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Article:	**Communication, Pashtun Culture, and Decision-making about the Polio Vaccine**
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ABSTRACT

This research theorizes health communication within the culture centered approach, to explore cultural dynamics of public health emergencies like Poliomyelitis (Polio)-a highly contagious and incurable viral disease. The Global Polio Eradication Initiative (GPEI) was launched in 1988 globally to eradicate poliovirus from the last two endemic countries - Pakistan and Afghanistan but facing serious challenges. Twenty-seven semi-structured in-depth interviews with ethnic Pashtun parents- refusal cases, from three high risk districts of Khyber-Pakhtunkhwa, Pakistan were conducted; analyzed using constructivists grounded theory to explore how the life experiences of these cultural participants shape their understanding of health, consequently, make decisions regarding immunization of their children against poliovirus. Resultantly, four concepts emerged: honoring familial hierarchy, alternative medicine, religion, and forced compliance. The findings of the research endorse necessity of dialogue and participation within health communication strategies supporting the alternative dimension, validates foregrounding and integrating culture at all stages of program development while addressing health crises. Cultural beliefs and values create strategic influences thereby shaping a sympathetic environment for [health] promotion and interventions programs.

Keywords Health Communication: Poliomyelitis (Polio), The Culture Centered Approach; Constructivist Grounded theory; Poliovirus Vaccines; Vaccination Refusal; Immunization

Introduction

Under the cultural understanding of health, disease and well-being, individuals' choices and decisions are intertwined within the cultural context such as family values, norms, and languages. Culture in many countries has been linked to exacerbating unhealthy behaviors, besides understanding, and defining other social problems (Room, 2013). This article tries to understand through parents' perspectives that to what extent do elements of culture (values, beliefs, norms, and traditions) contribute to health-specific meaning making in the context of polio vaccination in Khyber-Pakhtunkhwa Province, Pakistan.

The study based on culture-centered approach, foregrounds the agency of cultural participants based on dialogue between the researcher and the community members, with the goals of listening to the voices of cultural members in suggesting culture-based health solutions.

The polio epidemic in Pakistan is here since long, and the WHO along with other organizations is trying to eradicate it from the face of the earth. This study has used the culture-centered approach to understand what health meanings are created by the local people with respect to the polio health emergency (declared by the WHO), how and where these meanings and messages are negotiated and articulated (Dutta, 2008; Dutta & Basu, 2011; Dutta, 2019, 2020a).

The Culture-Centered Approach: Health Meaning Making

Health communication as early as 1960's generated debates and discussions to foreground culture and soon garnered support (Dutta, 2014). Lupton advocated for the inclusion of cultural aspect, critiqued the paternalistic and top-down communication patterns and power relations between professional and target groups (Lupton, 1994; Sharp & Leshner, 2014). Earlier western social and behavioral models were developed without incorporating culture and considering culture as a barrier (Northouse & Northouse, 1998; Airhihenbuwa & Obregon, 2000; Dutta, 2008).

Health communication conceptualization brought together by Dutta and others identified four approaches grounded on two dialectical tensions based on the perception of scholars theorizing culture as static or dynamic and also the communication means to achieve goals - social change or status quo (Dutta, 2008; Dutta & Zoller, 2008; Dutta & Basu, 2011; Dutta, 2014). Further adding that status quo requires the promoters to work within the established structures without altering the social fabric. In the latter case culture is considered as "transformative and contextually situated", therefore, social structures need reconfiguration and alteration to bring social change (Dutta & Basu, 2011, p.321).

This research study is based on culture-centered approach, the critical response developed by Mohan J. Dutta (2008) against the dominant paradigm, by incorporating culture into health communication programs (Lupton, 1994; Airhihenbuwa, 1995; Airhihenbuwa et al., 2000). This approach does not ignore the concerned communities, but advocate using dialogue, promoting communicative spaces to reach out to the marginalized and voiceless resulting in changing health attitudes and behaviors (Basu & Dutta, 2009; Dutta, 2010; Jamil & Dutta, 2011; DuPré, 2014). Dutta's culture-centered approach theoretical underpinning is based on cultural studies, critical theory, post-colonial theory and subaltern studies, presenting two fundamental elements: community and dialogue. Community in this approach plays a role

in articulating problems and providing solutions to those problems. The second part dialogue refers to engaging in a communicative process with the marginalized communities to understand health their issues, and how they perceive these problems and then generate community solutions.

