unprecedented reversals. Chronic diseases, consisting of cardiovascular and metabolic disease, cancers, injuries, and neurological and psychological disorders, are major burdens affecting poor and rich countries alike. In addition, health crises of epidemics such as HIV/AIDS, SARS and Avian Influenza are invariably recurring (WHO, 2006). As a result, the World Health Organisation has encouraged more innovative approaches in promoting health risk reduction and the reconsideration of risky lifestyle behaviour.

Within the global society context, the current health communication paradigm which is based on a Western perspective provides more opportunity for healthy growth in terms of both theoretical perspectives and research methodology. The invariably recurring state of diseases and epidemics, in developed as well as developing countries, indicates that
effective health promotion demands multi-perspectives (Geist-Martin, Ray & Sharf, 2003; WHO, 2004). The rise of social marketing strategies and culturally sensitive approaches has affected dominant Western paradigms in health communication.

On the other hand, the emergent of faith-based mass media such as Islamic radio and television has portrayed new trends in the mass media landscape (Hussain, 2003). The popularity of these media has given rise to the need to understand their values and effects on the audiences, in particular for health promotion.

2. Approaches to Research on Health Communication

The systematic study of communication and health can be traced back to 40 years ago (Castello, 1977; Ratzan, Payne & Bishop, 1996). The early empirical studies of health communication can be found in the work of Barbara Korsch and colleagues as early as 1968 (see Thompson, Dorsey, Miller & Parrott, 2003). It took communication researchers some time to turn their attention to health issues. The health communication division of the International Communication Association was founded in 1975. However, the study of health communication was sporadic and scattered. In addition, whereas some of the first studies were conducted by researchers whose primary interest was communication, more was done by those with an interest in medicine, nursing, or, occasionally, social science areas other than communication. Communication and health continues to be a focus of attention for scholars in many disciplines. Historically, health communication has evolved into a useful title to define this emerging field as a broad base of study. It is not limited to only physical, occupational, intellectual, social or emotional health, but encompasses all of these facets (Ratzan, Payne & Bishop, 1996).

The parameter for topics in health communication can be analysed by the Communication-Levels approach. With reference to Berger (1991), health communication should be studied within the existing levels of communication as a matter of academic simplicity. The levels of analysis referred to are interpersonal communication and mass communication. Interpersonal communication focuses on the patient-provider relationship (Arnston, Droge & Fassl, 1978; Sharf & Poirier, 1988; Wyatt, 1991), while mass communication addresses the issue of effective message dissemination for health promotion, disease prevention, and health-related messages transmitted through mediated channels (Maibach, Flora & Nass, 1991; Payne, Ratzan & Baukus, 1989).

Although the focus between communication and health varies, the contemporary focus among academics centres on the common relationship of communication and maintenance of health or the prevention of disease (Haider, 2005; Makoul, 1991; Rogers, 1996). This scenario supports the prediction that the trend in health communication research will favour the biosocial perspective, rather than the traditional biological view of health (Freimuth, Edgar & Fitzpatrick, 1993; Glanz, Rimer & Lewis, 2002; Jackson & Waters, 2005; Ratzan, Payne & Bishop, 1996).

The remarkable event that pointed to the need for social advocacy as a force in health was the Ottawa Charter in 1986 during the First International Conference on Health Promotion (WHO, 1986). The agenda of health communication as social change has been re-emphasised and was strongly advocated by the WHO in their conference in Bangkok.
Towards the end of the 20th century, the role of communication in health improvement has become a major agenda item among international organisations (FAO, 2005; WHO, 2003). The rise of HIV/AIDS and other infectious diseases such as Anthrax, Avian Influenza, Dengue and Tubercle Bacillus (TB) around the globe has led to the recognition of the urgent need for a large-scale public health communication response.

Lessons from other essential health programs suggest that, even with functioning health promotion systems, the results can be disappointing, mainly because of the lack of engagement with communities (Bryce et al., 2003; Zwarenstein, Schoeman, Vundule, Lombard & Tatley, 1998). For this reason, localised communication strategies have been suggested to be put in place to better engage and support social elements in preventing diseases and promoting good health (WHO, 2003). Health promotion interventions thus need to integrate strategic and effective action plans within the existing resource constraints (Chopra & Ford, 2005). This means there will have to be a move away from the traditional model whereby the health communication problem needs to be solved by internationally 'generalised models' to a more localised approach. The shifting of the paradigm in this field is timely and fits the current development communication or social change paradigm (FAO, 2005; Servaes, 2003; Servaes, Jacobson & White, 1996).

