Cultural Sensitivity in Health Promotion Program: Islamic Persuasive Communication[1]

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Although scenarios in global health are witnessing benefits from new medicines and technologies, nonetheless there are unprecedented reversals. As a result, the World Health Organization has encouraged more innovative approaches in promoting health risk reduction and the reconsideration of risky lifestyle behaviour. The concept of culture sensitivity has emerged as a key topic of interest to health communication. The growing awareness about culture argues both for a shift in the philosophical and theoretical approaches, and in methods underpinning health communication. On the other hand, a lack of understanding of Muslims and their cultural and religious tradition contributes to potential conflicts in health promotion. Thus, based on present study involves health promotion policy makers, implementers, and health practitioners, this paper suggests the use of Islamic values and elements in developing a strategy for communicating health promotion. In specific, this paper has three main objectives: (1) to briefly review the research on cultural sensitivity factor with focus on religious factors in health communication; (2) to discuss what are the values and characteristics that formulate Islamic persuasive communication in general and in health promotion specifically; and (3) to discuss the constrain and challenges of Islamic persuasion in promoting health. This insight may contribute to further development of health promotion strategy for Muslim in Islamic nations as well as Muslim communities in non-Islamic nations through interculturalisation process.

Introduction

The implications of socio-cultural contexts impact the effectiveness of health information transmission. As recommended by Bird, Otero-Sabogal, Ha and McPhee (1996), and Geist-Martin, Ray, and Sharf (2003), health promotion programs should not only demonstrate cultural sensitivity, but use culturally relevant symbols to communicate the message. The concept of cultural sensitivity has been classified into two distinct dimensions: surface structure and deep structure (Resnicow, 1999). Surface structure sensitivity refers to the extent that health resources match the intended population's social and behavioural features and appearances, while deep structure reflects how cultural, social, psychological,

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environmental, and historical factors influence health behaviours differently across racial and ethnic populations.

Although cultural sensitivity is a widely accepted principle among health behaviour and health communication researchers and practitioners, studies that focus on faith-based health communication are rare (Glanz,2002; Kline,2006). In contrast, the emergent and increasing faith-based media or communication institutions have significantly marked a growing interest in many areas of studies in the communication field (Meyer,2006; Mowlana,1996; Vries, 2001; Valle, 2002).

While many researchers have focused on Western (secular) communication conceptualisation (Valle, 2002; Mowlana, 1993; Hussain, 2006), this paper in particular seeks to answer questions related to the concept of persuasive communication from faith-based (Islamic) perspectives in health promotion.

Cultural Sensitivity in Health Communication

Cultural sensitivity is one of the most widely accepted principles among health behaviour researchers and practitioners. However, some researchers (Glanz, 2002; Thomas, 2006) admitted that its impact on psychosocial and behavioural outcomes has not been adequately described or empirically analysed. Cultural sensitivity can be defined as:

