COMMUNICATION FOR EMPOWERMENT AND PARTICIPATORY DEVELOPMENT: A SOCIAL MODEL OF HEALTH IN JAMKHED, INDIA

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This dissertation entitled
COMMUNICATION FOR EMPOWERMENT AND PARTICIPATORY
DEVELOPMENT: A SOCIAL MODEL OF HEALTH IN JAMKHED, INDIA

by

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has been approved for
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This research sets out to understand how communication can facilitate participatory development to improve poor people’s lives using the Comprehensive Rural Health Project (CRHP) in Jamkhed, India as a case study. For three and a half decades, CRHP has been using a holistic development approach for enhancing people’s health and well-being. CRHP helps poor families improve health through promotion and diffusion of new information, and through different communication practices empowers communities. Thus, communication is used at two levels: to provide new information and to engage people in a dialogue that leads to positive community action. The research used theoretical constructs guiding participatory communication such as critical thinking and problematization as a means for empowerment (Freire, 1970, 1973), the role of the communicator as a facilitator in orchestrating social change (White, 1999) and the role of para-professional aides and change agents in fostering the diffusion of new information and ideas for social change (Rogers, 2003). Two-months of fieldwork, conducted in six villages in the Jamkhed region, used multiple ethnographic methods.

The research concludes that communication processes using Freirean principles can contribute towards empowering poor people if conducted over a long period. Participatory communication and collective action can be successful if change agents act
as facilitators and are sensitive to people’s needs. Furthermore, the research indicates that genuine participation is slow and social change is even slower. It also concludes that participatory development and empowerment are dialectical processes that rely on dissemination of expert knowledge and an open dialogue between experts and local people. CRHP shows that empowerment is possible if the project staff, change agents and community members are motivated and willing to continuously change and adapt to the environment, and also challenge oppressive social and political practices. The research concludes that communication practices are important in organizing people to come together and to seek social change, but larger political and structural changes are also necessary to complement individual and community-level actions.

Approved:

David H. Mould

Professor of Telecommunications
To the Village Health Workers of Jamkhed.

These women represent how empowerment can transform people’s lives, and underscore the importance of community participation for sustainable development.
Preface

Writing this dissertation has been a remarkable experience. It has been a journey that has almost brought me full circle with respect to my roots. In hindsight, it seems only natural that the dissertation research took me back to the place, people and language that I am closest to, in the State of Maharashtra in western India. Although I had never been to Jamkhed, the town where this research is based, before July 2004, I have spent two-thirds of my life in this region of India. Yet, doing the fieldwork and writing the research helped me reflect on aspects of life in rural India that I knew existed, but had rarely experienced. As a result, the research has contributed considerably to my learning experience. I plan to continue doing research that adds to the theory and practice of communication for development.

For almost a decade, I have been with practicing, researching, studying, and to some extent teaching communication. My journey within communication has taken a natural trajectory. I have had the liberty to learn about advertising, mass communication, health communication, and communication for development. Within this vast field, I am fascinated how for centuries communication has been used to facilitate or influence positive and negative changes among individuals and society. However, given the stark inequalities between the rich and the poor all over the world, to me it seems only appropriate that we find ways to use communication to achieve a more equitable society. The ensuing chapters inform us, how a group of dedicated doctors and social workers have been using communication for positive social change among the poor in Jamkhed, India.
I was attracted to this remarkable story of human potential and participatory development, because the project implements most of the theories and models for involving the poor in development projects. Comprehensive Rural Health Project (CRHP) is a story about role reversals, challenging social norms, communicating with the people, demystifying technical knowledge, and above all respecting poor people. Ultimately the purpose of the project is to ensure that poor people take control over their future, and demand universal human rights such as good health, clean drinking water, and an opportunity to participate in the projects that are designed to benefit them. During the research, I was able to meet many poor people, especially poor women whose lives have been transformed due to their participation in the project, which is a testimony of the efforts of the people who make change happen in Jamkhed.

Finally, this research is important to me because despite numerous successful communication for participatory development projects, given the inequities in our world, there is still a need to learn how to implement effective and sustainable projects that can transform the lives of the poor communities. It is hoped that CRHP’s accomplishments presented through this research can inspire other human development projects.

Ketan S. Chitnis

Athens, Ohio

June 6, 2005
Acknowledgements

This research would not have been accomplished without the generous support and warm hospitality of Comprehensive Rural Health Project’s (CRHP) director Dr. Raj Arole, associate director Dr. Shobha Arole and the collaboration of Ms. Connie Gates, CRHP’s U.S.-based resource person. Dr. Arole and Shobha trusted in me and provided generous support to carry out the fieldwork in Jamkhed. They also made me feel at home during my stay at CRHP’s training center. Connie spent a good deal of her time introducing me to CRHP and Jamkhed, carefully editing my research proposal and above all helping me to gain credibility with the Aroles well before I arrived in Jamkhed. I would also like to thank the mobile health team members, in particular, Mr. Jhadav, Mr. Pandit, Ms. Renuka, Ms. Jerus and Mr. Dhotray, for their assistance in conducting the fieldwork. Additionally, I cannot thank enough the village health workers like Lalanbai, Sarubai, Yamunabai, Leelabai, Babai, Asha and Sureka for their enthusiasm and friendliness and for sharing their personal stories. They provided me invaluable insight about the project.

Back in Athens, the two people who have played a huge role in this dissertation are Professors David Mould and Arvind Singhal. As the chair, David supported me in every step of this project. Most importantly he helped me understand and situate Jamkhed within the historical context of India and the larger field of communication for development. Also, he spent hours editing the drafts to make this research reader-friendly. Finally, working with David for the past two years as his graduate assistant and
having him as a chair has been a tremendous learning experience, especially his efforts in allowing me to become part of the communication and development studies team.

Apart from being a mentor and agreeing to co-chair this dissertation, Arvind’s biggest contribution was to introduce me to Jamkhed. In his classic style of mentoring and piquing students’ interest to do research, in summer 2003, Arvind casually emailed me about Jamkhed and said, “you may want to check this project out.” Ever since, we have spent numerous hours discussing, researching, and writing about Jamkhed and other projects in the world that use a social model of health. Arvind has also been a big influence in helping me shape my research agenda in graduate school. In the four years I have known Arvind, he has inspired me, guided me, and provided numerous opportunities to publish research on contemporary topics in communication and development. I hope this is only the beginning of my intellectual journey with him.

My other two committee members, Professors W. Stephen Howard and William Romoser supported me in ways they may not be aware of. Steve has been instrumental in preparing me to conduct the fieldwork, and on numerous occasions he advised me on how best to write a sociological inquiry of this sort. Steve, if I have fallen short of your expectations, it is entirely due to my shortcomings, you have been a fabulous resource to me. Bill thank you for allowing me to do a dissertation that deals with community health and development, when I know so little about public health. I feel I have underutilized your expertise in the field of development, yet your comments have made me think broadly about the field and the place of communication for participatory development.
I want to also acknowledge Dr. Atmaram Gawande and Dr. Rajendra Koshal of the Friends of India Endowment, Athens, Ohio, Dr. Karen Riggs, Director, School of Telecommunications, the College of Communication, Ohio University and Dr. Arvind Singhal for providing funds to carry out this research.

Finally, I want to extend my gratitude to my parents, Neela and Sudhakar Chitnis, for making my stay comfortable between my research trips from Pune to Jamkhed. Moreover, I owe it to them for being there for me throughout graduate school. Without their encouragement, nurturing and constructive feedback this dissertation would not have been written. I also want to thank my in-laws, Madhu and Ashish Sengupta for their support during my time at Ohio University.

And lastly, the one person who stood by me during the one and a half years it took to complete this dissertation is Ami, my wife. Ami, you have been the best companion to have. You read many drafts, suggested thoughtful corrections, encouraged me throughout the writing process, and provided me invaluable moral support. I could not have asked for anything else. You have played a huge part in this research. I hope I can do at least half these things for you as you write your dissertation.

Ketan S. Chitnis

Athens, Ohio

June 6, 2005
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CHAPTER 1: INTRODUCTION

Scenes from Jamkhed: I

Sea of sarees. Every Tuesday, a stream of women clad in brightly colored sarees and carrying knapsacks find their way by bus, on foot or by hitching a ride to the Comprehensive Rural Health Project’s (CRHP) training center in Jamkhed. Typically, about 50 women from as many villages make this journey and stay overnight to participate in the training sessions. These women may seem like ordinary village women in their mid-thirties who sell vegetables at the bazaar (weekly market) or work on farms, but they are remarkably different from their peers. We realize this when they talk amongst themselves, when they make eye contact with strangers, and the confidence they exude while speaking in the training sessions. These women, many of whom have been coming to Jamkhed week after week for their refresher training for over twenty years, and some for more than thirty years, are the village health workers (VHWs).

Demographically, a VHW is a woman from the lowest caste or socio-economic stratum, in her early to mid thirties, and married with a couple of children or widowed. Within the Indian context, such women are often the most oppressed and marginalized due to the prevailing social structures (Arole & Arole, 1994). But the VHW defies the stereotypes of an oppressed woman; she is strong, empowered and above all well respected in her community. A VHW is the strongest link between the community she represents and the project staff in Jamkhed. She is the facilitator, a para-professional aide and an advocate for positive social change. The weekly training session uses communicative practices to train facilitators who in turn mobilize community
participation. Equipped with these skills, the VHWs help build the confidence and self-esteem of the most marginalized women and men in the villages.

*Village mapping.* Sharadwadi is a small village about seven miles east of Jamkhed. In the middle of the village, not far from the primary school, the local Farmers’ Club, comprised of young men in their twenties and led by the former *sarpanch* (village headman), has built a small platform with a tin roof. This is the community meeting hall where one finds many men and women actively discussing community problems. It is not unusual to find Raju, one of the active members of the Farmers’ Club, sitting with few friends and drawing a map of his village. With the help of Rambhabai, a tall slender woman in her thirties appointed by her community almost 10 years ago to become a health worker, and the project staff at Jamkhed, Raju and other members of the club have learned rapid rural appraisal tools to assess and monitor the social and economic problems facing their community.

When asked, Raju enthusiastically explains what he is drawing and how the community would use the maps. He says that by visually representing key landmarks such as a temple, a school, shops, lakes, and community hand pumps, they trace an outline map of their village. Then, the Farmers’ Club conducts a village census and plots each house on the map; there are about 350 households in Sharadwadi. The houses are ranked using different colors or signs for each socio-economic class. The four point ranking system introduced during the training at Jamkhed is simple and has been adapted to Sharawadi’s socio-economic reality.
For example, a house is marked with a green circle if the household owns land, grows enough crops to feed the family for a year and sells the excess crop for income. Such a house is self sufficient and at the top economically. A blue cross indicates families that own land and grow crops to feed the family for six months of the year; for the remaining time some household members seek employment in order to provide for the family. A yellow circle represents the third category, a household that does not own any land and whose members work mostly as menial laborers on farms or nearby construction sites. A red dot represents the last category of households; the poorest people in the community who barely make enough money to buy two meals a day.

The importance of mapping and ranking houses is two fold, Raju explains. First, the process of drawing the map and the ensuing dialogue helps the Farmers’ Club identify problems in the community and find local solutions. For instance, if a hand pump is not working or if there is too much stagnant water in certain parts of the village causing mosquitoes to breed, these issues can be resolved using community resources. Second, by ranking households once or twice a year, people in the community realize whether they are doing better or worse than in the previous year.