3. Issues of Culture In Health Promotion

The social construction approach to health communication has primarily emerged as a reaction to the biomedical perspective, long dominant in the health care arena. From a social construction perspective, the work of health communication scholarship is to unpack the socio-cultural sources of symbolic usage in health care. People often accept it as natural and inevitable without considering how meanings emerge from contextual and political sources in ways that mould health beliefs and behaviours. Social psychologist Elliot G. Mishler laid the foundation for seeing the implication of social construction theory in the context of clinical care. Starting with the proposition that “the world as a meaningful reality is constructed through human interpretative activity,” Mishler (1981) explained that “whether or not a particular behaviour or experience is viewed...as a sign or symptom of illness depends on cultural values, social norms, and culturally shared rules of interpretation” (p.141). Cross-cultural scholarship has been particularly useful in revealing the misunderstanding that arises from conflicting cultural constructions. The work of Kleinman (1988) and Kleinman, Eisenburg and Good (1978) has been pivotal in illustrating how illnesses are understood, explained, and acted on through ethno-cultural lenses.

Awareness that culture has been taken into account in the ways in which health communication is theorised and practiced is growing. There are two distinct yet interrelated approaches to health promotion efforts: the cultural sensitivity approach (Brislin, 1993; Geist-Martin, Ray & Sharf, 2003; Ulrey & Amason, 2001) and the culture-centred approach (Airhihenbuwa, 1995; Dutta-Bergman, 2005; Escobar, 1995). The cultural sensitivity approach is conceptualised as developing culturally appropriate health education efforts that would change attitude, beliefs, and behaviours of the target group. In other words, it is a process of tailoring messages to the cultural characteristics of the targeted audience. The culture-centred approach locates culture at the centre of theorising about the communication process. In other words, communication theories develop from
within the culture or community instead of originating from outside. Explanation of phenomena and articulations of pragmatic solutions based on the nature of the phenomena emerge from within the culture or subculture being studied (Dutta, 2007).

A significant proportion of the world’s disease problem is related to behavioural practices that can be influenced through communication (Hornik, 2002). Thus, the success of health communication in promoting behavioural change rests on effective communication. As a result, the ultimate challenge for health communication is to mobilise its resources to have an impact on behaviour change. This is done by stimulating individual emotion through communication processes that lead to intended behavioural change. Furthermore, efforts in health communication are made to construct health promotion programs centred on those understandings of human behaviour by trying to influence the knowledge base, the beliefs, or the social norms underpinning the behaviours, rather than just recommending new behaviour (Caplan, 1993).

Most of the early studies about communication and behavioural change perceived individuals as whole, undivided, and independent entities (Littlejohn, 1995). Regarding that, the early focus of health communication was mainly on individual psychology or emotion. This basis, which reflects the emphasis placed on theories of self in most Western cultures, is contradictory to most non-Western cultures (Littlejohn, 1995). Conversely, most other cultures emphasise socio-psychology; in other words, emotions are socially constructed. As advocated by Averill (1980), emotion consists of internalised social norms and rules governing feeling, whereby these norms and rules tell us how to define and respond to emotions. Much like Averill, Harre (1986) suggests that emotions are constructed concepts, like any other aspect of human experience, because they are determined by the local language and moral orders of the culture or social groups.

As a result, a decade ago there were strong arguments to shift from social psychological models of behaviour towards the application of socio-cultural approaches in understanding health-related knowledge and practices (Freimuth, Edgar & Fitzpatrick, 1993; Lupton, 1994; Milburn, 1996). It is also suggested that health communication programs should be developed within the culture of the everyday life of targeted groups (Caplan, 1993). An understanding of socio-cultural factors is important to explore more intensively the context in which people express their attitudes and behaviours related to health.

Culture is an important element of the foundation of every society. It may be described as attitudes and behaviours that are characteristic of a particular social group or organisation. Culture contributes to and also derives from the feeling of community, and helps individuals form their identity. Traditions reflect norms of care and behaviour based on age, life stage, gender and social class. Traditions, especially those coming from religion, are fundamental parts of culture that determine cultural norms, beliefs and practices. Thus, cultural identity can be engaged to promote the interests of a specific group.

Religion as cultural identity is believed to remain and persist. Although modernisation or development is associated with secularisation, current trends suggest religion is still framing the cultural context. According to Inglehart and Baker (2000), their research using data from the three waves of the World Values Survey indicates that religious beliefs persist, and spiritual concerns are becoming more widespread in industrial societies. They further conclude that:
Economic development tends to bring pervasive cultural changes, but the fact that a society was historically shaped by Protestantism or Confucianism or Islam leaves a cultural heritage with enduring effects that influence subsequent development. Even though few people attend church in Protestant Europe today, historically Protestant societies remain distinctive across a wide range of values and attitudes. The same is true for historically Roman Catholic societies, for historically Islamic or Orthodox societies, and for historically Confucian societies. (p.49)

This and other previous findings such as those cited in Smelser and Swedberg (1994) show that traditional values such as religion will continue to exert an independent influence on the cultural changes caused by economic development. Thus, these findings emphasise the persistence of traditional values such as religion, despite modernisation. This gives rise to questions such as: Does religion affect health promotion?; How does it happen?; and, How can it be manipulated to influence health behaviour?