Previous studies in communicable diseases and non-communicable diseases endorse the positive outcomes resulting from the inclusion and application of culture in health communication, and the concept's growing influence and importance are encouraged by increasing multiculturalism and diversity. It is evident from earlier studies that the inclusion of cultural aspect in health communication related to polio vaccination in Khyber-Pakhtunkhwa, Pakistan, has not been investigated in this manner.

Pakistan and Polio

Since the launch of GPEI in 1988, to eradicate the disease, which paralyzed more than 1,000 children every day across the world, poliovirus affected population has decreased and the number of cases brought down 99% globally. This initiative undertaken with the help and cooperation of more than two hundred countries, more than twenty million volunteers worldwide, and U.S. $18 billion of investment supported and funded by international organizations, i.e., WHO, UNICEF, CDC, Bill & Malinda Gates Foundation, RI, USAID (WHO, 2021). However, the only remaining countries in the world are Pakistan and Afghanistan, where polio is epidemic, which is the last 1% of the infected cases and a threat to every child everywhere.

Pakistan became part of the GPEI program in 1994 to reach maximum number of children for immunization. The accelerated efforts and energies instilled resulted in positive outcomes which saw a new low of 28 cases reported in 2005. This trend did not remain low for long but saw a surge from 91 cases in 2013 to more than 300 in 2014, representing more than 85 % of the global wild poliovirus caseload.

Table 1: WPV Polio Cases Across Pakistan's Provinces.

PROVINCE	2015	2016	2019	2020	2021	2022
PUNJAB			1	25	1	0
SINDH			0	45	2	0
KHYBER PAKHTUNKHWA	2		16	42	1	0
BALOCHISTAN		1	0	23	4	0
GILGIT-BALTISTAN			4	0	0	0
AZAD JAMMU & KASHMIR			0	0	0	0
ICT			1	0	0	0
TOTAL POLIO CASES	2	1	22	135	8	0

End Polio Pakistan, 2023

Polio Risk Classification Across Districts in Khyber-Pakhtunkhwa Province

Pakistan polio program has classified different areas as per the risk and severity factor determined on the base of variability in both quantitative and qualitative risk assessment and address the same through eradicating strategies- operational and communication.

These are referred to as Tier 1 'core reservoir', Tier 2, 'high-risk', Tier 3, 'vulnerable', and Tier 4, 'low risk', are

Table 2: High-Risk Districts.

Province	Tier-1	Tier-2	Tier-3	Tier-4	Total Districts
AJK				10	10
BALOCHISTAN	3	4	10	16	33
GILGIT BALTISTAN			2	8	10
KHYBER PAKTHUNKHWA	2	16	10	6	34
PUNJAB		4	6	26	36
SINDH	6	10	8	5	29
Grand Total	11	34	37	71	153

End polio Pakistan, 2023

Ethnic Pashtuns

The Pashtuns are mainly one of the major ethnic groups residing on both sides of the Durand line – the name given to the border, demarcated in 1893. Majority of Pashtuns are living in Pakistan, particularly in Baluchistan & Khyber-Pakhtunkhwa regions.

The social structures of ethnic Pashtuns are defined by anthropologists as having a segmentary lineage system based on the hierarchy- of position. The social groups are divided into many levels of hierarchy, and that flows from local level to upwards through these levels, based on familial relations and culture. Barfield (2010) notes that these familial and ethnic relations are valued more, among these ethnic group than abstract concepts emerging from ideologies. Studies (Hussian et al., 2016) suggest that ethnic Pashtuns 5 times more likely to contract poliovirus, and the data emerged of poliovirus infections reveals that 77% cases are from Pashtun population.