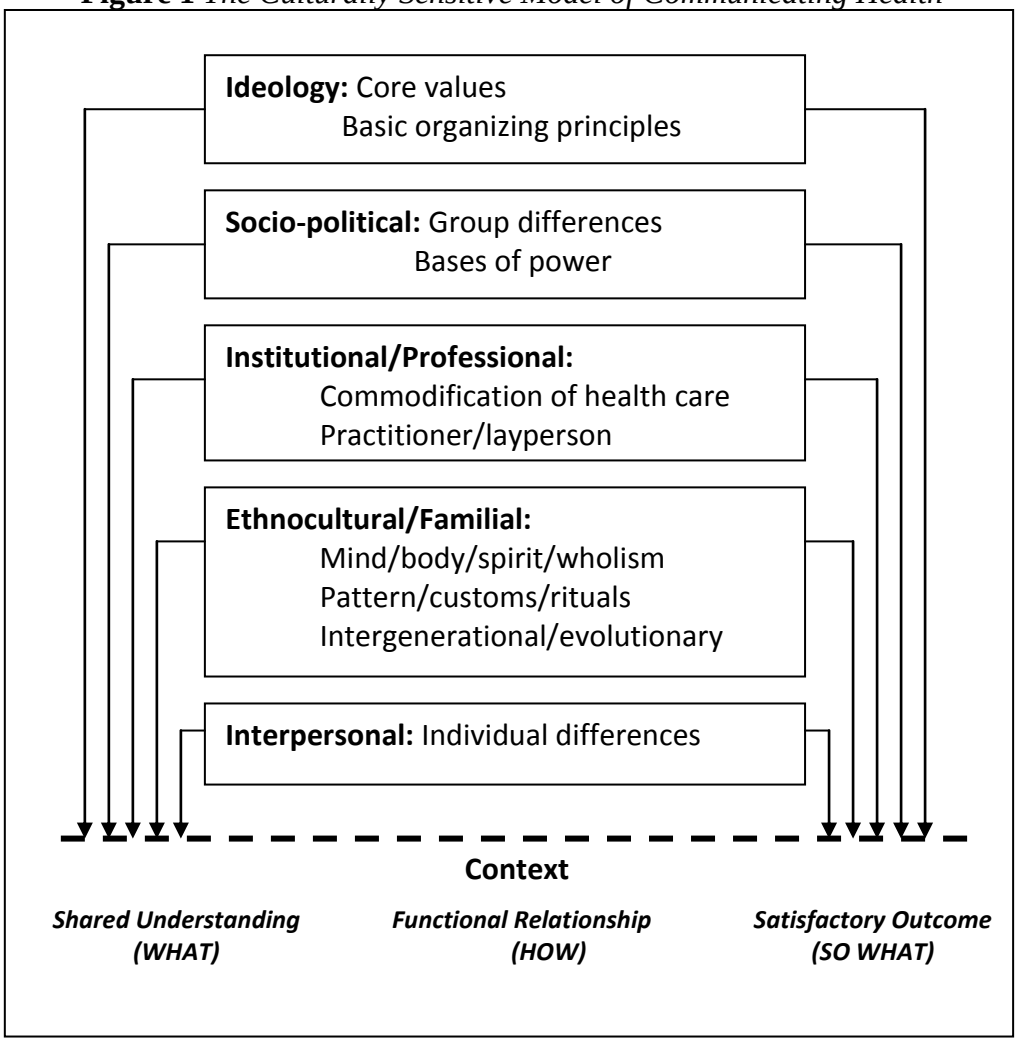
> … ethnic or cultural characteristics, experiences, norms, values, behaviour patterns, and beliefs of a target population, and relevant historical, environmental, and social forces are incorporated in the design, delivery, and evaluation of targeted health interventions, including behavioural change materials and programs. (Glanz, Rimer et al., 2002, p.493).

Resnicow, Braithwaite, Ahluwalia, and Baranowski (1999) further conceptualized cultural sensitivity into two primary dimensions, namely surface structure and deep structure. Surface structure is identified as matching intervention materials and messages to observable social and behavioural characteristics of the target community. It may involve using people, place, language, music, brand names, and locations familiar to and preferred by a target group. It also includes the channels (such as media outlets) and settings (such as religious institutions or schools) that are most appropriate for delivery of health messages and programs. In short, this dimension of cultural sensitivity refers to the extent to which interventions fit with the culture, experience, and behavioural patterns of a target group. On the other hand, deep structure reflects how cultural, social, psychological, environmental, and historical factors influence health behaviour. This less readily visible characteristic includes understanding how the target audience perceives the cause, course, and treatment of illness as well as how they perceive the determinants of specific health behaviour, and involves appreciation for how religion, family, society, the economy and the government, both in perception and in fact, influence their behaviour (Glanz, 2002).

One of the theoretical foundations that has been tested and considered best to elaborate how cultural sensitivity affects health communication is the Cultural Sensitive Model of Communicating Health (CSMCH) (Geist-Martin, 2003; Glanz, 2002). This model discusses how the vital role of communication is enhanced when cultural knowledge is incorporated in healthcare interaction. CSMCH explains the complex and multiple layers of meaning that a sender and a receiver bring to their relationships and conversations about health and illness.