Organizing women’s groups. On most evenings in many villages in the Jamkhed region, older men and women gather around the village temple to sing devotional and religious songs. But over the past few decades, a new practice has been institutionalized. There is now a weekly village meeting of women who discuss, debate, and propose solutions to common health and development problems. These women are engaged in a discussion concerning new information on preventive health and about how to stop
harmful social practices. This discussion is a result of the knowledge the women have gained from the VHWs and CRHP staff members who have also organized these women into a mahila mandal (women’s group).

There is no financial incentive to form the group, but by coming together, women provide each other with social support and discuss ways to solve domestic or community problems. Renuka, a social worker at CRHP, explains: “These meetings are facilitated by the health worker in the community, and we encourage her to talk about various problems such as children’s health, maternal health, domestic violence and alcoholism.”

Organizing women to come together and providing them a platform to share common problems and learn about new health practices has been one of the cornerstones of involving women in the development process of the Jamkhed region. Apart from social problems, Renuka adds, “we [the CRHP staff] also provide information and guidance to these women on income generation activities. We strongly urge the women to realize that if they invest their own money [from their savings or by taking a small loan] for their advancement in a business such as raising goats or chickens, then they can become self-sufficient and use the money for household expenses.”

Today, the mahila mandals in many villages are broken into smaller groups called self-help groups that are engaged in micro-credit programs. Six to eight women come together by contributing a small sum to the group. The combined savings are used as revolving capital by each member to start a small business enterprise or as a loan for a household emergency. Sindhubai, a member in her mid-fifties says, “prior to joining the mahila mandal I never went out [of the house], but now I interact with other women and
also men. I have learned about different topics from different people and I do things that I had never even dreamt of doing. Women as a group have become self confident and are recognized for their potential [by community members] as a result of this process.”

The examples above demonstrate the impact a development project grounded in participation and focused on ensuring that the poorest become empowered – gain control over their lives – can have on ordinary people’s lives. Moreover, the stories of the VHWs or young men like Raju are testimonials to human development efforts. The project’s outcomes underscore the belief that when people are given opportunities, some assistance and the freedom to participate, their lives can be transformed.

Purpose of the Research

The present research documents the story of the men and women who actively participate in Comprehensive Rural Health Project’s (CRHP) activities in the Jamkhed region. It recounts how ordinary people participate in development interventions, become facilitators in the change process, engage in collective action aimed at their own and their community’s well-being, and ensure good health and social progress. The research seeks to demonstrate how development, defined as “social, mental, cultural and spiritual growth in an atmosphere free from coercion” (Melkote & Steeves, 2001), is accomplished based on the principles of participation and empowerment. Communication strategies are central to such community-based and people-centered development endeavors because good communication allows people to gain new knowledge, challenge existing oppressive structures, and above all, gain control over their lives and thus overcome oppression (Agunga, 1997; Chambers, 1983; Freire, 1970/1998; Korten, 1984; Korten &
The research seeks to answer questions such as: Which communication processes result in transforming poor, lower-caste (and hence stigmatized) people into well-respected health workers? How do change agents motivate and organize people from different castes and classes? How can communication help achieve participation that results in collective action on a sustainable basis? Which communication strategies result in empowerment of ordinary people? And what challenges do marginalized groups face in becoming active participants in the development process? These questions will be addressed using ethnographic methods employed during two months of fieldwork in Jamkhed in the summer of 2004. The research relies on methods such as participant observation of the health worker training sessions, enrolling in a community health course, informal conversations with community members, transect walks during field visits, in-depth individual interviews and group interviews with men and women in the villages, the health workers and the project staff in Jamkhed, and observing and attending several entertainment-education activities performed by health workers, project staff and villagers. The data, in the form of narratives, field notes and official records, helps explain how communication plays an indispensable role in fostering participation and community organizing at CRHP.

Building upon the vast literature on participatory communication processes (Jacobson & Servaes, 1999; Servaes, Jacobson & White, 1996; White, 1999; White, Nair & Ascroft, 1994), the research explicates determinants of communication for
participation, using CRHP as an exemplary case in facilitating sustainable development. Given that the CRHP has been operating for three and a half decades, and has spread to over 250 villages and 250,000 people, this research argues that strategic use of communication is central to its success.

Participation of local communities is the cornerstone of holistic development (White, 1999; Melkote & Steeves, 2001). And communication aimed at empowering the most marginalized and overcoming cultural and social barriers can help achieve participation. At Jamkhed, the key processes are horizontal communication with community members and village leaders, dialogic communication during the selection and training of women to become health workers, relationship building and trust seeking between the project staff who are the change agents and para-professional aides such as VHWs and community members, and organizing and empowering community groups through facilitation to engage in collective action. Understanding how to integrate such processes into development interventions can contribute significantly to our understanding of the centrality of using communication more effectively in participatory development.

Description of Comprehensive Rural Health Project, Jamkhed

Comprehensive Rural Health Project (CRHP) was set up in 1970 by Drs. Rajanikant and Mabelle Arole. The Aroles trained as medical doctors at the prestigious Vellore Christian Medical College in India and as public health experts at the Johns Hopkins University in Baltimore, U.S.A.. Upon returning to India, they decided to establish a health and development project in one of the poorest regions in the State of
Maharashtra. They were invited by the people of Jamkhed, a small town some 250 miles east of Mumbai to help set up their project. Jamkhed is the center of a development block (an administrative unit serving approximately 100 villages) 5,500 square kilometers in area with 110,000 people in the Ahmednagar District, (Arole & Arole, 1994). At that time, a poor farmer in this severely drought prone region was more concerned about his animals’ health than that of his family’s, malnourishment was understood as an irreversible condition, and poverty was considered a curse from God (Arole & Arole, 1994, 2002). In the past thirty-five years, the people of Jamkhed have experienced a remarkable improvement in their health and social status (Taylor- Ide & Taylor, 2002).

The project, commonly referred to as CRHP or simply Jamkhed, is grounded on the following philosophy: by going to the people, identifying and training village-based aides to promote preventive health, facilitating community organizing in the villages, involving the most marginalized in community development, and thus empowering them, and providing affordable health care, a development program can become community-managed, sustainable, and positively impact the lives of the poorest people.

The program’s primary focus has been to improve the social, physical, mental and economic status of women and children, who, as in other regions of India, are the most marginalized groups. Yet CRHP believes in seeking cooperation and trust from the men and village leaders to ensure that communities take ownership of the project rather than become dependent on it. Based on the principles of primary health care, the program strives to address the root causes of poor health through preventive and promotive health practices. Overcoming root causes begins by organizing the poorest people into formal
or informal groups and empowering them with knowledge to discuss, analyze and solve their problems.

CRHP seeks people’s cooperation by listening to their needs and providing opportunities and resources to meet them. Jamkhed is a drought prone region; this exacerbates the poverty in the villages as most people are farmers whose livelihood depends on rainfall. CRHP began its development program by providing water to the communities, as it was their most important need. The project mobilized people to build community wells, farm lakes and check-dams so that farmers would not be solely dependent on the rain. In addition, farmers received information on agricultural techniques, water management and the use of fertilizers to increase their yields. CRHP also provides micro-credit to poor rural women to begin small entrepreneurial enterprises and teaches adolescent girls vocational skills. More importantly, CRHP works with people to help overcome cultural and social barriers that perpetuate poor health, such as severe caste discrimination and stigma due to diseases such as leprosy and tuberculosis (Arole & Arole, 1972, 1994, 1999, 2002). In essence, CRHP strives to ensure the project facilitates holistic development that enhances people’s lives.

Methodologically, it is hard to attribute all the changes in the region to CRHP’s interventions, because behavioral changes occur over time and can be easily affected by factors such as other development projects and policy changes resulting in overall socio-economic development. CRHP purposefully works with only those communities that are not reached by other agencies or adequately served by government programs (Arole &
Arole, 1972, 1994, 1999, 2002). Thus, in the case of Jamkhed, CRHP’s interventions would have contributed significantly to the social change in the region.

In 1970, CRHP began its project in Jamkhed by setting up a small hospital in an old veterinary clinic next to the weekly market in the heart of the town. From the beginning, the Aroles had decided to use the hospital only for emergency cases. CRHP’s focus has been to empower communities with knowledge and skills to practice preventive health behaviors and to manage commonly occurring health problems at the village level by training local women as health workers. By 1975, the project was working in 30 villages in the region. Seeing improved health and socio-economic conditions in the project villages, other communities approached CRHP to begin health programs in their villages. Over time, CRHP’s activities spread to other communities, and by 2004, the project had spread to over 250 villages and reached 250,000 people.

As a result of CRHP’s efforts and with overwhelming involvement of the communities, the region has achieved some of the best health indicators in India (Arole & Arole, 1994, 2002; Rohde & Wyon, 2002). Specific instances of progress as reported in Table 1 are: reducing child mortality from 180/1000 in 1970 to 26/1000 in 1999, achieved primarily by preventing communicable diseases such as diarrhea and pneumonia and by immunizing almost all the children under three years of age; improving women’s health by providing neo-natal care; increasing contraceptive use from less than 0.5% in 1970 to almost 60% in 1999; and enhancing the lives of many people by controlling chronic diseases such as tuberculosis, leprosy and providing artificial limbs.
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<td>80%</td>
<td>82%</td>
<td>97%</td>
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<td>74%</td>
<td>83%</td>
<td>98%</td>
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<td>Couples practicing family</td>
<td>&lt;0.1%</td>
<td>38%</td>
<td>60%</td>
<td>60%</td>
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*Note.* \(^1\)Infant mortality rate is the number of children dying per 1,000 live births before they reach the age of one. \(^2\)Crude birth rate is the number of children born per 1,000 women of child-bearing age. \(^3\)For children under five years of age. \(^4\)Percentage of women aged 15 to 49 years who were attended at least once during pregnancy by skilled health personnel (doctors, nurses or midwives).

*Source.* *Comprehensive Rural Health Project (2003).*
Rationale: Communication for Empowerment

Implications of Jamkhed for Communication for Participatory Development

Following World War II and spearheaded by the Marshall Plan in 1949, the field of development has grown considerably. In the 1950s and 60s, development meant mere economic growth and the progress of nations was measured in terms of their gross national product (Rist, 1999). Today, development practices focus on enhancing human potential and working toward improving people’s quality of life. These practices include social and economic progress and people’s freedom to participate in the political processes that affect their lives. Thus, development is defined as a people-centered process that results in providing opportunities and empowering the most marginalized to have control over their lives (Melkote & Steeves, 2001). Likewise, the role of communication for development is not merely the transmission of information and ideas about development, but the means through which people gain control over their lives (Melkote & Steeves, 2001).

Within this context, CRHP provides a unique lens to understand how communication is central to people’s participation in development projects and the importance of communication in organizing communities for collective action. In addition, understanding the roles of the change agents in people’s empowerment has implications for future participatory communication interventions. Specifically, the three principles underpinning CRHP’s programming – equity, integration and empowerment – guide most participatory development projects. Thus, explicating how these principles are
achieved through communication will advance the literature on communication for participation.