Methods

Data Gathering

This study is based on qualitative paradigm, the researcher chose a small, information rich and in-depth sample purposefully. The data has been collected from the ethnic Pashtun belt of Khyber-Pakhtunkhwa Province.

Data Analysis

Health communication, as a multidisciplinary field of study, recognizes the heuristic and practical utility of health communication, where culture remains at the heart of theorization. I employ a qualitative approach to answer the unexplored question. Moreover, this community- based qualitative investigation acknowledges the importance of theoretical and methodological framework devised by Mohan J. Dutta (2008) the culture-centered approach (CCA), documenting the co-construction and articulation of health meanings created by the marginalized cultural communities. Further, advocates for an alternative route to develop theory and application from within the culture – grounded in their lived experiences; against the "expert" driven (Western) message-based approach that may be unfamiliar with the local needs and context, strengthening the existing communicative power structures (status quo).

The process was initiated through purposeful selection of parents who refused to vaccinate their children against polio living within three high-risk Districts (Peshawar, Bannu, and Lakki

Marwat) in the Khyber-Pakhtunkhwa province. Data gathered by in-depth interviewing twenty-seven participants before reaching "theoretical saturation", during November 2020 and December 2022.

Results

This section focuses on the narratives that emerged from the data collected about the participants' construction of health meaning in the context of the poliovirus-global emergency. The data collection process and transcription went simultaneously, which helped me reflect on previously conducted interviews and questions; rephrasing questions, and making follow-up questions, where needed, also helped me refine the process of data gathering.

Hence, the qualitative data has been explored inductively (data-driven approach), to bring out varied concepts and generate theory thereof, asking for a 'constructivist grounded theory methodology' (Charmaz, 2000, 2006). I took a less procedural, and dynamic constructivist grounded theory analysis, where meaning is created within a context, where the researcher and the participants share experiences to generate and produce data.

Using Charmaz's (2006) constant comparative method requires reading, and re-reading the data, giving rise to codes, concepts, and categories, shaping into a tree, while going back and forth resulting in the emergence of larger themes. This mechanism was done through open, axial, and selective coding to identify themes from among the collected data.

However, the following section presenting the theme emerging from the data tries to answer the research question in a clear and unambiguous manner, more connected and interlinked throughout the explanation process.

Honoring Familial Hierarchy

Many participants elaborated on the concept of social cohesion and honoring family hierarchy by saying that family is everything.

One participant explained the patriarchal structure in the following words,

> "Within the household elders call the shots and the rest just follow. They are bread earners; they are the decision-makers. Females are just for home chores, and raising children, nothing more, decision-making is not meant for them."

All the participants agreed that the social structure here lacks female empowerment, where females cannot travel without a male companion/partner or see a doctor without the permission of a male elder.

Social hierarchical structures in Pashtun society matter much and play a prominent role in participants' stories. Family members and friends play a vital role across these stories where the participants compare familial trust with the healthcare providers (not trusted). In the context of health decision-making, the participants explained the role of individuals, family members and friends as good sources of information, sharing stories related to everything and anything. Elaborating the fast communication process within the community, he added,

> 'Word of mouth', spread like wildfire across the village within a short time."

All the participants insisted that the role of immediate family and extended family has a great role in decision-making; playing a strategic role as partner in efforts to mitigate social problems. Pashtun social structure is closely knit and remains family-oriented whereas extended family and friends exist as a vital social institution. Participants argued that the

concept of family and extended family is the foundation of society, whereas not restricted to blood relations.

The same family bond has another aspect through religion [Islam] bestows a central value to care for the near and dear ones and their relations (Abudabbeh, 2005). Family involvement and relationships work for the young ones as the first social institution encompassing traditions, values, and norms bringing and creating a profound cultural impact (Ayish, 2003).

Although across various regions of Pakistan values and norms are different, however, the three districts in question have almost the same cultural values, traditions and norms which play a role in understanding life and attitude towards health and well-being (Dutta, 2009). Interviews give us a clear understanding that these participants rely on their families and friends and extended families, making up a big source of individual learning and meaning making by understanding the world around them, besides traditions playing a vital role as well. As noted by many participants that the immediate family is not the only source of information, but the relation is much broader involving friends and neighbors, make critical decisions involving familial relations and whenever locating health care services, relocating, traveling, or making health decisions.