4. Religion and Health Promotion

The relationship between religion and health can be traced historically from scholars such as Sullivan (1989) and Koening, McCullough and Larson (2001). In the context of the health care debate, psychologists as well as health professionals believe that religion and good health are somehow related. In general, the contribution of religion to good health is mostly identified through healing, coping and the conduct of good behaviour. In health communication studies, religious approaches can be used in prevention efforts since most of the diseases are mainly communicated through personal behaviour. According to Koening, McCullough and Larson (2001), many studies have been conducted that cover topics about religion in mental health, physical disorders, health services, clinical applications, health promotion and disease prevention.

The relationship between religion and health behaviour is not a new phenomenon. Scientific studies of religion in contemporary society have been put into perspective for quite some time (Eister, 1974; Weaver, Pargament, Flannelly & Oppenheimer, 2006). Moreover, previous studies have indicated remarkable findings that religion is a significant factor in deterring health risk behaviour (Frank & Kendall, 2001; Furby & Beyth-Marom, 1992; Lorch & Hughes, 1985).

The aim of most health promotion campaigns is to prevent society from undertaking risk behaviour that potentially causes a particular disease. Most of these prevention efforts apply the knowledge-attitude-behaviour (KAB) change framework (Ajzen, 1992; Amonini & Donovan, 2006; Rice & Paisley, 1981). In that approach, theories and models of health communication explain how information and persuasion are able to create intended behaviour in targeted groups (Ajzen, 2002b; Janz, Champion & Strecher, 2002; Petty & Cacioppo, 1986b). Behavioural intention is a combination of the attitude towards performing a particular behaviour in a given situation and of the norms perceived. In other words, all those theories and models provide a framework on how to plan certain behaviour. Although there is general consensus on the utility of these frameworks, it is clear that in some instances they can only account for a small amount of the variance in health behaviour (Norman & Corner, 1996).
It is assumed that people act in a manner that is consistent with the moral or religious values they place on the potential outcomes of their actions (Chassin, Presson, Sherman & Edward, 1995). Despite that, adolescents also in fact act in ways that are compatible with their own values that might lead to health-endangering behaviours. This situation contradicts what Chassin, Presson, Sherman and Edward (1995) have claimed. As explained by Furby and Beyth-Marom (1992), the contradictory scenario is influenced by a desire to obtain benefits such as signalling maturity and autonomy from their parents. However, children or adolescents are able to cognitively appraise a situation and make healthful choices based on their moral values when specific behaviours are assigned to a moral value via religious teaching (Amonini & Donovan, 2006; Frank & Kendall, 2001).

Empirical studies have shown an association between religiosity and positive (or less negative) healthy behaviour. Researchers have found a negative relationship between religiosity and behaviour such as alcohol abuse and promiscuous sexual behaviour (Abraham, Sherran & Abraham, 1992; Bree & Pickworth, 2005; Hassett, 1981; Wallace & Bachman, 1991). Regarding the relationship between religiosity and drug use, studies have found strong negative correlation (Adlaf & Smart, 1985; Amonini & Donovan, 2006; Burkett & Warren, 1987; Lorch & Hughes, 1985; Lugoe & Biswalo, 1997).

A study conducted by Woldehanna et al. (2006) has revealed that faith-based/religious organisations are potential mechanisms and a potential strategy in HIV/AIDS prevention. This study analysed semi-structured interviews with 206 key informants of HIV/AIDS organisations across the world using qualitative software. Interestingly, all respondents were working for predominately secular organisations (non faith-based organisations). The interim reports conclude that the involvement of faith-based organisations is not only potentially useful in terms of utilising available social resources, but is able to create engagement between scientific prevention efforts and socio-cultural contexts (Woldehanna et al., 2006). Their findings support what Warwick and Kelman (1973) explained as the role of cultural and ideological biases in the choice of goals being often ignored because the change effort may have a hierarchy of values built into its very definition. These values may simply be taken for granted without questioning their source and their possibly controversial nature. This is because any health communication intervention should be understood as a planned social change phenomenon. Furthermore, as explained earlier by the cultural sensitivity approach in communicating health (Geist-Martin, Ray & Sharf, 2003), the socio-cultural element is expected facilitate and justify the health communication intervention framework.

Religious elements have been identified as potential normative components in the knowledge-attitude-practice (KAP) framework. Although religious elements as predictors of good health behaviours have been empirically proven, there is still a lack of attention from health communication researchers (Amonini & Donovan, 2006; Frank & Kendall, 2001; Lorch & Hughes, 1985). Interestingly, religion as a predictor of a person’s behaviour has appeared in many scientific theories. For instance, Fishbein’s Theory of Reasoned Action, one of the most widely applied to health issues, originally included the concept of moral (religion) or personal norms (Montano & Kaspryzk, 2002). In fact, there are other theories and models that have also indicated this component but in these studies it was not clearly addressed as a variable (Ajzen, 2002b; Janz, Champion & Strecher, 2002; Petty & Cacioppo, 1986a).
Studies have shown that religion has effectively worked as a coping and prevention strategy in health-related issues (Koening, McCullough & Larson, 2001; Salem, 2006). Religion has an important role in social integration and control. Religion is part of the culture or the way of life of a society, and it helps to maintain cultural traditions. Society can only survive if people share some common beliefs about right and wrong behaviour. Durkheim (in Koening, McCullough & Larson, 2001) saw religion as a kind of social glue, binding society together and integrating individuals into it by encouraging them to accept basic social values. So, it is mainly through religion that an individual is socialised into the values of the society. This set of moral beliefs and values may have been so deeply ingrained through socialisation that it may have an effect on the everyday behaviour of believers and non-believers alike. If some rule is broken, most individuals will experience a guilty conscience about doing something “wrong”, and this is a powerful socialising and controlling influence over the individual. Another important sociological function of religion is social support. Religious doctrines encourage positive social attitudes and self-sacrifice.