*Equity, Integration, Empowerment and Participatory Communication*

*Equity* is “ensuring what is needed for those who need it most” (Rohde, 2002, p. 321). CRHP purposely designed programs to include all people, particularly the lowest caste and the most marginalized, in the planning and implementation of its activities. Equity was necessary because village leaders and people belonging to the high caste invited the project staff to work in the villages. But unless the poorest people, who were often also marginalized and oppressed, were included, CRHP would not have achieved its goal of participatory development and of ensuring that people who need the most assistance and opportunity receive it. Trust from all sections in the population is important in order to facilitate participation from people of different classes and castes, resulting in community organizing and collective action. Equity has been achieved through involvement of all people, irrespective of their caste and class, by training the lowest caste women as health workers, and by organizing people through informal (weddings, sports, religious ceremonies) and formal networks (Farmers’ Clubs and *mahila mandals*).

Equity as achieved by CRHP is akin to the idea of “power to the people,” as put forth by White (1994). Participatory communication is based on the premise that power within a community, which is usually concentrated among the elite, needs to be devolved in order to achieve genuine participation. Equity in a development program allows the devolution of power. By reaching the most marginalized and by allowing them to
participate in their own community’s development, CRHP strives to distribute the decision making capacity among the various stakeholders, leaders and lay people in the community.

Integration in primary health care is the reliance on multi-sectoral partnerships to alleviate social problems. CRHP was founded on the premise that merely providing curative health services would not be a sustainable solution for achieving good health in the communities. Ensuring good health begins by dealing with root causes such as poverty, unemployment and lack of education. In addition, promotion of locally available resources and prevention of poor health through information and education are vital. Given the poverty of the region and the lack of water for farming and drinking, CRHP began by creating opportunities for people to work, get paid in cash or kind and, in the process, learn about health. Health therefore had to be integrated with other community development sectors such as agriculture, education and income generation. CRHP provided people with information on land management, farming techniques and water conservation to help communities grow enough food.

The new knowledge was supported by encouraging locals to share their indigenous knowledge about health. Instead of making people dependent on expensive or hard-to-access medical services, home remedies were promoted and local women were trained as paramedics to deal with issues such as malnutrition, lack of ante-natal care, pneumonia and diarrhea. Integration as used by CRHP is similar to the knowledge sharing principle, which relies on combining indigenous and expert knowledge in participatory development (White, 1994). This practice is similar to the process of a
researcher or program manager co-learning from the community (Chambers, 1983), as derived from Freire’s (1970/1998) concept of dialogic learning.

*Empowerment* is a process through which people gain control over their lives and can make decisions to improve their existing state (Papa, Singhal, Ghanekar & Papa, 2000; Rogers & Singhal, 2003; White, 2003). People’s right to be involved and be heard is at the center of participatory development, and this is achieved through empowerment (Melkote & Steeves, 2001). Many scholars have proposed that empowerment essentially has two dimensions: the personal level, whereby people gain self-confidence and improve their self-esteem to take on new tasks and become active participants in the project activities; and the group level, in which communities become empowered and people have access to information and a chance to participate as decision makers (Melkote & Steeves, 2001).

Empowerment is at the heart of CRHP: Arole (1999) states that only when people are given an opportunity to take control of their lives and allowed to make their own decisions can conditions improve in families and the community. Empowerment is operationalized by reaching the most oppressed, training the oppressed and engaging with them in a dialogue, and by being a facilitator in the change process. As a result, low caste, illiterate women have become confident enough to take on the roles and responsibilities of paramedic workers. Poor farmers have organized and approached bank officials for loans, and women who were confined to their homes have formed their own micro-credit groups and started small enterprises.
Participatory communication is understood as a necessary condition by those who believe development is a social process of transformation (Nair, 1994). CRHP’s vision of development is grounded in social transformation, in which communication becomes a key catalyst for facilitating change. Participatory communication is a democratic process of involving people in development through self-awareness and consciousness of their environment. This is achieved through dialogue, critical thinking and collective action (White, 2003). Participatory communication seeks to involve all people, particularly those who are often silenced and have no access to information or decision making. In essence, participatory communication processes help realize the three principles of equity, integration and empowerment, which are the cornerstone of CRHP’s development philosophy.

Implications for Theory-Practice of Communication for Participatory Development

In the past three decades, development programs have adopted participatory approaches that allow people to participate in the planning, implementation and evaluation of programs aimed at their well-being (Jacobson, 1994; Morris, 2003; Servaes, 1996; White, 1994, 2003). However, not all development programs are truly participatory, and even within the paradigm of participatory development, programs can be plotted on a continuum from participation as a means (collaboration between change agents and community) to participation as an end (empowerment of the people) (Oakley & Kahssay, 1999; White, 1996, 2003).

If CRHP was plotted on the participation continuum it would fall on the empowerment end of the spectrum. Therefore, understanding how CRHP has
operationalized participation will contribute to the theory and practice of development communication. It is hoped that this research will add to the theoretical knowledge in the field of communication for social change and provide useful tools for practitioners to design and implement future communication for social change programs worldwide.

This case presents an opportunity where theoretically complex constructs such as empowerment can be understood and explained through immersion in the community and engagement with the people who have or have not experienced a positive change in their lives. The literature on participatory communication proposes the role of dialogue and horizontal communication in raising consciousness of the communities as a necessary condition for development. Through engaged fieldwork, the determinants that result in open dialogue and facilitation could be empirically understood. By explaining the multiple roles of communication and communicators toward participation and empowerment, the research hopes to contribute to our understanding of the determinants of communication for participatory development, and how participatory communication can be used as a theory and praxis for social change.
CHAPTER 2: LITERATURE REVIEW AND BACKGROUND ON INDIA

Key Terms in Communication for Participatory Development

This study uses many terms common in the field of communication and development. This section reviews the key definitions and proposes that the terms be understood within these boundaries. The intention is not to enter the debate over development discourse and practice, but instead to avoid confusion.

Third world represents populations, either pockets of communities within a country or entire countries, that are economically poor and therefore under-developed or un-developed as compared to people in the rich nation states of Western Europe, the United States, and Japan, among others (Melkote & Steeves, 2001). In this study, the term third world is rarely used but it is explained because development and development communication are processes that are mostly associated with people who belong to the third world.

South is often used to represent populations in the third-world because most of the newly independent countries, following World War II, were in the southern hemisphere comprising Central and Latin America, the Caribbean, Africa and South and Southeast Asia. The poor countries in the South are often contrasted with the rich nation states in the North such as North America, Western Europe and Japan.

Development is the process of improving the living conditions of a society. Improvement is linked to economic and material progress as well as spiritual and human growth (Melkote & Steeves, 2001). While some theorists perceive development as
primarily the increase in production and distribution of capital, there is an increasing consensus to embrace development as a change in human conditions.

*Human development* strives to “enlarge the range of people’s choices to make development more democratic and participatory. These choices should include access to income and employment opportunities, education and health, and a clean and safe physical environment. Each individual should also have the opportunity to participate fully in community decisions and to enjoy human, economic and political freedoms” (UNDP, 1991).

*Communication* is the complex process of creation, transmission, maintenance and transformation of information and ideas, using a mix of interpersonal and mediated channels which are sustained by political, economic and social structures (Melkote & Steeves, 2001).

*Development communication* is the use of communication to stimulate debate and involve people in decision-making and action to bring about change. It is also the use of communication channels and messages to help people acquire the new knowledge and skills needed to perform in society and to be able to work with people from different sectors in the development process (Fraser & Restrepo-Estrada, 1998). Here, development communication is defined as the purposive use of interpersonal, participatory and mediated channels to buttress positive change among individuals and societies at the micro (communities), macro (nations) and meso (large regions) levels (Melkote & Steeves, 2001).
Participation in development is the conscious decision to reach out to and involve those people that would be most affected by the proposed development program. Specifically, participation refers to involving the un-empowered, the marginalized and the poorest people in any society (White, 1994).

Empowerment, when associated with development and participation in development, refers to the process by which individuals, organizations, and communities gain control over social and economic conditions (Melkote & Steeves, 2001). Thus, empowerment is linked to creating an environment where people who have control over situations that affect their lives are given the opportunity, knowledge, and power to bring about the change that would improve their lives.

Participatory communication is a social process in which groups with common interests jointly construct a message oriented toward the improvement of their living conditions and the change of unjust social structures (Mody, 1991). Participatory communication provides all people, including the marginalized, with access to information and communication systems and an equal opportunity to participate in creating new information and challenging existing unjust social practices (Servaes, 1996).

Communication for Development: An Historical Overview

Development scholars suggest that the “development age” was born out of Point Four, the last section of United States President Harry Truman’s 1949 inaugural address to the nation (Escobar 1995; Rist, 1999). Given the global socio-political situation after World War II, President Truman had initially decided to address three issues in his speech: (1) U.S.’s continued support of the United Nations, (2) expansion and
continuation of the Marshall Plan to rebuild post-war Western Europe, and (3) formation of a defense body, the North Atlantic Treaty Organization (NATO), to counter the impending threat of the Soviet Union. However, at the last moment, one of Truman’s advisors suggested adding a fourth point; expansion of the existing U.S. international aid program to Latin America to other countries in Asia and Africa (Rist, 1999).

The opening paragraph of Point Four stated that the U.S. would expand its scientific progress and industrial growth models to underdeveloped parts of the world in order to overcome the poverty and ill health that most people in these countries faced at that time. With this statement, over 2 billion people were labeled as “underdeveloped.” However, the U.S. was also providing hope that through progress and growth modeled after the West, poor countries could become developed (Rist, 1999). Over the next five decades, the field of development experimented with various theories and models to improve the socio-economic situation of underdeveloped nations (Melkote & Steeves, 2001).

A survey of the literature (Melkote & Steeves, 2001; Rist, 1999) points to the shifts in development practice from urbanization, industrialization and economic growth in the 1950s and 60s to the basic human needs approach in the 1970s. The 1980s saw the rise of the structural adjustment programs; which promoted political and economic reforms such as free trade between the North and the South, weakening of government control over economic policies and so forth. From the 1990s onward, development practice and discourse embraced people’s participation as a strategy for sustainable development. Although these movements and paradigms of development are not
mutually exclusive, demarcating the different eras of development provides us with a framework to compare and contrast the shifts in the field. Moreover, these shifts can be matched with the historical shifts in the research on communication for development. The following section links the development paradigms and development communication paradigms from the North American perspective.

*Early Voices: The Modernization Paradigm*

Point Four emerged out of the following context: (a) the intellectual movement in the social sciences in the West was heavily dominated by positivism and post-positivism, which hypothesized that social and economic progress can be universally replicated; (b) the Marshall Plan, which was launched to rebuild Western Europe after World War II, showed measurable and demonstrable success; (c) with the end of colonization in most parts of the world, the U.S. was emerging as an international economic and political force, and therefore, President Truman wanted to capitalize on growing world markets; (d) the U.S. wanted to promote democracy in as many countries as it could to counter the threat of Soviet Communism; and (e) the former European colonies, which were the Newly Independent Countries, were politically independent but economically vulnerable and seeking international assistance (Melkote & Steeves, 2001; Rist 1999; Rogers 1993; 1976).

In the 1950s, one of the most popular theories of economic growth that influenced American foreign policy was Walter Rostow’s take-off or stages of growth model (Rist, 1999). Based on a positivistic tradition, Rostow claimed that traditional societies, which were the poor countries from the South, had inherent social-structural impediments to
growth. However, through industrialization these societies could move from being traditional to mass consumption societies, much like the developed countries. Thus, development driven by international aid became synonymous with industrial production, economic growth and a market economy.