As shown in Figure 1, the model illustrating the five layers of meaning may assist one in considering that meanings must be made aware of to be culturally sensitive when conversing about health and illness. The similarity of communication context driven by the five layers establishes shared understanding that makes the functional relationship. As a result, the context contributes to a satisfactory outcome. It is also understood that each layer reciprocally influences the others in the communication process. Since ideology represents the larger spectrum that is an umbrella to the other layers, one can conclude that ideologies have powerful and important influence on health communication. In the context of this study, religion (Islam) is considered as an ideology in the Muslim community. The fact that Islam is the way of life and not only a set of theological propositions makes it significant to analyse how and to what extent it affects health communication among Muslim audiences.

Figure 1 *The Culturally Sensitive Model of Communicating Health*



(Source: Geist-Martin, Ray, & Sharf, 2003)

Religion and Health Communication

Studies have shown that religion has effectively worked as a coping and prevention strategy in health-related issues (Koening, 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 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 socialized into the values of the society. This set of moral beliefs and values may have been so deeply ingrained through socialization 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 socializing 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 construct from the Theory of Planned Behaviour (Ajzen, 1992). Linking health messages to religious or spiritual themes, or using religious elements on 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, 2002). As proved by Campbell, Demark-Wahnefried, et al. (1999), emphasizing personal feelings of religious pride or shame can invoke attitudes towards health practices.

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, 1992; Bree, 2005; Hassett, 1981; Wallace, 1991). Regarding the relationship between religiosity and drug use, studies have found strong negative correlation (Adlaf, 1985; Amonini, 2006; Burkett, 1987; Lorch, 1985; Lugoe, 1997). 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, 2006). Moreover, previous studies have indicated remarkable findings that religion is a significant factor in deterring health risk behaviour (Frank, 2001; Furby, 1992; Lorch, 1985).

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 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.

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, 2006; Frank, 2001; Lorch, 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, 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, 2002; Janz, 2002; Petty, 1986).

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 1 *Religion and Health – the Salutogenic Effect*

Religious dimensions	Pathways	Mediating factors	Salutogenic mechanism
Religious commitment	Health-related behaviour and lifestyle	Avoidance of smoking, alcohol, drug use, poor diet, unsafe sex, etc.	Lower disease risk & enhanced well-being
Involvement & fellowship	Social support & networks	Relationships friends & family	Stress-buffering, coping and adaptation

In the context of this paper, the functions and characteristics of Islamic communication are rooted in Islam's social fabric, and are believed to impact on health behaviour. Furthermore, as explained earlier, 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, 1998; Kagimu, 1998; Roesin, 1998; Surur, 2000), and Islamic institutions such as mosque, school and community centres (Lagarde, 2000; Woldehanna, 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.

Methodology

In order to examine the values and characteristics that formulate Islamic communication persuasion in health communication, in-depth face-to-face interviews were conducted with several respondents selected from government and non-government health related agencies. These respondents included Muslim and non-Muslim professionals or practitioners. The Muslim respondents were Imam (religious leader) (R1), Director of Health Promotion Division, Health Department (R2), committee member of Malaysia *Ulama* (Islamic Scholar) Association (R3), committee member of Penang Consumer Association (R4), and Director of Institute of Islamic Understanding Malaysia (R5). The non-Muslim respondents involved in this interview were honorary secretary of National Cancer Society of Malaysia (R6), committee member of Malaysian Medical Association (R7) and Assistant Director of Malaysia Public Broadcasting (R8). All respondents were interviewed by the researcher for between 60 and 90 minutes. Interviews were recorded with the permission of the respondents and transcribed. All of the interview transcripts were read by the researcher and coded in the style of grounded approach to data analysis. The three main areas explored by the interview were; what is Islamic persuasive communication conception, how Islamic communication approaches will positively impact health behaviour, and challenges of Islamic communication approach in health promotion.

Findings

Islamic Cultural Sensitivity in Health Promotion

In regards to Islamic communication 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 emphasized by Schleifer (in Arthur, 1993), Islamic texts such as Quran and *Hadith* have become 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).

In relation to general views about using Islamic communication as an approach in health promotion, all the respondents indicate supportive views. Most of the Muslim respondents have explained how important health in Islam and the relationship with the faith. In fact they have highlight that many of Quran verses explained about prevention actions related to health such as in chapter 2 and 4 (dietary), chapter 24 (sexual conduct), and others. Furthermore, as explained by respondent R3, Prophet Muhammad has laid very influential prevention statement argued the Muslims to take necessary actions about their life condition:

> ... the important about health not only explained in the Quran, but Prophet Muhammad clearly remind us about this famous *hadith* "Take advantage of five matters before five other matters: your youth, before you become old; and your health, before you fall sick; and your richness, before you become poor; and your free time before you become busy; and your life, before your death."