Religiosity relates to the influence of social referents and thus may be viewed as analogous to a construct in the Theory of Planned Behaviour (Ajzen, 1992). Linking health messages to religious or spiritual themes, or using religious elements in messages, may be appropriate motivational strategies. This can be done through manipulation of social effects such as linking health behaviours to specific biblical commandments or using the norms of the faith as a source of positive or negative sanctions (Glanz, Rimer & Lewis, 2002). As proved by Campbell, Demark-Wahnefried, Symons, Kalsbeek, et al. (1999), emphasising personal feelings of religious pride or shame can invoke attitudes towards health practices.

Involvement in religion may also be associated with increased responsiveness to fear-arousing messages. In fact, fear-arousing messages in the context of faith-based institutions have not been empirically examined. Analysis is needed to determine the effectiveness of this type of message in helping adherence health outcomes and the degree to which responsiveness to such messages is related to religiosity. It is hypothesised that these pathways could lead to lower disease risk and enhanced well-being through a Salutogenic orientation (Antonovsky, 1996). The possibility of the salutogenic orientation that links between religion and health can be illustrated as in Table 1 (Levin, 1996).

<table>
<thead>
<tr>
<th><strong>Religious dimensions</strong></th>
<th><strong>Pathways</strong></th>
<th><strong>Mediating factors</strong></th>
<th><strong>Salutogenic mechanism</strong></th>
</tr>
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<tbody>
<tr>
<td>Religious commitment</td>
<td>Health-related behaviour and lifestyle</td>
<td>Avoidance of smoking, alcohol, drug use, poor diet, unsafe sex, etc.</td>
<td>Lower disease risk &amp; enhanced well-being</td>
</tr>
<tr>
<td>Involvement &amp; fellowship</td>
<td>Social support &amp; networks</td>
<td>Relationships friends &amp; family</td>
<td>Stress-buffering, coping and adaptation</td>
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Table 1: Religion and Health – the Salutogenic Effect
With the rise of the Enlightenment, the West gradually separated religion from secular life. Ethical conduct of daily life was left to an individual’s principle as long as it was not in conflict with perceived public morality. In contrast, this separation of religion from the secular sphere did not materialise in Islam. For Islamic societies, religion not only encompasses a person wholly but also shapes the conduct of the individuals in general through application of Islamic socio-religious ethics. This argument explains that in the context of promoting health, a persuasive communication process among the Muslim community should apply its theological principles.

5. The Islamic Communication

The word ‘communication’ in Islam derives from ‘ittisal’ from the root word ‘wassala’ in Arabic, which means “to cause to reach” or “to bring” (Hussain, 2006, p.35). Besides that, the Quran (holy book of Islam) contains numerous terms which carry the meaning ‘to communicate’ such as qul (to say) (Quran, 12:5), nabba’a (to tell) (Quran, 12:37), kataba (to write) (Quran, 24:33), sami’a (to listen) (Quran, 7:204) and many others. In order to better understand this Islamic communication paradigm, the theory of tawhid (the unity of God, human beings and the universe), concepts of tabligh, and amr bil al-ma’ruf wa nahy’ an munkar (enjoining good and forbidding evil) provide the fundamental explanations.

Tawhid signifies a unique relationship between servants (man) of Allah (God) with the Creator (God) that excludes all similar relationships with anyone else. Man must be fully conscious of his freedom and independence vis-à-vis all beings other than Allah. It also integrates material and spiritual aspects in human relationships to attain felicity, the real objective of life. All initiatives to increase righteous deeds and eliminate mischief will consider the questions of sources, implementation technique and its impact from various aspects. In short, it is the eternal principle of tawhid that governs the Muslim community. In the context of Islamic communication, the theory of tawhid can be considered as providing the parameters that determine information and not the other way around. It can also be concluded that the Islamic communication paradigm is the paradigm of revelation.