Around the same time that Rostow’s model of growth dominated development practice, Daniel Lerner, a sociologist at Massachusetts Institute of Technology, undertook a large-scale study in the Middle East to understand the correlation between mass media and modernization. Lerner’s (1958) pioneering book, *The Passing of the Traditional Society*, became a seminal study in the field of communication and development, outlining factors that determine how traditional societies can get on the road to modernity. Modernization, loosely defined, was the ability to do away with the existing traditional lifestyle (Lerner, 1958).

First, Lerner claimed that people in modern societies possessed more empathy – “the capacity to see oneself in the other fellow’s situation” (Lerner, 1958, p. 50) – because they were used to being exposed to new ideas and thereby possessed the ability to change. Second, Lerner argued that exposure to mass media served as a multiplier of human imagination, as it transports people into real and imaginary worlds that people have never experienced. This condition favors the change that is sought by the modernization process. And third, Lerner hypothesized a “system of modernity” (Lerner 1958, p. 54) by demonstrating a high degree of association between the presence of mass media and modern institutions in other sectors.
Based on these factors, Lerner (1958) proposed a model which suggested that
traditional societies become modern, provided that they have the proclivity to became
more urbanized, more literate, more exposed to mass media and more active in the
political process for democracy. Likewise, Inkles (1966) devised a scale based on
attitudes toward modernization and was able to place different countries at different
points on the scale. Schramm (1964, 1967), another pioneer communication for
development scholar, claimed that mass media have three major functions for
modernization: (a) to create a climate conducive to change, (b) to serve as a multiplier of
information by reaching large numbers of people through different channels, and (c) to
create a sense of nation-ness by delivering the same messages to all sections of the
population. Around the same time, Everett M. Rogers (1962) proposed the diffusion of
innovations theory to explain how people adopt a new idea over time. According to
Rogers, people go through psychological stages during the decision making process of
adoption or non-adoption of a new product or idea. Rogers (1969) also devised a
subculture of peasantry typology, which explained how and why culture and internal
structures make farmers in developing countries resistant to change.

The modernization paradigm had its historical roots in a social scientific model of
development. Much like development theorists such as Rostow, communication for
development scholars believed in a linear staged model of attitude and behavior change
triggered by exposure to new ideas and information through the mass media. It is
important to realize that research by communication scholars such as Lerner, Schramm
and Rogers in the 1950s and 60s was perhaps influenced by research on mass
communication conducted during the 1930s and 40s, which also marked the establishment of the field. Rogers (1994), in *The History of Communication Study*, notes that the roots of North America’s mass communication research tradition are in Lasswell’s research on the role of media as propaganda, Lazarsfeld’s research on the powerful effects that media have on changing people’s attitudes and behavior, and Hovland’s research on the role of media in persuasion (Rogers, 1994). These three traditions – media for propaganda, media effects (limited and two-step flow), and media for persuasion – explain why communication for development scholars recommended setting up mass media institutions to promote the idea of modernization, and to persuade people to change their existing habits and adopt new ideas and behaviors.

The first development decade, which theoretically ended in the late 1960s, was dominated by large-scale projects. The projects used mass media based on the assumption that media exposure would have a direct effect on people’s knowledge and behavior, and that the media institutions would serve to promote and safeguard change. Studies based on the modernization theory suggested an association between increased literacy, which led to increased urbanization, which in turn, led to media growth and consumption. Lerner’s (1958) research showed that increased media consumption results in increased political awareness among people. Furthermore, it was hypothesized that literacy, urbanization and more information would lead to greater political participation. The diffusion of innovations theory when it was first proposed in 1962 advocated a centralized top-down model of information dissemination to foster innovation adoption (Rogers, 1976).
Critical Voices: The Dependency Paradigm

By the early 1970s, Latin American development communication scholars such as Juan Diaz Bordenave, Luis Ramiro Beltran and Elizabeth Fox de Cardona began criticizing the modernization theory (Servaes, 1999). Their criticism stemmed from several factors, including the shortcomings of the UN’s Economic Commission for Latin America, a precursor to the Marshall Plan, global events such as the 1973 oil crisis, the strengthening of the Non-Aligned Movement, which consisted of countries from the South, and the rising frustration with U.S support for dictatorial regimes in Latin America (Melkote & Steeves, 2001; Rist, 1999). Consequently, development progressed to the dependency paradigm, which emerged from the developing nations’ realization that they were reliant on Western nations for economic, technological and political transformation (Servaes, 1999, 1996).

Frank (1969), one of the theorists associated with this movement, claimed that the core countries (i.e. developed nations) made the periphery countries (i.e. underdeveloped or developing nations) over-dependent on aid, and that the core countries were prospering because of unfair trade practices. Dependency theory criticized modernization theorists for creating external structures that made it difficult for developing countries to grow. In addition, dependency theorists argued that modernization programs benefited only the elites in the developing nations.

The ideological basis for dependency theory can be traced to the fundamental tenets of critical theory, which hypothesizes that historical social structures such as race, gender, and social class are responsible for many inequalities in society (Melkote &
Steeves, 2001). Frank (1969) and others claimed that developing countries could move out of poverty if there was free trade between the developed and developing countries. However, the dependency movement failed to create the structural changes required for such a transformation. Therefore, some critics proposed self-reliance as a strategy to counter dependency. However, barring a few cases such as Tanzanian President Julius Nyerere’s *Ujamma* program, which aimed at village resettlement schemes for self-development, dependency theory was better at raising important questions and challenging the status quo than proposing lasting solutions (Rist, 1999).

Frank’s dependency theory was supported by growing cynicism among communication scholars. For instance, Beltran (1976) and Diaz-Bordenave (1976), two influential Latin American scholars, claimed that theories such as the diffusion of innovation and modernization unfairly attributed the problems of underdevelopment to internal social and structural problems. For instance, Lerner (1958) blamed poor and illiterate people for their own fate and claimed that underdevelopment was due to traditional practices and resistance to change. The dependency scholars argued that mass media in developing countries were accessible only to the elites, and likewise, adoption of new technology was restricted only to rich farmers. Proponents of dependency theory rightly pointed out that many modernization era programs that used mass communication to foster development were widening income and information gaps in the developing nations.

The questions about lack of effectiveness of communication led to two particularly important movements. First, in 1976, the East-West Center at the University
of Hawaii called for an international convention of communication for development scholars. At that conference, many shortcomings related to top-down, hierarchical mass communication for development were raised (see Schramm & Lerner, 1976). Second, in the 1970s, there were debates led by UNESCO over who had the right to disseminate information and control media systems. This resulted in the call for a New World Information and Communication Order (NWICO), which criticized media hegemony and modern communication systems that dominated traditional media and international news flow (Servaes, 1999). Likewise, the MacBride Commission’s study of communication problems called for structural changes to achieve balanced national and international news flow and culturally appropriate communication strategies in order to foster change (Mowlana & Wilson 1990; Servaes, 1999).

These events led some scholars, including Schramm and Rogers, to accept the criticism and adapt their models of communication to better suit the needs of people in developing countries. Schramm’s (1964) work on the role of mass media in national development focused on development as not only economic growth but also social and cultural progress. He acknowledged that poor countries in the South may be “underdeveloped economically but highly developed in some [aspects such as] …personal relationships…or art and philosophy…” (p. 10). Thereby, Schramm defined “underdevelopment” and “developing” as terms that merely denote phases in a country’s overall history.

In the Passing of the Dominant Paradigm, Rogers (1976) acknowledged that the diffusion theory had erroneously assumed non-adoption of modern ideas and products by
the Third World people due to societal and individual resistance. Notwithstanding the cultural barriers, development practitioners and theorists assumed that adopting new innovations would only be beneficial to people. Thus there was a pro-innovation, pro-persuasion, and pro-top down bias in diffusing new innovations, which overlooked the reasons for non-adoption. Rogers thereafter modified the diffusion theory to make it more culturally sensitive, realizing that the two-step trickle down process of communication did not take place in most cases. He proposed that diffusion programs integrate traditional and modern media and use community-based change agents and local opinion leaders. Furthermore, Schramm (1976) suggested that for communication to be effective there has to be a sufficient overlap between the sender and the receiver’s field of experience, and thus added an interactive feedback loop to his model.

Linked to this were other advances made in communication theory. For instance, models such as the knowledge-gap hypothesis (Tiechnor, Donahue & Olien, 1970) and the spiral of silence (Noelle-Neumann, 1974) posited that mass media exposure can create inequalities and that mass media access and ownership determine which voices are heard and which are silenced. Likewise, the powerful effects model, such as the magic bullet theory, which was the basis of the propaganda studies of the 1940s and 50s, gave way to minimal or limited effects (Klapper, 1960). Thus from the 1970s onward, communication as was field acknowledged that mere exposure to media messages is not enough, but certain social and psychological cues are essential to trigger change.

In sum, the proponents of communication for development acknowledged that media and communication are necessary but not solely sufficient to foster change. It was
thus seen as necessary to redefine communication from being a linear information
delivery system to a two-way process in which audiences play an active role in creating
and negotiating meaning.

Multiple Voices: The Alternative Paradigm

The criticism put forth by the dependency theory did not result in specific
solutions or recommendations to be adopted by development practitioners. However, it
did lead to many new ideas and the re-envisioning of the existing definition of
development. Furthermore, as social, economic and political conditions changed globally,
scholars began to view nation states as interdependent rather than viewing developing
nations simply as being dependent on the developed nations. In addition, development
thinking encountered another paradigm shift, moving away from critiquing structures and
systems of dependency to understanding development from a basic human needs
perspective. Robert McNamara, the U.S. Secretary of Defense during the Vietnam era
and later the President of the World Bank, is a key figure associated with this approach.
McNamara suggested that development programs should, at the least, provide access to
food, health, education, and safety (Rist, 1999). This approach marked a major
progression in how development became envisioned as a basic human right, and not
merely economic progress.

Along with McNamara’s basic needs approach, there was the report by the Dag
Hammarskjold Foundation entitled What Now? (Ascroft & Masilela, 1994; Servaes,
1999). It raised questions about the validity of the technological and economic emphasis
of the modernization approach, drawing attention to the growing poverty in developing
countries. The report concluded that: (a) the trickle down approach, which assumed that by raising the economic and social status of the elites the quality of life of poorer people would improve, was not taking place, (b) self-reliance was giving way to growing interdependency among nation states, and (c) within the field of social sciences, there was a movement toward constructivism and relativism, which recognized multiple realities based on multiple experiences and cultures, as opposed to an universal ideal. These movements, many of which emerged from the dependency theory, provided, for the first time, a realization that development does not preclude ignorance of the local culture and devaluing the knowledge that people in developing countries possess. The alternative paradigm acknowledges that there is no universal model for development. Every region or nation has unique circumstances and therefore development programs need to be altered accordingly (Kumar, 1994; Servaes, 1999).

Communication for development scholars were also taking stock of their role in the field of development. Schramm (1964) stressed that for any change to occur it must have cultural linkages and be sensitive to people’s customs and beliefs. Participation in communication was also being readily acknowledged as a necessary condition for future development programs (Bordenave, 1994). A marked shift in the definition of development from mere economic growth toward human development was articulated by Rogers as early as 1976. Rogers stated that development was a widely participatory process of social change, which includes social and economic development (including equality and freedom) through gaining control over one’s own environment (Rogers, 1976).
Advances in technology meant that communication media need not be concentrated in the hands of the elite and highly educated but could be controlled by people themselves (Nair & White, 1993). Community based communication was exemplified by many video and radio projects that handed the means of production to the poorest of the poor (Nair & White, 1993). Also, new communication technologies were understood as combining the mass media and interpersonal channels by allowing interactivity, synchronization and individualization (Rogers, 1986, 1993).

