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Dialogics, ethnography and health education

ABSTRACT

In recent years, the ethnographic method has been found to be an adequate instrument for public health and health education interventions. Nevertheless, its use contradicts certain intervention models, defined here as monologic, such as mass media campaigns and "rational actor" philosophies. Some epistemological foundations for these models were analyzed, such as the one-dimensional analysis of health/disease/care processes, the one-way communication and their hierarchical nature. In its place, a dialogic model based on the ethnographic method and organized from the criteria of multidimensionality, two-way communication and symmetry is proposed. Ethnography enables the effectiveness of interventions to be improved by providing an empirical basis for project design and allowing for social participation in health.

DESCRIPTORS: Anthropology, Cultural. Health Promotion. Health Education. Consumer Participation. Qualitative Research.

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INTRODUCTION

In the last decades, the ethnographic method has surpassed the sphere of anthropology and social sciences and it has been found to be a useful instrument to describe social determinants in health,[24] to develop and assess education and sanitary promotion programs[2] and to approach local health challenges that are becoming more and more global and interdependent.[14] The initial use of this method in interventions, aimed at indigenous and peasant groups of the so-called "Third World",[17] was broadened in several social contexts, including the advanced capitalist societies and those known as "middle-income countries". The reason for this proliferation is the evidence that every public health intervention, which aims to rely on the active participation of populations, should be founded upon local knowledge and practices.[3]

The ethnographic method and the techniques that comprise it are applied in an undifferentiated way to improve primary care quality in Brazil and Bolivia,[20] create community care strategies for infectious-contagious diseases in Latin America,[21] reduce child mortality due to dehydration in Asian countries[16] or establish strategies aimed at preventing the spread of malaria[15] in Sub-Saharan Africa, among other examples.

Nevertheless, the ethnographic method or some of its resulting instruments, such as the Rapid Assessment Procedures (RAP),[a] are not always used in health education to understand the local reality. Interventions that do not consider the local realities have not been defended in current manuals and professional journals. However, they continue to be those most frequently used, because of their easy implementation and because they do not question socioeconomic and social structures in which the high-risk behavior one aims to act on is included.

In other occasions, the ethnographic method is used without minimum knowledge about the more essential anthropological foundations or it is vulgarized as a "decoration" that enables the sensitivity of health educators towards local worlds, where they develop their practices, to be revealed. In these cases, the hermeneutic, inter-subjective and negotiation-related aspect, which presupposes that ethnography will be put into practice, is not considered in all its broadness, nor does it acquire a strategic position in the development of the intervention.

The objective of the present study was to critically appraise the monologic model of intervention and communication in health education research.

MONOLOGIC MODEL: PRESUPPOSITIONS AND ERRORS

The monologic model is understood as the procedures that originate from the undervaluing of local knowledge and practices, which, as a result, disregard ethnography as a possible instrument for the "analysis of the situation". In its place, researchers will defend the development of a dialogic, communicative model based on hermeneutics and on the negotiation between different systems of knowledge and representations present in the relationship with health education. In the dialogic model, ethnography can have a relevant role both in the investigation of the local reality and in the development of the intervention itself.

There is a type of intervention in health education in which the ethnographic model is not considered necessary. It deals with campaigns that are usually developed by mass media and which are based on principles that are hierarchically-oriented in the structure of intervention. The logic underlying these cases is that "transmitting" the "correct" and "scientific" information is enough to change norms of sexual behavior towards HIV/AIDS, reduce alcohol consumption in the adult population, cause adolescents to "say no" to drugs or, suddenly and as a result of marketing persuasion techniques, decrease the number of deadly traffic accidents.

The monologic model does not include exclusively "information-based" initiatives only. It also influences behavioral models that, once they are based on the idea of a type of universal rational individual making health decisions, limit the possibility of gaining knowledge about a local reality and, as a result, a dialogic relationship with it. This is the case of Green's Precede-Proceed Model[9,10] and the Health Belief Model (HBM),[12] which is characterized by its defense of an individualistic and fragmented approach to the social realities health educators work with.[8] Both from the information-based initiatives and behavioral initiatives, a passive representation of social groups is constituted, once their knowledge and attitudes are considered lay and their behavior seen as the result of lack of information. As pointed out by Bártoli,[1] there are two stereotypes that, although apparently contradictory, seem to be the starting point of one-way interventions: the group of users is perceived as either "empty" of knowledge, which health education should fill up, or as "full" of prejudices, superstitions and errors, which professionals should eradicate with information and persuasion. In both cases, users are viewed, from the professional sub-culture, as a passive container that can be "filled" or "emptied" through educational interventions.