These tawhidic principles contradict the Western social philosophy paradigm which is mainly based on secular thought. While tawhid emphasises the interrelationship between man, universe and God, the secularism doctrine is about the separation of those elements. As Shelat (1972) writes:

… the non-interference by the one with the other in its own separate field of action and neutrality of the state in matters of religion, secularism is an ideology which seeks to provide a theory of life as against the one provided by the religion. In tone, it is materialistic. For, it holds that human improvement can be sought through material means alone. It is wholly divorced from the unknown world. (p.8)

Despite the spread of secularisation throughout the world, Islam has shown a unique ability to survive the secularist juggernaut. As argued by Gellner (1981), this exceptional phenomenon has to do with Islam’s ability to take advantage of mobilisation opportunities of the modern nation-state. He claims that Muslims have been able to invoke their great tradition of religious practices as symbols of nationhood. National renaissance in Muslim nations has been able to promote purified religion as an alternative to the idealised
folkways so central to the Western nationalist. Thus, “in Islam, and only in Islam, purification/modernization on the one hand, and the re-affirmation of putative old local identity on the other, can be done in one and the same language and set of symbols” (Gellner, 1992, p.13).

The second principle that moulds Islamic communication is the doctrine of *amr bil al-ma`ruf wa nahy’ an munkar* (commanding to the right and prohibiting from the wrong). This principle explains the need and responsibility of Muslims to guide one another for better life according to the Islamic framework (Masud, 2000). This includes all the institutions of social communication such as the press, radio, television, cinema, and internet, as well as the individual in each community. This concept reflects the so-called social responsibility theory which is designed around the Islamic ethical doctrine. As Islam is an all-inclusive systematic religion, every set of ideas and realities covering the whole area of human notion and action is interrelated.

Therefore, every effort taken to create positive changes in the Muslim community should not only be based on logical conscience but must to a significant degree recognise its theological principles. This concept can further explain how social, economic, and political participation is extremely effective when Islamic entities such as the Quran, *sunnah* (the way of the prophet-Muhammad), *Ulama* (scholar), *Imam* (religious leader), and institutions are mobilised (Esposito, 1992). At this point, the doctrine of *amr bil al-ma`ruf wa nahy’ an munkar* appears to provide ideas on what and how Islamic messages are best carried out.

The third principle that provides understanding of Islamic communication processes is the concept of *tabligh*. In Arabic, *tabligh* connotes meanings such as to reach one’s destination, to arrive, to achieve one’s objective, to come to hear, and to come of age. However, the verbal form of this term means to cause something to reach, to communicate, and to report. Another literal meaning of *tabligh* is communication (Masud, 2000, p.xx). In the context of Islam, it is conceptualised that *tabligh* is the propagation of mission. In modern usage, the term *tabligh* is used interchangeably with *da’wah*. This concept primarily concerns activities aiming at strengthening and deepening the faith of Muslims and developing their ways of life in conformity with Islamic principles. In addition, it reflects the effort by Muslims to propagate, protect, or preserve a version of the Islamic faith, either to Muslims or to non-Muslims (Johnson & Scoggins, 2005).

Basically the practices of *tabligh/da’wah* are based on the Quran. Verses in the Quran provide some basic guidelines in conducting *tabligh/da’wah*. The Quran has laid down three main principles in the following verses:

Invite (all) to the way of your Lord with wisdom and beautiful preaching; and argue with them in ways that are the best and most gracious; for your Lord knows best, who have strayed from His path, and who receive guidance. (Quran 16:125)

Based on this verse, communication should work with wisdom and discretion, meeting people on their own ground and persuading and convincing them with examples from their understanding of knowledge and experience (Shaikh, 2000). Besides this, there are other verses in the Quran that explain styles, techniques, and strategies to implement the *tabligh/da’wah* concept (Bah, 2005; Mabaya, 1998). As a result, we can connote that the
The tabligh/da’wah concept can best explain how communications or messages can be disseminated in the context of the Islamic community.

The review of Islamic communication in the previous discussion explained that it is an integrated paradigm. In summary, the above discussion describes the principles and characteristics of Islamic communication. The notion that Islam is not only a theological dimension but is a set way of life indicates the importance of religious values in constructing social diffusion and changes. As the Quran and sunnah are the main references, manipulation of these elements in health messages is predicted to be effective. In addition, Islamic communication mediums such as mosque, school, Friday sermon, Islamic legal framework (shariah), endowment system (waqf), consultation council (shuura) and media institutions provide comprehensive mechanisms to articulate health promotion to the Muslim community. All of these elements are viewed by Leeuw and Hussein (1999) as components that are compatible to the Ottawa Charter for Health Promotion. The link between the Ottawa Charter and Islamic principles in promoting health can be simplified through diagrammatic representation as shown in Figure 1.

![Figure 1: Foundation of Health Promotion](source: Leeuw & Hussein, 1999, pp.348-349)

In summary, the three Islamic communication principles that have been discussed represent the philosophy, content, and strategy or practices of the health communication domain. Overall, the Quran and hadith would be the fundamental basis that governs the whole process of health communication in Islam. The philosophy, environment and objective of each health communication should stand according to the tawhidic principle. At the same time, the content or message of any health campaign must reflect the doctrine of amr bil al-ma’ruf wa nahy’ an munkar. In order to reach the interpersonal level of communication, the principle of tabligh or da’wah is the best communication practice or strategy that suits the Muslim community. An illustration of all these components is presented in Figure 2.