Adopting Islamic communication approach in health promotion is suitable in the context of cultural sensitivity according to Muslim respondents. Even from the experience and views of non-Muslim, they support the approach. As said by R6:

> ... I think it can. When you look people who come has strong belief, they have the spiritual strength. What makes the huge different is on how they look diseases, chances on how they react to things that caused and etcetera. That is one thing that has some true. So yes, I think religion in that capacity plays some part.

For R8 who has work in public broadcasting agency for more than two decades, she agreed that it is important for cultural aspect such as religion elements being utilised for changes in Muslim communities.

Islamic Communication in Health Promotion

In order to provide insight into understanding the Islamic communication conception, the respondents were asked about the principles and values according to Islamic teachings as well as their personal opinion. As predicted, *tawhid*, *amr ma'ruf nahy munkar* (commanding to the right and prohibiting from the wrong), and *da'wah* are immensely basic principles in Islamic communication. *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. In short, it is the eternal principle of *tawhid* that governs the Muslim community argued respondent R4. In the context of Islamic communication, the theory of *tawhid* can be considered as parameters that determine information and not the other way around mentioned by respondent R5. This is because the ultimate aim of Muslim is to get blessing from God in the day after. It can also be concluded that the Islamic communication paradigm is the paradigm of revelation.

In relation to *tawhid*, the doctrine of *amr ma'ruf nahy munkar* explains the need and responsibility of Muslims to guide one another for better life according to the Islamic framework. 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 as emphasised by respondents R1, R3 and R5. At this point, the doctrine of *amr ma'ruf nahy munkar an munkar* appears to provide ideas on what and how Islamic messages can be constructed.

According to R1, *da'wah* is a 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. This concept also seeks to explained on how communication in Islam to be carried out. Respondent R3 proposed three main strategies according to *da'wah* concept which has laid down in Quran in Chapter 16 verse 125, "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". 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).

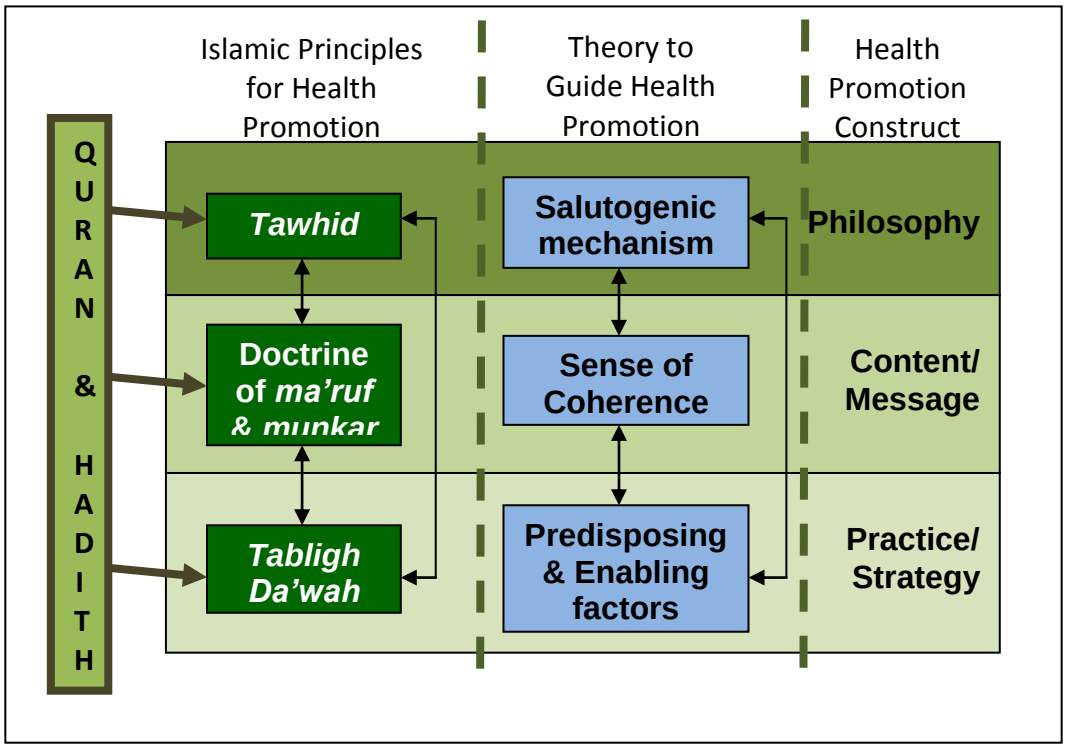
In addition, respondents also claimed that those Islamic communication mediums such as *masjid* (mosque), *madrasah* (school), Friday sermon, and other elements such as *shariah* (Islamic legal framework), *waqf* (endowment system), *shuura* (consultation council) and media institutions provide comprehensive mechanisms to articulate health promotion to the Muslim community. These is also supported by respondent R6 who claimed,