Communication scholars were critically assessing the theory of cultural imperialism, which was the result of the hegemony of the West in news and information flow. Post-modern theories that investigate power, ideology and culture led to redefining the role communication played in the development process.

One influential movement grew out of Paulo Freire’s (1973) writings on the pedagogy of liberation through education, which relies on true dialogue between the teacher and the learner and the power of communication to pose questions as a process of consciousness raising. Extending Freire’s pedagogy, development communication scholars began concentrating on communication as a process, as opposed to a linear, one-way activity of message transmission (Nair and White, 1993). Furthermore, the MacBride Commission Report and the NWICO debates, supported by UNESCO, paved the way for establishing community-based media in developing countries to serve the local communities (Mowlana and Wilson, 1990; Servaes, 1999). Also, communication theory was being influenced by intellectual movements such as social constructivism and interpretivism in the social sciences (Servaes, 1999). These movements recognized that
contextual development solutions were possible based on the needs of different people, as opposed to the top-down development programs implemented during the modernization era.

In sum, the alternative paradigm proposed changes that led communication scholars to introduce horizontal communication that included all stakeholders and relied on a mix of modern and traditional communication channels. Moreover, development praxis and advances in communication theory suggested that communication be culture-specific and provide a platform for community discussion and dialogue. Based on an interpretive epistemology, media messages did not necessarily have one meaning, since audience members could actively engage in the text and co-create meaning relevant to their conditions. Melkote and Steeves (2001) call such dialogic and horizontal communication communitarian or communicare – communication that results in creating and sustaining a community. The participatory approach to communication is a distinctive outcome of the alternative paradigm. Moreover, it is central to the present dissertation research and will be explained in depth later.

The paradigms in development and communication for development may have changed over the past five decades but the overall goal of development remains the same: to improve people’s quality of life of people, especially the oppressed and the marginalized, most of whom live in extreme poverty. Also, while new paradigms have been introduced, the older approaches to development are still practiced widely, resulting in an overlap of different communication and development approaches (Mody, 2002).
India was one of the first newly independent countries following World War II to experiment with communication for development on a large scale (Narula & Pearce, 1986). Many studies from the 1960s and 70s document the use of communication in rural India to spread innovations such as agricultural products and family planning methods as well as the role of the press in communicating the various development issues facing the country (Dube, 1967; Nair, 1967; Narula & Pearce, 1986; Singhal & Rogers, 1989, 2001; Rogers, 1973).

**Historical Background**

From the 1950s, communication for development was used in nation building, in creating an environment for modernization and in bringing about changes in social and cultural practices. This strategy was based on the American model of reaching farmers through extension programs (Narula & Pearce, 1986) to diffuse new practices and technology for enhanced production. The emphasis in India was on the use of mass media such as radio and interpersonal communication through extension agents, who were trained to explain and demonstrate the new farming techniques or other new behaviors.

This approach was markedly different from the grassroots movements led by Mahatma Gandhi that led India to gain independence from Britain in 1947. Gandhi’s vision of development was based on democratic socialistic practice, which favored non-exploitative social and political reorganization in rural India as opposed to relying on importing modern forms of technology for restructuring village life (Narula & Pearce, 1986). The purpose of this section is to describe the use of communication for
development by India’s political and administrative sector post independence, specifically focusing on the period between the early 1950s and the late 1970s.

Dube (1967, 1976) provides a well-grounded view of the role communication played in India’s path toward economic development. India inherited a well-established administrative and political communication network from the British. This system was used to train bureaucrats who would be instrumental in implementing government policies. The communication structure the British left behind consisted a national railroad network, radio, newspapers, and a postal service.

The Indian Planning Commission, established in 1950, consisted of politicians (the decision-makers), bureaucrats (the administrators) and technocrats (the experts in the field). These three groups are responsible for national development. The politicians made the decisions and created policies, the technocrats came up with the blue print strategies, and the bureaucrats were responsible for implementing these policies. Within these administrative structures, communication played a key role in disseminating information related to national emergencies such as floods, famines, and epidemics as well as in building a new image for the nation and creating new educational, scientific and development institutions. Therefore, communication occurred between many stakeholders; political and administrative, individual and community level, and between international aid agencies and the government, and its purpose was manifold.

India has always relied on a free press that is privately owned and serves as a watchdog, providing a critical account of development projects (Nair, 1967). The reliance
on mass communication, specifically radio, to tell people about the new constitution that was written after 1947, raises important questions about the faith the bureaucrats had in the media. In 1950, India had over 550,000 villages with 14 major languages and only 25 percent literacy; there was a strong reliance on mass communication to persuade people about the benefits of being a democracy. However, radio could not create the positive climate the government wanted because it reached less than one percent of the general population (Singhal & Rogers, 2001). The press on the other hand, even when it had a limited reach, largely favored the elites in the early years after India won her independence. Newspapers reached the opinion leaders and was able to influence the policy makers and the bureaucrats (Booner, 1959).

By 1956, almost ten years after Nehru had become leader of a newly independent India, his policies had crystallized into a two-pronged development approach: (1) modernization through massive investment in science and technology which would usher industrial growth, and (2) a community development program that would ensure development of roads, schools, wells and enhance agricultural productivity (Gopal, 1989). While one policy sought to modernize the country through massive public sector investments in building dams and setting up steel, iron and other heavy industries, another promoted the formation of small farm cooperatives. The cooperatives under the establishment of the Panchayat Raj (a local government comprised of five experts), in which village level governing councils were responsible for rural development, was similar to the Gandhian model of development (Narula & Pearce, 1986). Therefore, on the one hand, the government took on the task of micro-managing large scale
modernization projects, and on the other hand attempted to reduce bureaucratic control and promote voluntary collaboration among small farmers to foster development in rural areas.

These opposing models of development required different communication interventions. Mass communication was used to deliver educational and agricultural information to rural people (Mody, 1979; Narula & Pearce, 1986; Singhal & Rogers, 2001), while Nehru relied on eloquent political communication strategies to reach the urban people and convince them of the need to invest in industrialization (Booner, 1959; Dube, 1967, 1976).

*Communication and Development in Post-independence India*

Although radio broadcasting began in 1928, by the time India won her independence in 1947, All India Radio (AIR) had only six radio stations located in the metropolitan cities. Moreover, there were only 280,000 radio sets for a population of 350 million, or one radio for every 1250 people. Nehru’s government gave priority to expanding the radio broadcasting infrastructure, but the expansion was limited to state capitals and border areas. In addition, the radio programming in the 1940s and 50s was limited to news, drama and classical music, catering to the high-culture taste of the Indian elites. Radio was not targeted toward the working class or poor people, which comprised the majority of the population (Singhal & Rogers, 2001). During this time, many radio listeners would listen to foreign broadcasts (Radio Ceylon and Radio Goa on short-wave) to enjoy general entertainment programs. It was only in 1957 that AIR began an
entertainment channel, *Vividh Bharati*, that played Indian film music to cater to the masses (Singhal & Rogers, 2001). The number of radio sets in India increased steadily until the 1970s, after which it rose sharply; from 1971 to 1985 it grew almost three times from 12.5 million to 35 million. Perhaps this was because the cost of radio sets decreased and the number of regional radio stations broadcasting programs in the local language was on the rise. By 1996, there were 195 radio stations across the country that reached 97% of the population (Singhal & Rogers, 2001).

Unlike radio broadcasting, television broadcasting in India has a short history between the 1950s and 1970s. Television broadcasting began in 1959 on an experimental basis to deliver educational programming. It took another six years before regular daily entertainment and educational programs were aired from Delhi. By 1975, this service had spread to eight more cities covering the four regions of the country: north, south, east and west (Singhal & Rogers, 2001). In the mid-1960s, a visionary Indian technocrat and the founder of India’s space program, Dr. Vikram Sarabhai, pushed for a policy to use communication satellites for India’s national development. This was the beginning of the movement that led to the Satellite Instructional Television Experiment (SITE) program, which is explained in the next section. The Indian government began investing in the television infrastructure by the late 1960s to help establish the SITE program. By the early 1980s, the Indian government had invested enough money to launch two of its own satellites. These satellites were and are still used to broadcast programs on Doordarshan, the state-owned television network.
The history of India’s investment in the public broadcasting of radio and television has many parallels. Both media systems, AIR and Doordarshan, were launched by the government to disseminate information aimed for nation building and to promote various development programs. Both radio and television began as non-commercial ventures that were run by bureaucrats. The government invested heavily to widen the reach of radio, as well as television, by setting up regional transmission stations. While both radio and television eventually began airing commercials and thus generated revenue, both media are still controlled by the government, although an autonomous body, Prasar Bharati, was established in 2000 to oversee day-to-day operations.

The government has allowed cable and foreign satellite television networks to operate in India since the early 1990s as part of India’s New Economic Policy (NEP). The NEP, based on an open-market economy, allows foreign investment in various sectors, including media. This policy is different from the post-independence policy that required state-ownership or state-license to operate any business. As a result of foreign investments in the media, private satellite television broadcasts such as CNN, Star TV, BBC among others were introduced in the early 1990s (Singhal & Rogers, 2001). However, radio licensing is still controlled by the government and private radio stations are not yet encouraged. India allowed private FM radio stations in the mid-1990s, but soon the licenses were revoked. Today, through a complicated bidding process the government has begun offering FM licenses to private broadcasters, but radio is yet to become as a free enterprise that can be used to foster development goals or pursue
commercial interests. Overall, the use of radio and television for development in India has not shown much promise because its potential still remains untapped (Sanjay, 2001).

The next section provides examples of the successful use of radio and television for development in India between the 1950s and 1970s. Besides these few cases and the occasional entertainment education programs on AIR and Doordarshan in the 1980s and 90s (Singhal & Rogers, 1989, 2001), the Indian government has not effectively capitalized on radio or television for national development. Despite the vast reach – 97% people can access radio and over 50% regularly watch television – and the ability to reach people in their local language (Singhal & Rogers, 2001), neither TV nor radio provide basic information on development issues in the manner that was envisaged over five decades ago.

*Development Communication in Action*

**Radio forums.** In 1956, the government, in collaboration with UNESCO, decided to experiment with radio as a tool for rural development. The Pune Radio Forum *Listen, Discuss, Act* was aired once a week for half an hour (Schramm, 1967; Singhal & Rogers, 2001). The project was inspired by and modeled after the Canadian farm radio project of the 1930s. The format was a radio program about farming and organizing community listeners’ groups with a trained facilitator who would moderate a discussion following the program (Fraser & Restrepo-Estrada, 1998; Schramm, 1988).

The program encouraged community group listening, which was facilitated by the government by placing one or two radio sets in a community gathering place. Also,
development workers appointed an opinion leader to organize a group listening session followed by discussion. *Listen, Discuss, Act* aired information that the farmers could use to overcome common problems using local resources. For instance, the program discussed such issues as how to control pests and how to increase productivity by crop rotation. The group listening sessions also spurred communities to begin discussing other rural development problems and seeking community-driven solutions. The project was successful in organizing farmers for community action.

Thus, the radio forum that began as an experiment became a permanent feature but did not sustain as radio penetration grew and people stopped listening in groups (Singhal & Rogers, 2001). Apart from this experiment, the Indian government did not promote the use of radio as a community-owned medium for development (Sanjay, 2001). Radio has been used since the 1980s to produce entertainment education programs, but for the most part, radio was not used for its development potential. Instead, since the establishment of *Vividh Bharathi*, AIR has concentrated on producing entertainment programs that are commercially driven rather than produce programs on development issues (Singhal & Rogers, 2001). This is also true of television, as discussed in the next section.

