Introduction

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The developing countries in comparison to developed countries have shown a remarkable shift in higher growth rates since the late 1990s. The dawn of the new millennium has seen the emergence of new global groupings. Economic globalization is today's reality. It in a way led to the proliferation of satellite and cable television, online networks and increasingly sophisticated digital technologies. The growing availability of communication networks has transformed the global media landscape. In the current economic, technological, media and information contexts, communication is increasingly becoming 'glocal' (Hemer and Tufte 2005). The spread of new global media has been among the most powerful forces for change in public health avenues in these countries.

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Public health remains a crucial development challenge in these fast developing countries. Despite the geographical and cultural differences between them, the developing countries face certain common and pressing public health challenges. These include the prevalence of communicable diseases, such as human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS) and malaria, as well as burgeoning incidence rates of lifestyle diseases, such as cancer, heart disease and diabetes (which formerly were considered diseases of the affluent) (Barett et al. 1998). These nations are poised to combat the problems of double burden of disease—presence of some diseases associated with acute poverty, poor sanitation, food insecurity and illiteracy on one hand, and the growing non-communicable diseases (NCDs) associated with increasing affluence, changing lifestyles, nutrition transition and alcoholism on the other (Popkin et al. 2012). There is an increasing realization that this changing health scenario will continue to present major impediments to economic growth. It is indeed the case that economic globalization has brought improvements in healthcare systems, technologies of diagnosis, modern medical tools and, most importantly, newer sources of health information. It is also a reality that there is a co-existence of traditional health systems, faith-based healing techniques, and interpersonal methods of communication. It would be of great interest to study how the changing media landscape in these countries is impacting the overall public health communication scenario. With an emphasis on mediated communication that seeks to produce individual change for improved health outcomes, communication scholars have traditionally focused on developing mediated message materials, using even the new media, rather than engaging in articulations about the location of the health behavior in the larger context of changing economies and rapidly varying communication technologies (Parker and Thorson 2009). This book explores a different perspective and investigates how the field of health communication has responded to rapid changes and innovations in the media context in developing countries such as India, Russia, China, Papua New Guinea, Kenya, South Africa and Brazil.

The application of new and emerging information, communication and networking technologies for health programs has been affected to a great extent by geo-political, historical and demographic factors, which are compounded by global and strategic imperatives. It is known that specific communication practices in different healthcare settings can affect the success of healthcare management and development (Ngwainmbi 2014).

Various schools of thought have found that electronic media, information and communication technologies (ICTs) have the capacity to support education and health sectors, build local capacity, support knowledge sharing and networking (Lucas 2008). The evidence of the critical role these communication processes can play with local communities in effective health policy needs to be explored. In addition, the degree of persistence shown by the indigenous cultures and normative systems provides for yet another interesting area of study. It is in this context of phenomenal growth in business and economic application of healthcare provided by both private and government sectors that the potential of health communication in developing economies is ever expanding. Policymakers have started exploring this in their creative expressions. As much as these forms pose challenges for policymakers in developing countries, they also point out the need to theorize and critically engage with the proliferation and adoption of new practices in health communication. The over-arching aim of this collection of essays is also to capture the contours that the field of health communication has taken in these changing communicative contexts, and the complexities and controversies thereof. These perspectives are presented in four broad thematic parts: (a) health communication—discourses from tradition to modernity; (b) health communication in the changing media landscape; (c) framing of health in media; and (d) emerging issues.

The chapter by Chasi, argues around the belief in witchcraft, which is considered a significant basis for misconceptions that lead to people failing to understand the medical science of HIV/AIDS in ways that exacerbate the epidemic. Overcoming belief in witchcraft is hence seen as an essential indicator of movement towards adoption of belief in medical science and the avoidance of high-risk HIV-related behaviors. Yet, people can understand and believe in the medical science of HIV/AIDS while also believing that witchcraft plays a hand in how certain individuals are more predisposed to harms associated with HIV/AIDS than others. With discussion of witchcraft and violence against alleged witches, this chapter advances new understandings of how witchcraft and the moral philosophy of Ubuntu[1] are entangled, with implications for present and future communication on HIV/AIDS. A distinctive and important conclusion is that it is important for scholars to move beyond narrow views that locate health options in the realm of confrontations between the West and the rest—towards more nuanced and complex readings. Such readings should take into account how goodness is itself entangled with practices such as witchcraft and how the world has many poles that are interrelated in complex ways.

The next chapter, by Malikhao, discusses how rapid development in China has caused a number of environmental hazards, food insecurity, and communicable health diseases. How the Chinese government has tackled pollution and major epidemics such as severe acute respiratory syndrome (SARS) and airborne diseases in major cities, and how Hong Kong has handled its major epidemics, are analyzed in depth. Also, NCDs emerging from the changes of lifestyles in China are discussed. Health communication policies and planning in China have been assessed critically. Political-economic policies are seen together with health communication policies related to communicable and non-communicable diseases.