> "I got chance to go to mosque to talk to some Malays women … some corporate Malay women invited me and I use to go to mosque and give talks. I went about 12 mosques to talk to small group of people about cancer issues, sexual issues and treatment. Things like that are more acceptable... But you can't do it in open public because it is not acceptable."

In elaborate more on how Islamic communication should be, all of the Muslim respondents suggested that, it is vital to use verses from the Quran and *hadith* in constructing health messages. Most importantly, "... all the messages should be related to the Islamic faith. It would be more impact when health message is supported by Quran, *hadith*, or even *ulama* and *imam* opinion", suggested respondent R2. This view is shared by respondents R7 and R8. Furthermore, respondents R1 and R3 assumed that strategy able to be threat appraisal that can create fear arousal to some extent so that there is some positive health behaviour.

In summary, the main 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 ma'ruf nahy munkar*. In order to reach the interpersonal level of communication, the principle of *da'wah* is the best communication practice or strategy that suits the Muslim community. An illustration of all these components in relation to the Salutogenic Effect proposed by Levin (1996) is presented in Figure 2.

Figure 2 *Pathways of Islamic Health Promotion Theory*



Challenges

The acceptance and practices of Islamic communication in health promotion pose several challenges. At a very fundamental stage, it needs Islamic scholar as well as health practitioner to support the idea.

> "The issue that face than, also can be quite pain, because…. you will have a lot of your traditional proponents coming up there and using Islam as an excuse to deny health promotion or treatment compare to conventional approach (scientific based treatment). So you need to be able to make people to understand that they are using the Islamic approach that there is a moderate line or scientifically basis".

In order to face this challenge, R1 recommended that more discussion, workshop and even in policy making process should engage Islamic scholar together with health practitioner. In addition, the orientation about Islamic propagation among Muslim clerics needs some reformation. The faith well-being of Muslim should also emphasis health as one of the elements. Muslim opinion leaders such as *imam* and cleric should be provided with more and better understanding about health scenario, issues and understanding. There is a need for change of their attitude and perception about health issues and faith.

Majority of the respondents have anticipated that politic scenario will be another challenge. For some political reasons or struggle, Islamic communication approach might face difficulty to widely implement.

The result and analysis of this study that suggest the Islamic communication can indeed be useful for cultural sensitivity health promotion need to be empirically tested. As this study was mainly exploratory, the Islamic persuasive communication conception framework discussed need to be tested across or to wider Muslim communities.

Conclusion

Ultimately, the study of culture provides a fertile ground for developing health communication theories and practices that respond to the cultural needs of communities. The increasing emphasis on culture suggests the relevance for developing meaningful fusion of theory and practice in order to best understand the ways in which culture may be mobilized for health application. Thus examining conception of Islamic persuasion will lead to an understanding of how Islamic health promotion works and how it impacts Muslim health behaviour. Although Islamic communication approach in health promotion discussed in this paper sounds potential, yet more empirical research need to be done.

References

Abraham, C., P. Sherran, et al. (1992). 'Health Beliefs and promotion of HIV-preventive intentions among teenagers: A Scottish perspective.' *Health Psychology, 11,* 363-370.