A female participant informs,

> "All sorts of information come through these familial gatherings, children's vaccination, care, and health. While visiting a doctor we go together with the permission of our men."

Family involvement and the traditional hierarchical system have a high impact on meaning-making and resultantly decision-making processes related to health and wellness.

Alternative Medicine

It was evident from most of the interviews that strong cultural values, beliefs, and traditions are creating self-imposed barriers where participants talk about avoiding Western biomedical treatment or formal health service utilization. Instead, these participants prefer to avail traditional and ethnic healthcare, homemade remedies, and spiritual healing The use and preferability of alternative medicine among these participants present varied reasons like lack of knowledge of western concepts and terminologies, and diagnostic techniques (Ma, 1999). However, this form of treatment is the preferred option during illness for treatment.

Participant (27) claimed that females are more prone towards seeking homemade remedies and spiritual healers, influenced by experienced women in the family or neighborhood. While highlighting the ease and less expensive nature of seeking alternative medicine,

Participant (25), shared his experiences,

> "Neighborhood had access to cheap and easily available home remedies, or spiritual healers, making it the first choice."

And exchange of eggs, chickens, and butter is possible, while in biomedical treatment impossible.

It is quite revealing that this form of treatment; home remedies & spiritual healing, is presenting a big challenge and a major obstacle in the prevention and treatment of diseases, in this case, eradication of poliovirus.

Although many interviewees noted that their use of western and local (alternative) medicine pattern is varied, most of them experiment with Western medicine at later stages. Instead of opting for it from the beginning is an evidence that these decisions are culturally influenced by individuals and community's experiences, knowledge and belief system encompassed around wellbeing and health. Failing to understand these culturally put health practices among the community, the healthcare system brings considerable challenges in the shape of mistrust, hesitancy, and ill cooperation. These beliefs further generate skepticism and uncertainty towards Western medical practices and even organizations facilitating [local] health care system. Most of the participants highlighted the point that from a very young age, they haven't seen their elders adopting modern health practices or seeking biomedical treatment, however, stayed well. The modern concept of prevention remains a foreign and Western concept, ill-fitted with the common belief and value system.

Participants repeatedly raised concerns and dislike about the hectic and tiring processes of testing too much, expensive nature against the accessible, cheap, and quick procedures seeking alternative medicine. Further, Participants' interviews also revealed the closeness of people to the ancestral cultural practices whether related to family hierarchy, kinship, collectivism, and honor. These people would stick to the old ancestral practices whatever the consequences and costs, even their lives.

Forced Compliance

Articulating the concept of following in the footsteps of their forefathers rejecting any new trends emerging, the newest concept of forced adherence applied by the government. Participants articulate the mechanism utilized to compel the people to comply with the government initiative whether participants like it or not, giving rise to severe conditions of negativity and resistance. Most of the participants considered it as 'suspicious', and pledged to resist, and challenge whoever try to impose any practices against their belief system.

All the Participants showing anger,

> "Government forcing people to follow orders [angrily] doesn't make any sense, there must be something behind it; we are better off without it [polio vaccination].''

Participants vehemently defended their right to decide for themselves and mentioned,

> "Forcing public to adhere will fail here, it always fires back. You [government] are making them stubborn & suspicious; changing their mentality and behavior is not easy, it is a slow process, it will take time."

"Compulsion" and "forced" adherence by threat of police cases, imprisonment and denying access to personal documentation processes. Besides, officials and police showing up at the doorstep asking people to vaccinate children is not a respectable way to convince.

Religion

Under this researcher data analysis religion [Islam] emerges as the way of life for the cultural participants guiding their values, beliefs, morals, and actions. There are instances where cultural participants reflect their beliefs arguing and contesting the logical side of vaccine production processes. The participants suspecting the vaccination production process as dubious, mistrust the ingredients, use of 'pig-fat', which is 'haram'- forbidden in Islam, or may cause infertility.