*Mass communication campaigns.* Overall, after India’s initial attempts at using mass communication for development (radio in the 1950s and television in the 1970s and 80s), mass media have taken on a business-oriented model. However, on another level, mass communication has been used to promote specific issues such as family planning in the 1960s and 70s. A major mass media campaign to increase awareness and use of
contraceptives was part of the government-led family planning program in the 1960s, widely publicized as the “red triangle” campaign (Soni, 1983). It promoted small families and gender equality. The mnemonic showed a family of four with a boy and girl child encased in an inverted red triangle. There was also a massive media effort to promote government-subsidized condoms, Nirodh, through outdoor advertising and radio commercials. But the overall budget for promotion of family planning initiatives was less than three percent of the total budget, which in itself was about one percent of the total government expenditures in the late 1970s (Soni, 1983). The meager funding partly explains how communication for development, though considered as a vital tool to reach to the people, was given a very low priority in terms of budgetary allocations by the bureaucrats.

*Satellite television for development.* In 1975-76, India was one of the first countries to use a direct broadcast satellite to reach remote rural areas with educational and development programs (Mody, 1979). This pilot project, Satellite Instructional Television Experiment (SITE), has been hailed one of the most unique and successful uses of television to foster development as part of India’s modernization program. SITE was launched to disseminate educational information ranging from science-based programming for children to new agricultural techniques for farmers, family planning for young couples and values of national integration and patriotism. Programs were broadcast daily for four hours to six under-developed states: Rajasthan, Bihar, Orissa, Madhya Pradesh, Karnataka and Andhra Pradesh. Community TV sets were placed in 2,338 hard to reach villages in these six states.
The programs were intended not only to educate audiences but also to give Indians expertise in handling telecommunication software and hardware before the launch of the first national satellite planned for 1981 (Mody, 1979). This initiative had multiple stakeholders, including the Indian Space Research Organization (ISRO), Doordarshan, India’s state-owned TV network; the National Council of Educational Research and Training (NCERT); All India Radio (AIR); and the U.S. National Aeronautics and Space Administration (NASA), which leased its ATS-6 satellite to India for that period (Block, Foote & Mayo, 1979; Mody, 1979).

This initiative had been conceived and implemented based on the synergistic strengths of the stakeholders. On the technical side, professionals were used to manage the equipment and provide back-end support. Innovative technology such as chicken-mesh antennas, which could be transported from the cities and assembled in a village, allowed for ease of transportation and set-up of community television sets (similar to the community radio groups used during the Radio Farm Forum). Furthermore, community television sets were set up in villages which had electricity; in a few areas which did not have electricity, battery operated TV sets were installed. There was good communication between field level staff and the program managers to deal with technical snags that occurred during or after transmission of the programs (Mody, 1979).

On the program end, the content was thoroughly researched and delivered in four languages for the six SITE states. There was a good mix of children’s and adult learning programs, and the project also aired culturally relevant entertainment programs. But this careful planning and implementation was not sustainable. Not only were there many
field-level difficulties in deciding where to put the community TV sets, but also the programs could never completely capture the local cultural nuances of the 2,000 plus villages. After one year of the pilot project, it was discontinued because the lease for the satellite ended; more importantly, television was seen as a more viable option for urban centers than rural India (Singhal & Rogers, 2001). This explains why in the early 1980s, when India launched its own satellites, the focus was on entertainment programming instead of development related information. However, SITE is a pivotal example of the application of satellites for large-scale rural development projects, not only for India but for all developing nations at that time (Block, Foote & Mayo, 1979).

Community television. After the SITE program was discontinued in 1976, the Kheda Communication Project (KCP), a collaboration between Doordarshan and the Indian Space Research Organization, was launched in the village of Pij in the state of Gujarat. KCP was one of the only long-running experiments that used community TV to serve development needs (Agarwal, 1994; Singhal & Rogers, 2001). In the Kheda district, a low-power transmitter was used to broadcast regular television from 1975 to 1985 to about 1000 villages with over 3 million people. Lessons learned from SITE were used to plan and implement the television programs. In the mid 1970s, a local milk production center was set up in the Kheda district, and was able to generate enough income for some farmers. Yet there was great disparity between these rich dairy farmers and the poor landless farmers in the region. Communication was seen as a means to inform and empower the poor farmers to become organized and collectively overcome the domination of the rich dairy farmers.
The KCP television programs reflected the exploitation of the poor and focused on how the rich and the poor can work together. The programs used villagers and KCP members as actors, writers, and producers of dramas on exploitation, minimum wages, caste discrimination, alcoholism, the operation of milk and other cooperatives and local and national elections. Chatur Mota (Wise Elder) and Nari Tu Narayani (Women You Are Powerful) were two popular programs produced by KCP. Both programs were based on an entertainment-education strategy with the active participation of audience members. Additionally, theater and puppet shows were organized by the community members on issues ranging from family planning to dowry (Singhal, 2001). Overall, KCP used an integrated model of communication, which included traditional and modern mass media and community forums, for dialogue and debate.

The communication project aimed to improve the self-confidence of poor people and create a sense of awareness among them. KCP also encouraged inter-sectoral cooperation in the district through the use of extension agents from the milk cooperatives, agriculture, local banks, and health workers. As the project was funded by the government, it was free of any corporate interests and therefore could tackle social and commercially non-viable issues. However, KCP was discontinued in 1985 when the Indian government relocated the antennas to Chennai, a metropolitan city, to set up a second entertainment channel (Singhal & Rogers, 2001). Until 1988, KCP continued its broadcast over a ten-kilowatt transmitter located in Ahemdabad, the closest city. But after the community demonstrated and put pressure on the politicians, Doordarshan finally
relented and established a transmitter in the community. By 1994, KCP broadcast its programs five days a week for one hour (Agarwal, 1994).

There is no conclusive evidence that development and social change occurred exclusively due to television programming that aired for a decade, but anecdotal evidence and descriptive analysis suggest that television exposure helped bring about change in the Kheda community. KCP has been viewed as a “people’s medium” due to the alliance between the poor farmers and the change agents. Although the communication project involved local people, there is also evidence that top-down communication worked better during some aspects of decision making. Nonetheless, the project helped establish the credibility of television as a medium through which social change was possible. KCP also faced severe difficulties, primarily from people in power and who had vested interests in the villages (Agarwal, 1994). Apart from KCP, there are many other community-based development and communication projects in India, most of which do not rely on mass media. These are reviewed in the next section.

*Primary Health Care and Community Development*

Peasants are shrewd and rational; but rational in the context of a culture which has built into it the experience and wisdom of centuries…. Even the poorest peasants have a great amount of knowledge of every aspect of the encompassing environment gathered as a result of centuries of observation and experience. (Srinivas, 1993, pp. 284-285)

In implementing development projects, there is an inherent tension in integrating poor rural people’s intimate knowledge about their environment with the technical knowledge of outside experts. The primary health care approach, which seeks to resolve this tension between local and expert knowledge, thus deals with the social determinants
of health by incorporating technology within the existing community needs and resources (Wyon & Rohde, 2002).

India’s experiments with the primary health care approach involve many political, administrative and institutional factors. However, this section focuses on the role of decentralized health policy and the link between community participation and improving health and development of the rural poor. First, this section traces the historical developments of the decentralized governance, or the Panchayati Raj, which seeks to devolve power to village-level councils and local leaders. Second, the community health worker system is discussed in relation to community participation. Lastly, the role of communication in realizing community participation as part of the decentralized health system is addressed.

The Indian Caste System

To understand community development it is important to understand the significance of the caste system in India. The word caste has its roots in the Portuguese word *casta*, which means breed, race or ethnicity. In India, the caste system is a complicated set of rigid social structures that determines people’s social mobility and acceptance within a community. According to the Hindu varna (caste) structure, people are born into one of the four castes. Traditionally, depending upon their caste, people were restricted to a particular occupation. Also, there is a hierarchy within the four castes based on the notions of purity associated with each caste. For instance, the Brahmins are the highest caste; they are traditionally the priests, and thus the purest. The Kashatriyas, or Marathas are the next caste; they are the warriors who belonged to the royal families,
and thus they are wealthier than the Brahmins. The Vaisyas belong to the third caste; traditionally, they are the affluent businessmen and traders. The Sudras, the fourth caste, which is the least pure, are traditionally artisans and laborers and among the poorest communities. Outside of the four castes are the impure, or former untouchable people, known as Dalits or Harijans. The people from this group are scavengers and cleaners (janitors) in the community (Srivinas, 1996).

Sudras are categorized as backward castes and the Dalits are categorized as other backward castes, because socially, these groups are the most oppressed by the dominant castes. After independence, the Indian government banned caste discrimination practiced in the form of untouchability. Apart from the Sudras and Dalits, other communities that are economically backward and socially ostracized are the indigenous people categorized as scheduled castes and scheduled tribes (Srinivas, 1996). The 2001 Census of India classifies 16.2 percent of the population as belonging to scheduled castes and an additional 8.2 percent as belonging to scheduled tribes (Census of India, 2001). Today, as a way to improve the social and economic status of people belonging to the backward castes, other backward castes, and scheduled castes and tribes, the state has reserved seats in all government offices and in government-run schools and colleges.

Srinivas (1993), a prominent Indian sociologist and an expert on the caste system, says, “one of the main features of rural India is the presence of numerous, strong, land-owning castes [the dominant caste] which enjoy a high status, wield power over other castes, in particular scheduled castes, landless laborers and numerous small artisans and serving castes” (p. 285). The dominant castes are usually skilled, land owning farmers
with some education who control the bulk of agriculture in a village. The dominant castes also tend to exploit people who serve them – servants, laborers and daily wage earners – by under-paying and over working them. The dominant castes are also socially conservative, and thus resistant to change.

Since independence in 1947, the introduction of welfare reforms such as the abolition of untouchability, the reservation of seats in government offices and educational institutions for lower castes, the introduction of land reforms, and the provision of basic services to the poor lower castes has helped improve their social and economic status. Yet, the dominant castes tend to wield tremendous power in the villages, primarily because of their higher social status in the community. Thus, any change in rural India can occur only if the leaders at the local level, who are mainly the dominant castes, agree to cooperate with the government or other change agencies.

Decentralization and Health

Over the past 30 years, international development has seen a trend toward a primary health care approach to health and development. This approach emphasizes disease prevention through health education, health promotion and community participation, rather than making communities and people dependent on expensive health services (Morley, Rohde & Williams, 1983; Rohde, Chatterjee & Morley, 1993; Rohde & Wyon, 2002; Taylor-Ide & Taylor, 2002). In 1940, Jawaharlal Nehru outlined a goal for India’s primary health care strategy: training one health worker for every 1000 people within the next five years. In 1946, the Bhore Committee report proposed India’s first
national health policy; an integral part of the policy was training local people who could provide health education, promotion and basic health services to the poor (Bose, 1983).