In Chapter 4, on sexual health in Russia, Golousov and Strovsky deal with sexual health not only as a term, but also as a media priority for coverage. Initially, it dwells upon the theoretical frameworks of sexual health, then sexuality as an historically 'female issue' in Russian society. Finally, attention is paid to the media coverage of the sexual health issues. Also examined are the content of some contemporary journals, such as the Russian version of *Cosmopolitan*, *Zhenskoe zdorovye* ('Women's Health') and *Psychologies*, elucidating how sexual health is framed in modern Russian media.

Muturi, in Chapter 5, discusses advances in ICTs that are being embraced widely in the health and development fields. Organizations across countries are exploring the role of ICTs in improving citizens' social and economic conditions as well as their overall health and well-being. In the health sector, ICTs are viewed as the next breakthrough in healthcare systems where eHealth, or the combined utilization of the digital technologies to process, transmit, store and retrieve digital data for clinical, educational and administrative purposes by health professionals is increasingly becoming the norm. In her chapter she discusses the use of ICTs in healthcare systems. She states that in the African context, the use of ICTs for health purposes is particularly critical due to disease burden and to the significant erosion of healthcare infrastructure amidst limited human and financial resources, which make most of the population vulnerable to health threats. When used appropriately and with the necessary guiding policies and resources put in place, ICTs have great potential to improve health service efficiency, expand or scale up treatment delivery to thousands of patients, and to improve patient outcomes. She also discusses the role of HIV/AIDS communicators and educators in transforming technical health information by packaging it for a variety of target audiences, disseminating it through various media outlets, and making it digitally accessible to the users for health decision making.

Since HIV/AIDS was declared an epidemic more than three decades ago, there has been an abundance of information disseminated through various media outlets. In the past two decades this information has been packaged electronically on CD-ROMS or disseminated online through websites, emails and listservs that have linked researchers, educators, and practitioners around the world. International organizations also prepare media kits that include factsheets and surveillance datasets on the epidemic, and make them available through their websites. She argues that ICTs are being viewed as important tools in preventing global epidemics through facilitation of rapid collection and dissemination of information, interaction between user groups, as well as communication and inter-agency collaborations. Her chapter explores the use of ICTs in HIV/AIDS communication in Kenya, one of the most affected countries in the African region.

Chapter 6 by Vemula argues for stronger mHealth and eHealth policies to be adopted in a country like India. He gives an overview on various mHealth initiatives which are being provided to increase access to healthcare and health-related information for the hard-to reach population in India. It outlines the importance of mHealth's improved ability to diagnose, track diseases and disseminate test results in timely fashion. More actionable public health information is also provided by mHealth, thus expanding access to ongoing medical education and training for health workers. It gives the doctors the flexibility of sending short messages (SMSs) to patients about their appointments for management of diseases. Furthermore, mHealth helps in decreasing the time required for analyzing large amounts of data generated, which is difficult with a paper-based data collection system. Such initiatives can be especially helpful in cases of NCDs because of the numerous follow-ups required, thereby generating large amounts of data. There is no proper documentation and reporting of various on-going pilot projects using mHealth for NCDs in India. Due to the widespread adoption of mobile technology in healthcare, mHealth is now viewed as inevitable because more than half of the doctors and healthcare payers in developed and emerging markets around the world are using this platform. For India, the percentage is up to 60 percent, ranking second among the developing economies in adopting mHealth (PwC 2014[2]). The pace of adoption will likely be led by emerging markets that rank highest among ten countries on a score of mHealth maturity (PwC 2014). Consumers in India have very high expectations of mHealth, particularly in developing economies as mobile usage is increasing manifoldly (Garai 2011). The

Indian government is intervening to address such issues arising from mHealth interventions. Successful implementation of mHealth makes the right information available at the right place, at the right time, and in the correct form. Vemula reflects upon the existing mHealth pilot programs that are in place and working to integrate mHealth into the Indian healthcare system. As wireless technology increases in flexibility, popularity and distribution, it will play a key role in the new healthcare delivery model. There are many apps and web-based approaches towards mHealth interventions in India.

Papua New Guinea is another case study on the changing dynamics of the media landscape in developing countries. Rarely do we get to hear about HIV/AIDS from this small country in the southern Pacific Ocean above Australia, where HIV prevalence is less than 1 percent (UNAIDS 2014[3]). Thomas and Eby here investigate village cinemas (*haus piksa* or *CD haus* in Tok Pisin) as sites for distributing messages about HIV/AIDS in the Highlands of Papua New Guinea. The Komuniti Tok Piksa (KTP) project addresses the lack of locally produced content around HIV/AIDS. The objective of the project is to understand local narratives around this health issue and translate them into visual education and prevention material in collaboration with the communities. She dwells on the potential of village cinemas as spaces to engage audiences in discussions and learning around HIV/AIDS in the country's highlands. Through evaluation of the KTP films, she highlights the need to engage in local narratives and stories in meaningful ways to affect attitudes and educate audiences. The facilitated screenings of these films, she says, were important for engaging audiences in reflection and dialogue.