On the other hand, blind faith [fatalistic approach] towards religion plays differently. Participants believe in God as all-powerful, where physical and worldly resources do not play any role but the 'Will of God' falls into play without seeking any medical intervention for health and illness.

Many participants referred to this by using the words, 'MashaAllah', 'Alhamdulilah' [All praise to Allah] while discussing their good health, while many rejected biomedical treatment on the plea mentioning their strong belief in Allah [God], who will safeguard them from illness, and/or give health without seeking any treatment. During COVID-19 religious beliefs played a strong role. Public refused to obey government instructions regarding public gathering and attended masjid (mosque). During a discussion one participant talked about religious imams challenging people to hug, which was strictly against the SOPs. Further, also disclaiming Saudi Arabia's leaders who do not allow people to do 'Tawaaf'- a ritual to go around 'Kaaba' and banned travel to Macca for Umra & Haj. The imam requesting Saudi government emotionally to send Aeroplan for them to observe the required rituals, because they [imam and public] cannot let it happen.

Participants' quoted history embedded within religious beliefs, "Before this polio people had children, many born without any illness or defect, and a few with defects. It is Allah's will, who are we to decide?". Others claim that disabilities are results of bad 'spirit' or 'bad eye', that's why they seek spiritual healing mechanisms; using "taweez' or putting a black mark on face to avoid bad eye.

Participant (2) consider beliefs essential for better health, besides acknowledging religion [Islam] as a protective cultural construct, affirming most of the participants' views by saying,

> "I have not seen any illness myself and in my children, I get up very early in the morning pray in the quiet early hours, and then take my children for 'namaz [prayer] with me."

Thoresen and Harris (2002) argue that people's way of life and their belief, and practices –religion and spirituality, give them an understanding of health and wellbeing.

Dutta and others (2008; Kleinman, Eisenberg, & Good, 1978) understand that health and illness are culturally constructed experiences therefore within the realm of religion health and its construction are located within their own contextual web of worldview.

Most of the participants are of the view that religious [Islam] culture has greatly influenced the participants' worldview; it has a profound and direct impact on the values, thinking and decision-making process. It remains the strongest cultural element among the ethnic Pashtuns specifically from the Khyber Pakhtunkhwa region.

Koenig et al. (2008) discusses and segregates the potential effect of religious beliefs on health as a coping tactic, as a source of social support, and as a behavioral modifier. Religion, prayer, and behavior change has been observed and recognized by other researchers as well (Jantos & Kiat, 2007).

The gathered data reveals another aspect of religion. Participants' perception and approach take a turn towards the historical and political aspect of religion, building a discourse of 'West' and 'Islam'. This becomes widely accepted and holds foot due to the collaboration of INGOs- widely considered west centric, implementing Western agendas, besides certain negative events, or incidence, i.e., reported (allegedly) fake vaccination campaign in district Abbottabad to trace Usama bin Laden, an Al-Qaida Leader.

Participants [hatefully] talked about their concerns in these words,

> "They [non-Muslims] cannot be our friends, they want us [Muslims] to get weak, they want our population to decrease and then to control us; so how can we trust them?"

Another participant added,

> "Bill Gates is behind all this. He does not want us [Muslims] to prosper. Do you really think he is doing it for charity? Or for God? he is a businessman; there may be people above him, using him. He became wealthier due to these vaccines."

During COVID-19, these ideas strongly emerged not only in this region but across the world, strengthening the negative perception. Another participant referred to "New World Order', "launch of the Illuminati' and the sinister plans of 'West' against the 'Muslims'.

Discussion

This study offers theoretical and empirical findings to explore how communication and culture influence health perceptions, meaning making, and decision-making, particularly regarding polio vaccination. The existing research on health communication, specifically related to polio vaccination, reveals three critical limitations that hinder the intervention and prevention strategies adopted for eradicating poliovirus. The current corpus of literature on polio eradication efforts shows repetition and duplication, frequently referring to the determinants, and barriers affecting refusals and resistance among the parents, including incoherent and ineffective communication designs and strategies.