Traditionally, health information was passed on in a one-to-one setting. The innovation of communication technologies and growth of populations have made mass media available and necessary to provide an alternative way to disseminate health-related information. It is claimed that print mass media functioned as a medium for public health information campaigns as early as the 1940s (Egger, Donovan & Spark, 1993). The advent of sophisticated electronic media and better understanding of the process of communication have led to the development of campaigns that not only provide health information, but also attempt to persuade individuals to adopt recommended healthy behaviours (Atkin & Wallack, 1990). Starting with the ‘hypodermic needle’ approach which illustrated the direct effects of mass media on the receiver, a more rational view is developing from an emerging analytical and theoretical literature encompassing all aspects of education, persuasion and influence (Atkin, 1985).

The exchange and transmission of health information occurs among and between individuals, dyads, groups, organisations, and mass media. The mass media level of communication refers to communication that is sent from a single source to a somewhat undifferentiated audience, most commonly in the form of public health campaigns. Mass media channels include television, radio, magazines, newspapers, internet and direct mail. The contribution of mass media and its effect on society has been documented globally and across disciplines (McQuail, 2000; Preiss, 2007). Mass media has become the primary socialising agent in modern society. It not only tells us what to think or how to behave, but most importantly it shapes people’s perceptions. The mass media presents people with certain ways of seeing and making sense of social reality. This then raises the question of
who is telling the stories and the related issues of what stories are being told, what values they contain and how they are being received and affected.

In relation to religion and health communication, these issues can be considered from two angles suggested by Arthur (1993). First, the issues can be considered in relation to the explicit treatment of religious themes in the broadcast media and, second, they can be considered as regards the ways in which religious ideas and values are implicitly present throughout the mass media. This examination is able to help religious and health communicators to identify some of the core questions to address if they are to function successfully in a media-rich society. The relationship between religion and media has recently been subject to more thorough reflection, in academia as well as in public debate (Meyer & Moors, 2006). Today, we not only witness a spread of televangelical formats in Pentecostal movements in America, Asia and Africa, but also the deliberate and skilful adoption of various electronic and digital media by Muslim, Hindu, Buddhist, Jewish, or other religious movements.

In most situations, mass media is more often being used to promote and market good health behaviour among society. This approach, which provides a framework to integrate marketing principles with socio-psychological approaches to develop programs better able to accomplish behaviour change goals, is known as social marketing (Wallack, Darfman, Jernigan & Themba, 1993). It also involves the mobilisation of local organisations and interpersonal networks as vital forces in the behaviour change process. A key principle of social marketing is that it seeks to reduce the psychological, social, economic, and practical distance between the target group and the behaviour.

In general, many researchers agree that public communication campaigns can play a vital role in communicating health information, placing health on the public’s agenda and contributing to changing lifestyle behaviours (Atkin, 1981; Backer, Rogers & Sopory, 1992; Flay, 1987; Hafstad & Aaro, 1997; Hornik, 2002; Maccoby & Alexander, 1980; McGuire, 1984; Snyder, 2007; Wallack, Darfman, Jernigan & Themba, 1993). In sum, the potential for positive effects appears to be enhanced through better application of formative research, more attention to problem definition, detailed audience analysis, appropriate channels and format, realistic goal setting, supplementation with local-level activity, and better use of theory and previous research (Atkin & Wallack, 1990; Hornik, 2002). The meta-analyses of 270 mediated health campaigns or promotions conducted by Snyder (2007) indicate positive impact on a wide variety of health issues. Her analyses, which represent America and other countries, have shown mediated campaigns are as effective as school-based and clinical-based interventions. Another meta-analysis of health campaigns among children and adolescents supports Snyder’s findings. In this study, Parcell, Kwon, Miron and Bryant’s (2007) meta-analysis, which included nine health mediated campaigns, revealed significant effects in preventing or reducing children’s unhealthy behaviour. In broad-spectrum, both of the mentioned analyses showed that mass media exerts influence in informing and creating intended health behaviour.

As the campaign record grows, so does the opportunity to examine additional aspects of campaign effectiveness. There is an ever-changing media landscape that has worked in past or recent campaigns that needs to be evaluated. The rising numbers of community media such as faith-based broadcasts not only indicate media variety but also, interestingly, how its approach and values associate with the audience (Stout & Buddenbaum, 1996; Vries & Weber, 2001). The association between audience and media
partly can be explained by the socio-cultural perspective. Katz, Gurevitch and Hass (1973) proposed five categories of human needs that are gratified by the uses of media: cognitive, affective, personal integrative, social integrative and tensions release.