[a] Scrimshaw S, Hurtado, H. Procedimientos de asesoría rápida para programas de nutrición y atención primaria de salud: enfoques antropológicos para mejorar la efectividad de los programas. Los Angeles: Centro de Estudios Latinoamericanos de la Universidad de California; 1988.

This is what certain authors have called "one-way communication system"[11] and which is known as the "monologic model" by the present study. This model is characterized by a series of epistemological principles or attributes, such as: 1) one-dimensionality, 2) one-way communication, and 3) hierarchy, which, curiously, are the opposite of what the application of the ethnographic method in health education means.

Principle of one-dimensionality

The classic academic inclusion of health education in the field of medicine has led to the systematic and often poorly analyzed application of biological models or biologists in the field of health promotion. This includes the absence of knowledge about social sciences and communication in the curricula of health educators, confusion between the therapeutic role and the educational role and the application of individualistic models to understand the social and cultural phenomena that condition health behavior. In this way, the professional perspective has leaned towards adopting a one-dimensional or exclusively biological approach, although health and disease processes clearly have a "biological, social, political, economic, symbolic, among others" multi-dimensional character. This is possible by means of the work of reification of phenomena, which presupposes the denial of global and local forces that act on health-disease processes and the so-called "risk behaviors". Objectives characteristic of health promotion, such as the reduction in cavities in the child population, the use of primary care services by illegal immigrants, the fight against tobacco use, the completion of treatment by chronically ill individuals or the condom use among adolescents, have been excessively understood as realities that are independent from political-economic conditions and the historical-cultural background where they are created.

The complex amalgam of types of behavior, inequalities of class and gender, cultural perceptions and representations that converge towards any of the so-called "risk behaviors" is thus hidden on behalf of a model that systematizes socio-cultural variables, as if they were physiopathological phenomena. The only problem is that a risk behavior such as smoking can hardly be reduced to an exclusively biological or psycho-biological aspect. The financial interests of the tobacco industry during the last decades; the cultural representations associated with the consumption of this substance, which have frequently presupposed specific male and female stereotypes; the existence of an unequal distribution of this habit in the social classes of many countries or the more harmful composition of cigarettes in poorer countries are factors that influence and determine the forms of cigarette consumption, in addition to their levels of toxicity. Nonetheless, these dimensions of the problem are considered from the monologic model as epiphenomenal or simply as overly intricate to be considered in health promotion processes. This is the old strategy of reification, which has been well described by Taussig[22] and Scheper–Hughes,[19] and which consists in dissociating health and disease processes so that they are perceived as natural realities, independent from the population, their histories and social structures.

Principle of one-way communication

One-way communication characterizes the monologic intervention, i.e. the existence of a communication flow that moves from professionals towards the unfortunately so-called "target population", but not the other way around. This deals with the non-critical application of the biomedical-clinical communication model in the field of education to health, so that the population becomes the patient and the health educator becomes the therapist. What is essential is that, in this case, researchers face a systematic lack of knowledge from the native perspective and the behaviors, attitudes and values this perspective is associated with. The starting point of the one-way communication logic is that, once native knowledge is lay, it is not necessary to have it to develop interventions. Once more, it is about applying the previously mentioned image of users as containers that are "empty" or "full" of prejudice. In both stereotypes, it is what enables one to define the users' position of supposedly not knowing, compared to that of professionals as those who know.

Typical examples are the campaigns organized by mass media, which do not promote two-way communication. However, programs organized by health teams are also considered to be based on one-way communication, as they do not make an exhaustive analysis of the situation of a local reality or restrict this analysis to morbidity and mortality statistics or to an inventory of needs, exclusively designed from the perspective of professionals. Thus, this is a theoretical model of communication that can, in practice, acquire expressions that vary from completely one-way statements to hybrid or mixed initiatives, developed from partial or incomplete knowledge about the local realities. Nevertheless, in all these cases, one-way communication becomes monologic, once another attribute is included, thus increasing it: hierarchy.

Principle of hierarchy

Foucault and thinkers from the Frankfurt School stated that all forms of knowledge are also forms of power. In the case of the present study, it is difficult to argue that the idea that popular discourses are determined by inaccuracy and superstition does not include a somewhat subtle form of domination supported by scientific discourses. The attribution of positions of knowing and not knowing in the communicative game is also a justification for the vertical, one-way action and, in this

measure, health education is the stage of a relationship of power which, in contrast, is not new.