This research, as noted earlier, responds to gaps in the current literature by drawing on and foregrounding the Culture-Centered Approach (CCA), which advocates alternative conceptualization of communication, against the message-based theorization of health communication.

Participants' statements reinforces the concept that communities and individuals value culture, and has immense influence; making meaning out of their context and taking a decision regarding their health and well-being per se. Whereas it necessitates taking an alternative route against a top-down model while informing and instructing individuals and communities; culture centered approach towards health communication provides the key to unravel the required information needs, through engaging in dialogue and discussion with individuals & communities using building blocks of trust and understanding.

Participants' data analysis reveals that Culture, and its elements play a pivotal role in the lives of these people using it as a lens to grasp the social landscape and make meaning out of it. The same helps them to understand and perceive health and well-being; the decision to follow health prevention recommendations or resist it, all revolves around cultural ambit, where individuals are more concerned about, and values their beliefs, norms, and traditions.

The findings largely and emphatically support Mohan. J. Dutta's (2008) recommendations regarding health communication that the cultural dimension shall be the inclusive part of it. The same has been supported within the growing scholarship in health communication, by integrating cultural aspects from the developing stage, to designing, implementing, and reviewing health communication efforts (Dutta, 2008; Basu & Dutta, 2009; Dutta & Basnyat, 2010; Dutta & Basu, 2011; Jamil & Dutta, 2011; DuPré, 2014). Additionally, this research highlights the importance and necessity of dialogue, and participation within

health communication strategies, by valuing those at the margins and incorporating the voices missing from the mainstream communicative spaces.

Although culture plays a significant role in health communication, it is often treated as an afterthought and not fully integrated into health communication programs. This approach merely pays lip service to cultural insiders. Health communication programs that use this method identify cultural factors as variables and then target these factors using message-based strategies, such as culturally sensitive or tailored approaches (Dutta-Bergman, 2005). It is a well-established fact that "when technical interventions are at cross purposes with deep-rooted cultural values, culture always wins" (WHO, 2015).

Fundamentally, cultural influences reach deeper than the superficial worldview and fathom beyond the policy perspectives about immunization, where beliefs and values, and local traditions remain the powerful factors that exert influence on applied health communication. Conclusively, overwhelming evidence suggests that substantial reforms are required to achieve global health initiatives and commitments, including poliovirus eradication, without falling into the trap of "commitments" and "good intention", which are not sufficient for public health objectives. Further, replicating this research and foregrounding culture would help understand decision making processes, health choices and form of treatment within different cultural setups. This study embedding culture by exploring cultural beliefs and values that shape and influence health related attitude and behaviors, establishing foundation for further studies.

Health communication, as noted above, is in the early stages as a field in Pakistan; hence it needs the government's attention and encouragement by supporting academic endeavors to initiate further research in the field with a distinct emphasis on the role of culture. This, it is hoped, would inevitably result in creating awareness and accumulating health communication knowledge and research. This research further reinforces the necessity for developing and strengthening health communication as an academic discipline, creating opportunities by engaging and collaborating with research scholars and academicians in the region and beyond.

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References

Abudabbeh, N. (2005). Palestinian families. *Ethnicity and family therapy*, 487-498.

Airhihenbuwa, C. O. (1995). Health and culture: Beyond the Western paradigm.

Ayish, M. I. (2003). Beyond western-oriented communication theories a normative Arab-Islamic perspective. *Javnost-The Public*, *10*(2), 79-92.

Basu, A., & Dutta, M. J. (2009). Sex workers and HIV/AIDS: Analyzing participatory culture-centered health communication strategies. *Human Communication Research*, *35*(1), 86-114.

Barfield, T., & Nojumi, N. (2010). Bringing more effective governance to Afghanistan: 10 pathways to stability. *Middle East Policy*, *17*(4), 40-52.

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin, & Y. S. Lincoln (Eds.*), Handbook of qualitative research* (pp. 509-536). Thousand Oaks, CA: Sage.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* London: Sage

Chaturvedi, S. K., & Desai, G. (2011). Spirituality, distress, depression, anxiety, and quality of life in patients with advanced cancer. *Indian journal of cancer*, *48*(1), 55-59.