Acosta-Alzuru's Chapter 8 centers on the illness and death of Hugo Chavez, the former president of Venezuela. It focuses on how 'news hungry' media are 'fed' regularly to retain the image of a towering leader in Venezuela in modern history. Two years after his death, he is still the main buttress of the Venezuelan Bolivarian Revolution. Chávez was ubiquitous on Venezuelan media. In frequent and lengthy live broadcasts—mandatory for all outlets—he spoke to the nation, made decisions, defined strategies, gave government handouts, appointed and fired ministers and officers. In short, he was the Bolivarian Revolution—its creator, image and spokesperson. What happened when such a president fell terminally ill? How were medical information and the president's discursive absences handled? Chávez's health pervaded Venezuela during the last 21 months of his life. Yet, information was sparse and tightly controlled by him and

the closest members of his Government. There were no medical reports. In contrast, the rumor mill worked non-stop and some journalists were particularly predictive of the President's subsequent announcements. This situation brought out the tension between public figures' right to privacy and citizens' right to know about the health of their leaders. This chapter fleshes out that tension by examining the discourse around Chávez's health and illness, identifying the Government's underpinning tactics and whether these were consonant with Chávez's general media strategy and/or reactive to media reports.

Brazil is characterized by a noticeable divide between modern structures generated through capitalist expansion and archaic structures that vary from one region to another. However, this is not so much a geographical issue as it is an issue of the level of penetration of capitalist modernization in the service sector, including the realm of health. The presence of "hybrid structures"—part of which would tend to behave like a capitalist system with the other as a pre-existing archaic structure—is indeed a unique phenomenon. Paiva and Sacramento look at Brazil's health scenario in this context. They talk about exclusion, which refers not only to people of a certain social class, but also to the characteristic diseases of the archaic sector of those hybrid structures. This is the framework in which this chapter analyzes the media's systematic silence on diseases "from another era," which paradoxically remain endemic in contemporary life. They argue that silence or discursive negligence seems to be an indication of the media's complicity with the hegemonic sphere of production and supply of health-services-related information.

Gavaravarapu explores the links between the growth of television and nutrition transition in India. He explores the path television has traversed in India from the days when it was introduced as an educational tool. In the early days, television—which was under government control—was seen as a tool not only for promoting health, education and agriculture but also as a potent medium for development support communication (DSC). After India adopted neo-liberal economic policies in the early 1990s, the communication policies underwent a drastic change. The state-controlled media agencies, namely All India Radio (AIR) and Doordarshan (national television network), till then dedicated more to the objective of public welfare, were asked to generate their own revenue. Radio and television were laid open to private players. From the days of the solitary few soaps and televised mythological dramas when millions of viewers stayed glued to their sets to

today's television mills that cater to a growingly information-hungry nation, India's television has seen a sea change. The emerging technologies and the new media are also intensely intertwining themselves with television. As a result, more and more Indians are glued to TV screens both at home and on the move. With changing technology, the screens no doubt are slimming but TVs are blamed in part for the bulging girths of India's upwardly mobile population. This chapter explores the role of television in revolutionizing the food and nutrition landscape in India.

Pant and colleagues' Chapter 11 examines health communication programs in India using a gender-integrative approach. The health sector has retained the attention of policymakers, educationists, and social change leaders alike as a crucial development sector, and it is also a sector where gender is critical. Health communication programs in India have been impacted by both the paradigm changes vis-à-vis development and the changing approaches to communication for development. From big media-based top-down communication programs, there has been a gradual appreciation of local, context-based and participatory-communication approaches in the health sector. At the same time, gender has emerged as a key component in debates surrounding development and communication. This chapter describes how gender would be an important category in the design and implementation of health programs in India, where the voices and experiences of women have to be considered while creating these programs.

In the final chapter, Sinha observes that health communication in developing country context has not been reaching those at the bottom of the social and economic spectrum and emphasizes on the importance of human channel of communication for reaching 'the last mile'

This book attempts to advance new understandings of: how media and technologies have been harnessed to improve the health of populations; whether the technologies really empower those who use information by providing them with a choice of information; how they shape health policy discourses; how the health information relates to traditional belief systems and local philosophies; what would be the implications for health communicators; how certain forms of silence are produced when media articulates and problematizes only a few health issues and sidelines others. The endeavor has been to bring together current research and discussions from fecund grounds of policy, practice and theory of

health communication. This, therefore, is a compilation of some well-researched essays of academic and research value, and it attempts to give some new insights into health communication and its approaches in the developing countries.

NOTES

1. A humanist philosophy of South African origin.
2. Price Waterhouse Coopers (2014) http://www.pwc.in/press-releases/global-mhealth-adoption.jhtml accessed on 22-05-2015.
3. http://www.unaids.org/en/regionscountries/countries/papuanewguinea accessed on 12/12/2015.

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