In the European historical context, the prevalence of the vertical and monologic model in socio-health interventions has been frequent. The following are examples of this: the interactive development of the *Medizinischepolizei* or medical police, in the 17th and 18th centuries, in Germany; health policies of the so-called French urban medicine, in the 18th century, or of the legislative measures (the famous "Poor Law") and welfare to reduce mortality in the English working class, in the 19th century. In all cases, the vertical orientation emerges as a variable that continues to exist in the colonial period, becoming stronger as time passes and as a result of the progressive "trust"[7] that populations established with professional or expert systems.

The majority of discussions and criticisms to the monologic, one-way model are centralized in their ineffectiveness to stimulate citizen participation and to qualify ("empower") the populations in terms of health. This type of intervention shows a trend towards promoting passivity and causing users to perceive health educator discourses as distant and domineering. These are reasons through which this model contradicts the objectives that are usually considered important to promote health by international agencies, such as the World Health Organization (WHO) and the Pan American Health Organization (PAHO). Based on the monologic model, for example, some of the priorities that have been established by the Declaration of Jakarta,[b] in terms of health promotion in the 21st century, can hardly be met, such as the development of social responsibility in health, the stimulation of associationism or "empowerment" of individuals and communities to maintain health and the fight against the disease.

ETHNOGRAPHY: TOWARDS A DIALOGIC MODEL

As expected, the dialogic model of intervention must be constituted by criteria that are the opposite of those that defined the monologic prototype. In other words, a dialogic intervention should be: multidimensional, rather than unidimensional; two-way, rather than one-way; and based on symmetrical and reciprocal relationships, rather than hierarchical or domineering in its approach. In fact, the health education model, known as participatory, can be considered dialogic, once it includes the three principles previously mentioned.

The problem is that different participatory strategies do not constitute a homogeneous paradigm. Diverse philosophies and interventions converge into this orientation, such as the current, program-oriented WHO directives (Declaration of Jakarta), the Gramscian approach of Perugia's *Centro Sperimentale di Educazione Sanitaria* (Health Education Experimental Center)[1,20] and the more isolated contributions of experts such as Freudenberg,[5] Rifkin,[18] Werner[25] and Vuori,[23] among others. With a few exceptions, such as the School of Perugia, which clearly deepens the participatory model and which is a classic point of reference in this field, orientations frequently result in lack of theoretical foundation for their proposals. In many cases, the ideological and political basis becomes excessively preponderant, disregarding the fact that dogmas can debilitate the native senses and create a new form of domination. For this reason, it is necessary to delve deeply into these three inverted criteria of the dialogic model to reflect on questions that are avoided in practice.

Principle of multidimensionality

A multidimensional proposition presupposes more than just a simple increase in the number of factors that intervene in health and disease processes. This is not a simple group of social, cultural, economic and political variables, among others, surrounding the resistant monologic center, the biological dimension. The sum of factors must also change the nature of the existing explanatory theory, otherwise there would be a variation of the unidimensional perspective, hidden in the majority of bio-psychosocial orientations in medicine and psychiatry and structured from the hierarchy found in the root of the word "bio-psycho-social" itself. More objectively, these models understand that the social dimension of health and disease processes is determined by the psychological dimension and, this, in its turn, subject to the biological level. In other words, this trilogy supposedly has determination paths from bottom (biology) to top (society), but not the other way around. In addition, the term "biopsychosocial" usually describes a hierarchy existing in these professional spheres: "bio" (doctor), "psycho" (psychologist) and "social" (social worker). In it, there are possible paths from bottom to top (a doctor who acts as a psychologist), but not the opposite (a psychologist who acts as a doctor).

Both the pure one-way approach and its more complacent formulation – the biopsychosocial model – usually contradict actual situations in which the social processes affect and determine the biological dimensions of the disease. Very generalized, classic examples are the impact of poverty on morbimortality of populations or the role of worker exploitation in the number of work accidents. By denying or prioritizing biological determination over social or socioeconomic determination, mystification is produced, a covering

[b] Organização Mundial da Saúde. A Declaração de Jacarta sobre Promoção da Saúde no Século XXI. Jacarta: 1997. http://www.who.int/healthpromotion/conferences/previous/jakarta/en/hpr_jakarta_declaration_portuguese.pdf

of social relations involved in the health and disease process and a type of intervention which is very centered on the "biological body" and not centered on the "social and bio-political bodies". This covering transcends the level of analysis and reaches that of intervention, once educational actions will be directed towards individualized spaces (for example, towards workers, in accident prevention), rather than the remaining participants and social instances involved in the process (for example, public authorities and companies that can reduce outsourcing and insalubrity).