Adlaf, E. M. and R. G. Smart (1985). 'Drug use, religious affiliation, feelings and behaviour.' *British Journal of the Addiction, 80,* 163-171.

Airhihenbuwa, C. (1995). *Health and culture: Beyond the western paradigm*. Thousand Oak, Sage Publication.

Ajzen, I. (1992) Persuasive communication theory in social psychology: A historical perspective. Available at http://unix.oit.umass.edu/~psych586/readings/ajzen.1992.pdf [8 May 2006]

Ajzen, I. (2002). 'Perceived Behavioral Control, Self-Efficiacy, Locus of Control, and the Theory of Planned Behavior.' *Journal of Applied Social Psychology, 32,* 665-683.

Amonini, C. and R. J. Donovan (2006). 'The relationship between youth's moral and legal perception of alcohol and marijuana and use of these substances.' *Health Education Research ,21(2),* 276-286.

Antonovsky, A. (1996). 'The Salutogenic model as a theory to guide health promotion.' *Health Promotion International, 11(1),* 11-18.

Azzi, A. (2004). Development Communication. *Journal of Global Communication Research* Retrieved 12 September 2005, from http://gcra.uaeu.ac.ae/journal/dec2004/4.pdf.

Beamer, L. and I. Varner (2001). *Intercultural Communication in the global workplace*. Singapore, McGraw-Hill Book Co.

Bree, M. B. M. v. d. and W. B. Pickworth (2005). 'Risk Factors Predicting Changes in Marijuana Involvement in Teenagers.' *General Psychiatry, 62(3),* 311-319.
Burkett, S. R. and B. O. Warren (1987). 'Religiosity, peer association, and adolescent marijuana use: A panel study of underlying causal structure.' *Criminology, 25,* 109-131.
Campbell, M. K., W. Demark-Wahnefried, et al. (1999). 'Fruit and vegetable consumption and prevention of cancer: The Black Churches United for Better Health Project.' *American Journal of Public Health, 89(9),* 1390-1396.
Dutta, M. J. (2005). 'Theory and practice in health communication campaigns: A critical interrogation.' *Health Communication, 18,* 103-122.
Dutta, M. J. (2007). 'Communicating about culture and health: Theorizing cultured-centered and cultural semsitivity approaches.' *Communication Theory, 17,* 304-328.
Eister, A. W., Ed. (1974). *Changing perspectives in the scientific study of religion.* New York:John Wiley and Sons.
Escobar, A. (1995). *Encountering development: The making and unmaking of the Third World.* Princeton, NJ: Princeton University Press.
Frank, N. C. and S. J. Kendall (2001). 'Religion, risk prevention and health promotion in adolesencts: a community-based approach.' *Mental Health, Religion & Culture, 4(2),* 133-148.
Furby, L. and R. Beyth-Marom (1992). 'Risk taking in adolesence: A decision making perspective.' *Developmental Review, 12,* 1-44.
Geist-Martin, P., E. B. Ray, et al. (2003). *Communicating health: Personal, cultural and political complexities.* Australia: Thomson Wadsworth.
Glanz, K., B. K. Rimer, et al., Eds. (2002). *Health Behavior and Health Education: Theory, Research and Practice.* San Francisco, CA, Jossey-Bass.
Hassett, J. (1981). 'But that would be wrong... '. *Psychology Today, November:* 34-50.
Hussain, M. Y., Ed. (2006). *Media and Muslim Society*. Kuala Lumpur: Research Centre, International Islamic University Malaysia.
Janz, N. K., V. L. Champion, et al. (2002). The Health Belief Model. In K. Glanz, B. K. Rimer and F. M. Lewis. *Health Behavior and Health Education: Theory, Research and Practice*. San Francisco, CA: Jossey-Bass.
Kabir, M. A., H. Mahmoud, et al. (1998). *HIV/AIDS prevention and control through the creation of awareness by mobilizing religious leaders.* Paper presented at Twelfth International Conference on AIDS, Geneva.
Kagimu, M., E. Marum, et al. (1998). 'Evaluation of the effectiveness od AIDS health education intervention in Muslim Community in Uganda.' *AIDS Education and Prevention, 10,* 215-218.
Kline, K. N. (2006). 'A decade of research on health content in the media: The focus on health challenges and sociocultural context and attendant informational and ideological problems.' *Journal of health communication, 11(1),* 43-59.
Koening, H. G., M. E. McCullough, et al. (2001). *Handbook of Religion and Health.* New York: Oxford University Press.
Lagarde, E., C. Enel, et al. (2000). 'Religion and protective behaviours towards AIDS in rural Senegal.' *AIDS, 14(13),* 2027-2033.