In the context of this paper, the functions and characteristics of Islamic media are rooted in Islam’s social fabric, and are believed to impact on health behaviour. Furthermore, as explained in the earlier section, Islamic communication strategies have exerted significant influences on the targeted group health behaviour. The review of literature has shown that the usage of Quran and Hadith quotations (Yacoob, 1985), roles of Islamic opinion leaders (Kabir, Mahmoud & Ali, 1998; Kagimu et al., 1998; Roesin, 1998; Surur & Kaba, 2000), and Islamic institutions such as mosque, school and community centres (Lagarde et al., 2000; Woldehanna et al., 2006) were significant communication strategies in promoting health among Muslims. However, all of these studies do not specifically evaluate how Islamic communication elements such as strategy and message impact on the receiver. As Atkin and Wallack (1990) and Hornik (2002) claimed, that phenomenon has eventuated because, historically, much health communication has been studied by non-communication scholars.

The Islamic revivalism phenomena across the world have seen the emergence of more alternative institutions offered by Muslim communities (Esposito, 1992; Mowlana & Wilson, 1990). One of the reflections of this is that more Muslims have become attracted to Islamic media (Hussain, 2006; Meyer & Moors, 2006) but, conversely, the role of the Islamic media in social change such as promoting health behaviour and well-being is not much known or investigated. To the best knowledge of the author, it is hard to find either international or local publications on the role of the Islamic media in communicating health promotion messages. This may be due to a lack of interest among researchers, perceptions that faith-based media only deal with gospel, or to the fact that health promotions rarely were conducted in the Islamic mainstream media. In addition, as Leeuw and Hussein (1999, p.352) noted:

... our extensive efforts to identify scientific and empirical evidence of Islamic ‘Ottawa’ health promotion have yielded minimal results. We can only speculate as to the reasons for the absence of health promotion projects and evaluations in the international literature (including text in Arabic, sic.)

In mainstream media, the marginalisation of religious discourse may be problematic in that many medical and scientific ideas are unable to “address existential questions of ultimate meaning or justice that often trouble people when they face a life-threatening illness” (Seale, 2001, p. 437). There is a need to know more about the effect of different media campaign techniques offered by Islamic media. We need to know more about matching message themes and emotional appeals with production features to maximise the effect on particular audiences (Farrelly, Niederdeppe & Yarsevich, 2003). While research on health communication challenges tacitly assumes that some form of consensus could be reached about the right way to represent health issues, research related to socio-cultural context issues suggests that the basic understanding of the issues discussed are contested and that competing groups are making claims on the system. In these contexts, the question is whose voice is privileged, why, and to what effect, including the media’s own interests and how those interests affect coverage (Kline, 2006). Paralleling the argument, Salmon and Atkin (2003) claim that conventional choices of media have not consistently produced
impressive results, and it may be worth exploring a more diverse variety of channels or media.

The impact of radio might be expected to be less than other mass media such as television. However, the effect of radio is likely to be more sustainable because of its lower costs and because topics merely broached on television can be expanded on radio to achieve a deeper understanding of issues. Based on this argument, radio can be categorised as a good secondary medium where television is used as the primary medium. In contrast, radio can also be a primary medium, particularly in country or remote areas. In fact, in the context of community communication channels, radio always is the best medium in transmitting information to the specific group (Atkin & Wallock, 1990). Moreover, current media technology and innovation is changing the trend of radio usage in either urban or suburban areas. Portability, dual modes of transmission (analogue and digital), inclusion in other electronic devices, and segmentation are some characteristics of radio that might make it the primary medium in certain situations or groups of people. Although radio is limited by its perish-ability and by its inability to show images, on the other hand it also has distinct advantages for making longer-term exposure possible (Islam & Al-Khateeb, 1995), for the cost effectiveness and for its flexibility. In summary, radio, as identified by Egger, Donovan and Spark (1993), is an effective medium for extended exposure, intellectual stimulation, local issues, back-up support for television, ‘expert’ interaction, immediate feedback, medium-budget campaigns, and contact with socially and physically specific groups.

There are a few studies on the effect of mediated health promotion in the Muslim community, but none of these studies involves Islamic channels. The studies cover issues such as smoking, reproductive health, mental health, HIV/AIDS, sexually-transmitted infections, food, water and sanitation (Abdul Hameed, Jalil, Noreen, Mughal & Rauf, 2002; Sheikhholeslam, 1996; Tawilah, Tawil, Bassiri & Ziady, 2002; Yacoob, 1985; Yasamy et al., 2001) and suggest media such as radio should be highly utilised. This might be right because many Muslim communities are still in underdeveloped or developing countries where radio might be the most accessible medium and provides huge coverage. Thus, it is strongly recommended that Islamic communication strategies be inculcated in those health promotions. The recommendation parallels with Ashy’s (1999) arguments on how health and illness in an Islamic context contrast with Western perspectives. According to Ashy, health and illness in Islam is best understood in the context of religious conceptualisation of tawhid (as explained in the previous section). As a result, health promotion for the Muslim community is assumed to have a better impact when it is planned and implemented within the Muslim socio-cultural context.