In this perspective, multidimensionality should not be restricted to a structured hierarchy from biological determinism and, for this reason, both the analysis of the situation and the intervention should consider the multicausality relations that are behind a risk behavior or a certain phenomenon of morbimortality. The role of ethnography in this context is to provide its classic holistic and contextualized view.

Principle of two-way communication

Two-way communication or the exchange of messages, ideas, representations and information between professionals and the social groups that interventions are aimed at is a principle intrinsic to health education models such as the participatory model. Thus, two-way communication and participation are not possible without health educators' access to the field. Ethnography provides a model for both contacting and establishing communication bridges with the local reality.

Differently from the clinician, who establishes their relationship with the patient based on the opposites of knowing/not knowing and in which this patient is usually the one who goes to both the symbolic dimension and the real dimension of the former, the ethnographic process presupposes an inversion of roles and situations.[13] In the field work, the ethnographer is the one who adopts a position of not knowing (about the local reality), while the informant is the one who knows. In addition, it is the investigator who moves to the informant's context, not the other way around. These are reasons for which one can affirm that the roles of clinicians and ethnographers are, for the most part, contrary to each other.

As previously pointed out, in one-way communication models, the prototype of clinical relationship is that which is controlling relationships and preventing knowledge from the local perspective and reality. In this context, the ethnographic context enables the situation to change. Access to the field, the position of not knowing, the contact and the simple interview with social participants itself imply a form of analysis and intervention which is fundamentally hermeneutic. In other words, the ethnographer seeks knowledge that belongs to another and rejects his technical jargon to assimilate their informants' vocabulary and universe of senses. In this aspect, ethnography is comparable to reading a text or deciphering a hieroglyph, once, in these cases, the reader-interpreter does not add a code to the work, but rather attempts to discover the code that gives meaning to this work or hieroglyph. From the anthropological perspective, the code of the text becomes the so-called local culture, native perspective or emic perspective.

Principle of symmetry

The third challenge for health promotion is to establish a symmetrical relationship between professionals and social groups that stimulate social participation in health. From a more ideological perspective, Werner[25] describes two types of participation: the weak one and the strong one, which are, in truth, two extremes to classify different interventions. Weak participation would be characterized by two-way communication from top (professionals) to bottom (community) and by a series of premises such as the "vertical approach", social control by professionals, inequality and manipulation. On the other hand, strong participation presupposes inverted two-way communication, from bottom (community) to top (professionals). "Equality", "liberation", "self-management", "control by the people" and the "horizontal approach" are key aspects.

It is clear that the model of "strong participation", defended by the present authors, can contradict the existence of professionals itself. In reality, Werner's model continues to be vertical, one-way and monologic, even though its verticality is the opposite of that of the "weak participation" model. This lack of accuracy when defining the participatory model causes its capacity of meaning to lose strength.

Differently from Werner's model, this study defends a model that puts the different social participants in a position of greater reciprocity, without changing the active role of professionals. In many occasions, the function of professional systems must be to follow the decisions and promote civil society and associationism to counterbalance national and trans-national health policies. Professionals are also part of the local and global communities, where they develop their role. To this extent, not to rely on these professionals or to put them in a subordinate position can only result in new "weak participation". It is possible to develop health promotion programs by exploring the possibilities of the ethnographic method, once the establishment of greater symmetry also results in greater co-responsibility and "empowerment" of participants and social groups.

CONCLUSIONS

The current challenges of education and health promotion cannot be approached by the exclusive exercise of

delegation in health professional systems, with their sophisticated protocols for investigation, intervention, information and management. Social groups experience their local realities and the limitations of a world which is ever more interdependent. The recognition of different professional systems as active communities in decision-making in health is their task and responsibility as well. In this context, the ethnographic method can lead to a model of dialogic relationship, because it provides the epistemological and methodological basis to be "between" (*Zwischen*) professional and lay groups. In truth, it would not be daring to affirm that only an interstitial position is capable of facilitating a "breaking away" from traditional conceptions of professionals and a new representation of their experience, based on an approach that is closer to lay knowledge. In this exercise of breaking away, one finds the conditions necessary for a self-critical and self-reflective exercise in health systems and for the understanding (*Verstehen*) of different local worlds in a perspective of dialogic relationship, which promotes social participation in health.

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