Leeuw, E. D. and A. A. Hussein (1999). 'Islamic health promotion and interculturalization.' *Health Promotion International, 14(4),* 347-353.
Levin, J. S. (1996). 'How religion influences morbidity and health: Reflections on natural history, Salutogenesis and host resistance.' *Social Science Medical Journal, 43(5),* 849-864.
Lorch, B. R. and R. H. Hughes (1985). 'Religion and youth substance use.' *Journal of Religion and Health, 24(3),* 197-208.
Lugoe, W. L. and P. M. Biswalo (1997). 'Self restraining and condom use bahaviors: the HIV/AIDS prevention challenges in Tanzania school.' *International Journal of Adolescence and Youth, 7,* 67-81.
Meyer, B. and A. Moors, Eds. (2006). *Religion, media and the public sphere.* Bloomington: Indiana University Press.

Montano, D. E. and D. Kasprzyk (2002). The theory of reasoned action and the theory of planned behavior. In K. Glanz, B. K. Rimer and F. M. Lewis. *Health behavior and health education: Theory, Reserch and Practice.* San Francisco, John Wiley & Sons: 67-98.

Mowlana, H. (1993). 'The new global order and cultural ecology.' *Media, Culture and Society, 15,* 9-27.

Mowlana, H. (1996). *Global communication in transition: The end of diversity?* Thousand Oak: Sage Publications.

Petty, R. E. and J. T. Cacioppo (1986). The elaboration likelihood model of persuasion. *Advances in experimental social psychology, 19,* 123-205.

Resnicow, K., T. Baranowski, et al. (1999). 'Cultural sensitivity in public health: Defined and demystified.' *Ethnicity & Disease, 9,* 10-21.

Roesin, R. (1998). *Islamic response to HIV/AIDS impact in Indonesia.* Paper presented at Twelfth International Conference on AIDS.

Salem, M. O. (2006). *Religion, Spirituality and Psychiatry*. Available at http://www.rcpsych.ac.uk/pdf/Mohamed%20Salem%20%Religion,%20Spirituality%20and%20Psychiatry%201.5.06.pdf

Shaikh, K. M. (2000). *Da'wah in Modern Times*. Karachi, Pakistan, Royal Book Company.

Surur, F. and M. Kaba (2000). 'The Role of Religion Leaders in HIV/AIDS Prevention, Control and Patient Care and Support: A Pilot Project in Jimma Zone.' *Northeast African Studies 7(2),* 59-80.

Thomas, R. K. (2006). *Health Communication*. New York, Springer.

Ulrey, K. L. and P. Amason (2001). 'Intercultural communication between patients and health care providers: An exploration of intercultural communication effectiveness, cultural sensitivity, strees, and enxiety.' *Health Communication(13),* 449-463.

Valle, C. A. (2002). *Communication and Mission*. London, World Association for Christian Communication.

Vries, H. d. and S. Weber, Eds. (2001). *Religion and Media*. Stanford, California:Stanford University Press.

Wallace, J. M. and J. G. Bachman (1991). 'Explaining Racial/Ethnic Differences in Adolescent Drug Use: The Impact of Background and Lifestyle.' *Social Problems 38(3),* 333-357.

Weaver, A. J., K. I. Pargament, et al. (2006). 'Trends in the scientific study of religion, spirituality, and health.' *Journal of Religion and Health 45(2),* 208-214.

Woldehanna, S., K. Ringhein, et al. (2006). *Faith in action: Examing the role of faith-based organizations in addressing HIV/AIDS*. Washington, Global Health Council.

Yacoob, M. (1985). 'Communicating fundalmentals of water and sanitation in Moslem communities.' *Journal of Religion and Health 24(4),* 287-293.