The Bhore report outlined the characteristics of a primary health care model, which were reiterated thirty years later at the 1978 Alma Ata Declaration where 134 world leaders ratified this approach. Four years after the declaration, India reaffirmed its belief in the primary health care approach in its national health policy *Health for All: An Alternative Strategy* (Antia, 1993; Bose, 1983), the first such statement since independence. The new policy was drafted because by the late 1970s, many public health officials realized that the country's health system had not kept up with the commitments made in the Bhore report, as there was an over emphasis on building high-technology health infrastructures in urban areas that catered to the elites at the cost of services for poor people. The new policy hoped to correct these imbalances in health services through the “universal provision of comprehensive primary health care services” (Chatterjee, 1993, p. 344). Moreover, training lay people as health workers and giving them important responsibilities also marked a step toward human development at the individual and community levels (Mukhopadhyay, 1983).

Prior to the British colonization of India, the village (with a population of approximately 1,000 people) was the smallest unit of administration. Within a village, a *panchayat*, which is an assembly of five elders, was responsible for local development efforts. “The five *panchas* led the executive, administrative, judicial and developmental activities of their villages” (Bhatia, 1992, p. 275). But under British rule, the district (with a population of 1 to 3 million) was made the unit of administration (Bhatia, 1992). Thus,
local village councils lost the power to determine what development could occur in their communities (Antia, 1993). The British established a District Collectorate and appointed a District Collector from the city to recover taxes from people in the villages, since the existing panchayats did not cooperate and collect taxes (Bhatia, 1992). In 1959, the government reintroduced the earlier system of village-level administration through the Panchayati Raj, a system of local self-government. “The Panchayati Raj is an age-old Indian institution through which the common people can participate in decisions and activities concerning their own welfare” (Antia, 1993, p. 291).

The system provided the majority of Indians, 70% of whom live in the over 600,000 villages, with an opportunity to participate in their own wellbeing. Administratively, this was a three-tier system at the village, block (a group of a hundred villages) and district (a group of two or three blocks) levels, as shown in Table 2. But these efforts to decentralize governance failed because of lack of funds at the village level and because state governments resisted devolving power (Hardgrave & Kockanek, Jr., 1993).
### Table 2

*India’s Administrative System at the Local Government Level*

<table>
<thead>
<tr>
<th>Unit</th>
<th>Administrative body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Village</td>
<td>A panchayat, or council, of elected village representatives.</td>
</tr>
<tr>
<td>Development Block (comprising 100 villages)</td>
<td>A panchayat samiti (group of councils) made up of elected heads from the village panchayats.</td>
</tr>
<tr>
<td>District (comprising two or three blocks)</td>
<td>A zila parishad at the district headquarters with its own leaders.</td>
</tr>
</tbody>
</table>

Source: Park, 1967, pp. 87-88
In 1977, thirty years after independence, a new government led by the socialist Janata Party sought to decentralize healthcare by reinstating the community health program proposed by the first health policy in 1946. In 1980, the Janata Party was defeated because of its populist policies, which created budget deficits and made the government unpopular with many Indian elites, the private sector and the international development community (Chatterjee, 1993). Indian’s decentralized healthcare policy, agreed upon by signing the 1978 Alma Ata Declaration, was now in the hands of the Congress Party.

In the past, the Congress Party government was known to favor large-scale health services concentrated in urban areas, which catered to the rich (Chatterjee, 1993). However, in 1982 the government formulated a new national health policy in response to the global commitment: Health for All by 2000. The policy gave priority to training community health workers over investing in expensive hospitals and favored community participation to help the poorest achieve good health (Chatterjee, 1993).

In 1989, the government made further strides toward realizing the decentralized health policy by proposing the Panchayati Raj bill. “[The] Panchayati Raj seeks to realize the goal of decentralized administration and decision making by people themselves especially at the grassroots level” (Chauhan, Antia & Kamdar, 1997, p. 109). While many people believed that decentralization was an effective form of governance in India, especially after four decades of failed development due to centralized and top-down bureaucratic policies, allowing village councils control over the health system took almost forty years to achieve. The Panchayati Bill was proposed to make local
governments accountable to the central government, but the politicians and bureaucrats at the state level annulled any effective transfer of power to the local communities (Antia, 1993). There was a clause in the bill’s last paragraph that made it impossible to transfer power and funds from the state capitals to the local village level governments. This resistance to decentralization eventually led to the bill being defeated in the Rajya Sabha (Council of States), because many believed that Prime Minister Rajiv Gandhi was trying to centralize power through this bill.

Hardgrave & Kockanek, Jr. (1993) point out that though decentralization is seen as a necessary strategy for the development of the nation, it needs to happen in phases: first from the central government to the state governments and then from the state governments to the local village governments. The Panchayati Bill attempted to by-pass the state governments, and was predictably unpopular among state level politicians and bureaucrats. With the defeated bill, the local governments (zila parishads, panchayat samiti, panchyats) have become extensions of the political barons who control them from the state capitals (Antia, 1993). The revolutionary change that the Panchayati Raj sought to achieve in the Indian administrative structure is explained as follows:

The truth is that nowhere have our people been merely passive recipients of benefits delivered to them by a generous donor. They have their institutions, values, beliefs and world views and these have to be taken note of in any situation of intervention by outside agencies. For instance, forces present in local society may want health care diverted in a certain direction and might even prevent care reaching some others. Further, the villages are changing and the pace of change is increasing and the Panchayati Raj represents a massive effort, a near revolutionary effort, at changing political and social order at the district and lower levels (Srinivas, 1993, p. 285).
The above statement summarizes the divide between those Indian administrators who believe that development initiatives need to be imposed from the outside, as in the traditional top-down model, and those who believe that people have a right to participate in matters concerning their own well being, including access to good healthcare.

*The Community Health Care System*

The community health care system (CHCS) operationalizes decentralized health care to correct imbalances in the centralized health care system, which prioritizes infrastructure development and providing curative services. Under the CHCS, decision making and implementation of most health activities is at the village level. At its base, catering to a population of about 2,500 in four to six villages, is a sub-health center. At the next level, a group of sub-centers with a population of 20,000 to 30,000 is served by the primary health center (PHC). And a community health center (CHC) with a 30-bed hospital serves a cluster of five PHCs catering to about 100,000 people. Above the CHC is the *Taluka* hospital (small district) for about half a million people and a district hospital serving two to three million people (Chatterjee, 1993).

The sub-center has a pair of male and female multi-purpose workers trained in the government’s key health programs, such as family planning and maternal and child health. At the PHC there are two doctors, and at the CHC there are four specialized doctors providing pediatric, obstetric and surgical services, as well as seven nurses and midwives and other paramedical staff (Chatterjee, 1993). Table 3 describes the four-tiered decentralized health system.
The CHCS proposed that at least 80% of the health needs should be met at the PHC, which serves a group of twenty villages, and 15% of the preventive, promotive and curative health needs at the CHC (Chauhan, Antia, Kamdar, 1997, p. 109). With the different health care services in the villages, almost 95% of the health care needs are to be met at the block-level which has a CHC. Thus, the majority of the rural people can have affordable and accessible health services.
Table 3.

*Community Health Care System* (adapted from Antia, 1993, p. 347)

**Village-based System**

<table>
<thead>
<tr>
<th>Population</th>
<th>Administrative unit</th>
<th>Health unit</th>
<th>Estimated care</th>
<th>Per capita cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,500</td>
<td>Panchayat</td>
<td>Village Health Unit or the Sub-health Center</td>
<td>80%</td>
<td>Rs. 30</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Multi-purpose worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 Village health workers (female)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 Dais (female trained birth assistants)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20,000</td>
<td>8-10 Panchayats</td>
<td>Primary Health Center</td>
<td>13%</td>
<td>Rs. 27</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Doctors</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 Nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10 hospital beds</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 3 (continued).

<table>
<thead>
<tr>
<th>Population</th>
<th>Administrative unit</th>
<th>Health unit</th>
<th>Estimated care</th>
<th>Per capita cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>100,000</td>
<td>Development Block</td>
<td>Community Health Center (Rural Hospital)</td>
<td>5%</td>
<td>Rs. 23</td>
</tr>
<tr>
<td></td>
<td>(Panchayat Samiti)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Senior Medical Officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventive services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Doctor</td>
<td>60-100 hospital beds</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 Health assistants</td>
<td>5 Specialists</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Statistician</td>
<td>4 General Practitioners</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total per capital cost for the Community Health Care System</td>
<td>Rs. 80</td>
</tr>
</tbody>
</table>

Referral System

<table>
<thead>
<tr>
<th>Population</th>
<th>Administrative unit</th>
<th>Health unit</th>
<th>Estimated care</th>
<th>Per capita cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 million</td>
<td>District</td>
<td>District Hospital</td>
<td>1.75%</td>
<td>Rs. 100</td>
</tr>
<tr>
<td>5 million</td>
<td>City</td>
<td>Tertiary Care Hospital</td>
<td>0.25%</td>
<td>Rs. 100</td>
</tr>
</tbody>
</table>
Role of the Community Health Worker

The backbone of the community health care system is the community health worker (CHW) scheme. The basic philosophy of training community health workers is to enable ordinary people to have the knowledge and ability to manage their own health, thereby promoting community participation and minimizing people’s reliance on the government-run health program (Bose, 1983; Chatterjee, 1993). Moreover, by focusing on women and the weakest and most marginalized sections of the population (such as harijans or lower castes), and by promoting preventive and curative care through community health workers, this program aims at narrowing inequities in health (Bose, 1983).

Raj Narain, the controversial health minister of the Janata Party government, believed that laypersons from the villages could be trained in preventive health practices and the provision of basic curative services (Bose, 1983). Most other politicians and the Indian elites, including doctors, felt that training thousands of health workers would be a wasteful effort. They also believed that Narain’s proposal of training laypersons to provide curative health would make it appear that the government was promoting quackery and faith healers, a practice already prevalent across India that many times led to fatalities.

Although Narain lost the health portfolio within six months, in 1977, as formerly planned, the community health worker (CHW) scheme was introduced in 741 (13%) of the 5,686 primary health centers (PHC) in all states except Jammu and Kashmir, Tamil Nadu and Kerala, which already had an alternative system (Bose, 1983). The scheme
planned to train one CHW for every 1,000 people within three years in order to ensure that every citizen had access to health education and health services. In fact, the government exceeded its goal. By 1982, only five years into the CHW scheme, under the Congress Party government, over 400,000 community health workers had been trained, even in the most remote corners of the country (Bose, 1983; Rohde, Chatterjee & Morley, 1993).

Each village was to identify one person from the community to receive three months training at the nearest PHC and become the CHW. A local person would face less resistance from the community than an urban health worker. The CHW would be trained and receive technical support from the government, but s/he (only 6% of the CHWs were women in the initial years) would not become a government employee. Instead, the village council would supervise the CHW’s tasks. Upon completion of the training, the CHW would work two to three hours per day and be paid Rs. 50 a month ($5 based on the 1977 conversion rate) (Bose, 1983; Chatterjee, 1983). The typical responsibilities assigned to a CHW were:

1. helping the local health center in the government-run routine programs such as children’s immunization, family planning, maternal and children’s health and mental health services;

2. sensitizing the community regarding environmental sanitation and personal hygiene;

3. participating in health education programs;
4. treating common illnesses and referring patients to the nearest hospital in case of emergencies or severe illness.

The CHW scheme faced problems soon after its launch. The CHWs were dissatisfied with the small honorarium, but the government neglected their pleas by merely renaming the program the *Community Health Volunteer Scheme* and refusing to recognize these workers as government employees. However, the biggest setback came in mid-1979, when the central government decided it would provide only 50% of the funds and require the state governments to finance the rest (Bose, 1983; Chatterjee, 1993). Such administrative hurdles continued for the next few years. Finally, in 1981 and under a new government, the CHW scheme was once again 100% centrally financed but the health workers continued to receive only a small honorarium and were never hired as government staff. Being a government employee would have meant a higher social status and an incentive to continue their work. The lack of status caused growing dissatisfaction and led to poor performance. However, the government felt it was important to separate the health workers from the government’s medical bureaucracy, since the basic premise of this scheme was to allow people to have control over their health.