Closser, S. (2010). *Chasing polio in Pakistan: why the world's largest public health initiative may fail*. Vanderbilt University Press.

Closser, S. (2012). "We can't give up now": global health optimism and polio eradication in Pakistan. *Medical Anthropology*, *31*(5), 385-403.

DuPré, A., & Overton, B. C. (2010). Communicating about health: Current issues and perspectives.

Dutta, M. (2007). Communicating about culture and health: Theorizing culture centered and cultural sensitivity approaches. Communication Theory, 17(3), 304- 328.

Dutta, M. J. (2008). *Communicating health: A culture-centered approach*. Polity.

Dutta, M. J. (2014). A culture-centered approach to listening: Voices of social change. International Journal of Listening, 28(2), 67-81.

Dutta, M. J. (2019). What is alternative modernity? Decolonizing culture as hybridity in the Asian turn. *Asia Pacific Media Educator*, *29*(2), 178-194.

Dutta, M. J. (2020a). COVID-19, authoritarian neoliberalism, and precarious migrant work in Singapore: Structural violence and communicative inequality. *Frontiers in Communication*, *5*, 58.

Dutta, M. J., & Basu, A. (2011). Culture, communication, and health: A guiding framework. In *The Routledge handbook of health communication* (pp. 346-360). Routledge.

Dutta, M. J., & Basnyat, I. (2008). The radio communication project in Nepal: A culture-centered approach to participation. *Health Education & Behavior*, *35*(4), 442-454.

Dutta, M. J., & Zoller, H. M. (2009). Theoretical foundations: Interpretive, critical, and cultural approaches to health communication. In *Emerging perspectives in health communication* (pp. 11-38). Routledge.

Egbert, N., Mickley, J., & Coeling, H. (2004). A review and application of social scientific measures of religiosity and spirituality: Assessing a missing component in health communication research. *Health Communication*, *16*(1), 7-27.

Hussain, S. F., Boyle, P., Patel, P., & Sullivan, R. (2016). Eradicating polio in Pakistan: an analysis of the challenges and solutions to this security and health issue. *Globalization and health*, *12*, 1-9.

Jamil, R., & Dutta, M. (2012). A culture-centered exploration of health: Constructions from rural Bangladesh. *Health Communication*, 27, 369-379.

Jantos, M., & Kiat, H. (2007). Prayer as medicine: how much have we learned. *Medical journal of Australia*, *186*, S51-S53.

Koenig, H. G. (2008). Concerns about measuring "spirituality" in research. *The Journal of nervous and mental disease*, *196*(5), 349-355.

Lupton, D. (1994). Toward the development of critical health communication praxis. *Health Communication*, *6*(1), 55-67.

Northouse, L. L., Templin, T., Mood, D., & Oberst, M. (1998). Couples' adjustment to breast cancer and benign breast disease: A longitudinal analysis. *Psycho-Oncology: Journal of the Psychological, Social and Behavioral Dimensions of Cancer*, *7*(1), 37-48.

O. Airhihenbuwa, Bunmi Makinwa, Rafael Obregon, C. (2000). Toward a new communications framework for HIV/AIDS. *Journal of Health Communication*, *5*(sup1), 101-111.

Rehm, J., Marmet, S., Anderson, P., Gual, A., Kraus, L., Nutt, D. J., ... & Gmel, G. (2013). Defining substance use disorders: do we really need more than heavy use. *Alcohol and alcoholism*, *48*(6), 633-640.

Sharp, P. A., & Leshner, A. I. (2014). Meeting global challenges. *Science*, *343*(6171), 579-579.

Thoresen, C. E., & Harris, A. H. (2002). Spirituality and health: what's the evidence and what's needed. *Annals of behavioral medicine*, *24*(1), 3-13.

World Health Organization. (2021). Global polio eradication initiative annual report 2020 and semi-annual status updates, January-June and July-December 2020.