In the case of Muslim social, economic and political development, scholars admit that Islamic principles play a crucial role but require some reinventing in methodology (Armstrong, 2000; Donohue & Esposito, 2007; Esposito, 1992; Ibrahim, 1996). Developed Muslim states such as Malaysia and Turkey have provided some evidence on how modernisation has to work in parallel with Islamic principles (Mehmet, 1990). The process of Islamic revivalism across the globe since the 1960s indicates the need to understand social change processes through Islamic mechanisms. As Armstrong writes:
In their frustration many have turned to Islam. The secularist and nationalist ideologies, which many Muslims had imported from the West, seemed to have failed them, and by the late 1960s Muslims throughout the Islamic world had begun to develop what we call fundamentalist movements. (cited in Levinton, 2001, p.21)

In the context of this paper, using an Islamic channel such as a radio program to promote better health behaviour among Muslims is assumed to have a better impact compared to non-Islamic radio programs. Studies of Islamic revivalism in Malaysia have proved da’wah (Islamic propagation) was regarded as a distinctive socio-religious movement. Through various strategies of Islamic communication and advocacy, it has impacted on Malaysia’s political, economic and social institutions and policies (Anwar, 1987; Hamid, 2003; Jamil, 1988; Monutty, 1989). This phenomenon has instilled Islamic values in development and modernisation processes, also known as Islamisation, and needs more evidence from other disciplines besides politics and economics (Roff, 1998).

A doctoral thesis by Ghani (1996) concluded that the process of Islamisation of media in Malaysia had taken place since the 1970s. According to Ghani, radio and television have played a major role in the elaboration of Islamic discourse in the past three decades. It was evident from the early 1970s that television in particular might be a potent force for Islamisation. In 1973, government-owned Radio and Television Malaysia (RTM) was televising no more than thirty minutes a week of Islamic content, and existing entertainment programs were frequently criticised by da’wah groups for purveying decadent and non-Islamic, Western material. Then, a Religious and Da’wah Unit was set up within RTM that year, and three years later was producing and broadcasting twenty-two programs a week. To date, Islamic programs make up over 10 per cent of the total output of broadcasting hours. The impact of Islamisation again witnessed another Islamic media development when in July 2001 the first 24-hour broadcast of Islamic radio was launched. The establishment of Radio IKIM.fm is seen as another mechanism in promoting and educating Muslims about development and social change (BERNAMA, 2007). Although this medium provides much accessibility for Malaysian Muslims, no studies that examined its role in health behaviour change could be found. The establishment of the Religious and Da’wah Unit in RTM, and IKIM.fm later on was seen as ironic. Both seem to have similar functions. However, it can be assumed that there are high demands for Islamic media that led to the establishment of IKIM.fm.

In regards to Islamic media and health promotion, Leeuw’s and Hussein’s (1999) analysis on Islamic value systems, and the Ottawa Charter for Health Promotion, provide promising evidence. As emphasised by Schleifer (in Arthur, 1993), Islamic texts such as the Quran and Hadith are vitally significant to the Islamic tradition. These two sources have become a major factor that creates cultural unity within a universal religious community drawn from such diverse cultures as those of the Arab, African, Persian, Turkish, Indian, Malay, Bosnian and Albanian cultural contexts. Islamic communication concepts and principles, supported with its communication channels, are believed to be the best methods in promoting health among Muslims:

…health promotion is already a natural and integrated part of Islamic societies. Some sense of reality should be applied, however. Even though Quran and Sunnah provide important guidance toward health promotion, much of these insights and such knowledge seems hardly applied...For health promotion, specifically, we do observe that Islam nevertheless provides more coherent foundations than many other belief systems. There is a role and responsibility for health authorities, communities and
academics to apply the principles from those foundations to contemporary social and health challenges. Once the intrinsic value of health promotion has become apparent to those actors, the establishment of a unique and modern Islamic health promotion is within reach. (Leeuw & Hussein, 1999, p.350)

7. Conclusion

At the outset of this review, I suggested that the topics and focus of previous research not only give certain impressions about how the media can represent health concerns, but my intention is also to bring into sharp relief opportunities for redirection in the research, so as to expand the repertoire of media domains and content analysed to faith-based media impinging on the health behaviour of people. On the other hand, it is also suggested that research should not be limited to studies of specific media groups because it might miss an important element of the social understanding that affects health issues of these different groups (Kline, 2006). Thus, examining health promotion messages broadcast by Islamic media will lead to an understanding of how Islamic persuasion works and how it impacts on Muslim behaviour.

As health issues continue to intensify around the globe and in Muslim societies specifically (Leeuw & Hussein, 1999; UNICEF, 2005), gaining the upper-hand against health problems around the Muslim world will require rapid and sustained expansion of prevention, and adaptation of Islamic concepts in health promotion. Since cultural sensitivities such as religion have been proven to be potential elements in behavioural prevention, exploring religious communication aspects will bring research with new perspectives into the health communication field. It is also believed that in the era of globalisation, understanding different approaches from various communities’ perspectives will lead to better understanding of social change. In spite of this, this paper not only provides an attempt at clarifying the value of Islamic health communication in Islamic nations, but also of its value in Islamic communities in Western nations through the process of inter-culturalisation.

References


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