Yet, two decades after introducing the community health care system and training community health workers, the country’s health system has faltered and failed to deliver adequate health services to the poor, who are the majority among the 1.1 billion people of India.
Barriers to the Community Health Care System

The community health care scheme, with its emphasis on training a local woman as a health worker and delegating the supervisory role to the local government (panchayat or panchayat samiti), is meant to ensure that the poor and hard to reach have access to preventive, promotive and curative health. This model is “based on the principle that health lends itself both technically and culturally to be operated most cost-effectively in a decentralized system” (Antia, 1993, p. 354). Delivering health care is much more than building hospitals in the district capitals or cities. The bulk of health care needs must be met at the village level, where the majority of Indians (almost 70%) live. Despite the importance of providing community-based health, the system in India has not been successful (Chatterjee, 1993).

The primary reason for failure has been attributed to the poor performance of CHWs. Chatterjee (1993) states that instead of focusing on preventive health, the CHWs provided curative services because their training was delivered by doctors and based on a curative model. Mukhopadhyay (1983) also points out that merely selecting and training village women does not guarantee the success of the community health care system. Moreover, volunteer agencies that worked on a small scale were more successful in training laypersons as health workers, perhaps because of regular training and their firm belief in a preventive approach to medicine.

Another major reason for the poor performance of the CHWs was the administrative bottlenecks and the status of health workers as volunteers (Chatterjee, 1993). Had the health workers been recruited as government staff, they would have had
certain benefits such as job security. Also, being government workers would give the CHWs an improved social status in the community and some power. But if the CHW was a government worker and was inefficient, the local council would not have the authority to hold the worker accountable. Keeping the CHWs as independent workers, not government employees, gives the local government leverage (Bose, 1983). Also, the voluntary nature of the work made it attractive only to those village men and women who were truly dedicated to serve their community.

In essence, the program was based on the assumption that the benefits of being a government employee would not be an incentive, because the health workers would gain social status due to their service in the community. This has been partly true, but the local government officials who supervise the CHWs often do not treat them with the respect they deserve. This results in low morale and poor performance on the part of the CHWs (Chatterjee, 1993).

Five years after the CHW scheme was launched, the following lessons were learned and health planners were expected to improve the scheme based on this assessment (Bose, 1983):

1. Communication specialists and paramedic personnel need to be involved in order to persuade and motivate rural communities to practice preventive health.
2. Health workers need to be trained by professionals in management and education.
3. Health professionals such as the district medical officer in charge of the PHC need to be trained in interpersonal communication skills to deal with patients.
4. Formative research such as community health assessments needs to be conducted, and lessons shared with doctors and local government officials before launching any community specific programs.

5. Medicines should be made affordable to poor people by selling them through subsidized non-profit stores.

6. Medical schools need to incorporate realities of rural India into the curriculum when training future doctors and nurses.

Yet, even in the 1990s, little effort was made to revitalize the CHW scheme. Chatterjee (1993) concludes that CHWs should be given pre-assigned roles, specifically in health education, prevention and the provision of basic curative services. The CHW should not be made an extension agent of centralized health programs such as family planning and maternal and children’s health. Moreover, both males and females need to be trained, with preference given to female workers, as the CHW has to deal mostly with women and children’s health problems.

Communication for Community Health Care

This section briefly reviews the role of communication and community organization to harness and deliver primary health care as envisaged by the community health care system in India. The focus is on understanding the gaps and limitations of effective communication for participation to deliver primary health care.

An integral part of the community health care system is implementing specific government initiated public health programs to combat tuberculosis, leprosy, malaria and promote family planning and maternity services. All these programs were supported by
information, education and communication (IEC) activities (Antia, 1993). IEC was broadly divided into three components: (1) health education, (2) health information and (3) communication. Health education consisted of providing accurate information to people about the cause of their disease or illness, ways to prevent the transmission of communicable diseases, and information on how to distinguish essential drugs and medications from those that could be potentially harmful. Health education could be understood as health promotion with an emphasis on prevention of illnesses. On the other hand, health information dealt with raising awareness about available health services such as the primary health center, the community health center and even private medical facilities. Lastly, communication used various channels such as electronic, print and traditional mass media. Interpersonal communication was primarily used by the CHW, who is the vital link with the community and thus charged with diffusing information learned during the training.

The IEC programs’ biggest limitation was the over emphasis on information, which was disseminated from health experts or health volunteers to the community without taking into account the real needs of the people. This approach is similar to the top-down communication that characterized the modernization era, when the focus was on building communication systems and delivering information through communication channels without involving community members in the process (Melkote & Steeves, 2001; Servaes, 1999). The government used a one-way information model; health information was tailored to key programs such as leprosy, family planning, tuberculosis, and other such programs, irrespective of community needs. There was a strong emphasis
on producing products such as posters, pamphlets, and radio and television spots and on broadcasting health messages at bazaars (weekly markets). Communication meant disseminating information and did not help people take control over their lives. Thus, even in India, communication efforts were linear and top-down and much like the modernization paradigm that dominated communication for development programs until the 1970s, lacked a focus on community participation.

Antia (1993) rightly points out that communication cannot succeed unless there is close human rapport. He believes that instead of relying on artificially imposed impersonal messages, communication for health needs to have human interaction. In actual practice it [communication] is more in the nature of a discussion, often under a tree in the village or the verandah of a school or gram panchayat, where technical health information is exchanged and discussed with practical wisdom, of the villagers and their health workers. Only then can special problems of each village...be understood and solutions evolved (Antia, 1993, p. 381).

This criticism of message-based information without community participation is similar to the criticisms discussed earlier about re-conceptualizing the role of communication in the different paradigms of communication for development (Dervin & Huesca, 1999; Huesca, 2002; Jacobson, 1996; Melkote & Steeves, 2001; Servaes, 1999; White, Nair & Ascroft, 1994). If development programs such as India’s community health care system are being designed to reach all people, particularly the most marginalized and voiceless, then communication needs to harness community participation and move away from focusing on specific activities and products such as posters and advertisements. The limitations of the top-down, message-driven IEC programs popular in the 1960s and 70s and the concerns raised by development support
communication in the 1980s and participatory communication in the 1990s (Fraser & Restrepo-Estrada, 1998; Melkote & Steeves, 2001) are not addressed if communication is still used merely for information dissemination and awareness building.

In India’s community health care system, community organizing has been identified as the most important element (Antia, 1993). The contemporary communication for development paradigm emphasizes the use of communication for participation and organizing (Rogers & Singhal, 2003; White, 1999), yet India’s health program does not effectively use communication for this purpose. There are a few efforts in India, primarily from the non-profit sector, to effectively deliver health to all by integrating community participation and using communication to promote good health (Antia & Bhatia, 1993; Morley, Rohde & Williams, 1983; Rohde, Chatterjee & Morley, 1993). But the community health worker scheme has largely failed to effectively mobilize and use communication to promote health and development.

Theoretical Approaches to Participatory Communication

*Freire and Participatory Communication*

The alternative paradigm, with its emphasis on human development, set the stage for participatory development (Servaes, 1999). This section outlines the various approaches to participation employed by development communication scholars and practitioners since the early 1970s. The primary theoretical framework draws upon constructs proposed by Paulo Freire, a Brazilian educator-philosopher. Freire’s ideas have provided the central organizing framework for numerous people-centric development interventions (Minkler & Wallerstein, 2002; Singhal, 2004; White, Nair &
Ascroft, 1994). The subsequent section discusses additional participatory communication models that were used to pose research questions for the study.

Freire’s ideas concerning people’s participation became popular in the late 1960s when revolutionary social movements arose in most Latin American countries. This period also saw the rise of the dependency movement among Latin American social scientists who sought a new relationship between developed and developing nations. These movements led scholars and practitioners to value locally derived development practices as opposed to those designed by outside experts (Servaes, 1999). Freire was a staunch proponent of involving people in development practice.

Freire’s work (1970/1998, 1970/2000, 1973), conducted mostly in adult literacy programs in Brazil and Chile, focused on the pedagogy of liberation, achieved through critical thinking and collective action. Freire’s philosophy of education and his ideas about participation are grounded in the belief that people are meant to be free from any form of material, social and psychological oppression (Soler-Gallart & Brizuela, 2000; Thomas, 1994).

For Freire, literacy and education are universal rights achieved through cultural communication, and not through cultural transmission from teachers (educated people) to students (uneducated people) or from developed to developing countries (Soler-Gallart & Brizuela, 2000). The central concept of Freire’s theory of liberation, a process of overcoming oppression, is conscientization. Conscientization refers to the process in which men, not as recipients, but as knowing subjects, achieve a deepening awareness both of the socio-cultural reality which shapes their lives and of their capacity to
transform that reality (Freire, 1970/2000). Freire also explains that “conscientization implies going beyond the spontaneous phase of apprehension of reality to a critical phase, where reality becomes a knowable object, where man takes an epistemological stance and tries to know” (Freire, 1971, p. 4). Awareness raising is not an abstract idea, for it implies taking action to bring about change:

Conscientization implies that when I realize that I am oppressed, I also know I can liberate myself if I transform the concrete situation where I find myself oppressed. Obviously I cannot transform it in my head: that would be to fall into the philosophical error of thinking that awareness creates reality, it would be decreeing that I am free, by my mind (Freire, 1971, p. 5).

Conscientization is thus a process that allows people to become active participants in examining their environment and questioning the structures that lead to oppression. Friere proposed that people can free themselves of oppression if they are given a chance to pose problems and critically reflect on the existing structures of oppression. Becoming aware of one’s conditions is achieved through an iterative process of reflection and taking action, which provides the stimulus for change.

Freire used dialogue as an integral part of the conscientization process. Dialogue between the learners and the teacher proceeds by posing problems that stimulate critical thinking, making communication an integral part of the conscientization process (Soler-Gallart & Brizuela, 2000). Dialogue is based on the premise that the teacher, along with the student(s), is a co-learner, and that together they engage in a process of problem-posing as opposed to problem-solving, learning from lived experience, reflecting on the problem and taking action based on a collective response. This continuous and iterative
process of reflection and action results in the learners gaining self-confidence to
overcome obstacles to their growth, such as oppression.

Freire (1970/2000) closely associates oppression with the concept of the *culture of silence*. Freire explains that the oppressors, both within a society and from other societies, ensure that people do not become aware of the structures that cause oppression. This perpetuates a culture of ignorance and silence that exacerbates oppression. To overcome this silence, Freire (1970/1998) proposed cultural action, a form of education that values knowing through dialogic communication.

Freirean dialogic communication occurs when the teacher uses *generative words* or *generative themes* to stimulate a group discussion among the learners. This pedagogic approach, called *culture circles* or *learning circles*, is used to problematize the issues raised by the generative words and themes. The learners in the learning circles are asked to decode these generative words and the situations represented by these words and themes. This process is achieved through dialogue and leads to learners gaining self-confidence and raising their consciousness to overcome oppression.

The above methodology, termed *codification*, is operationalized through dialogue and reflection. Codification consists of multiple stages (Freire, 1970/1998). The first is descriptive, and includes pointing out the various elements that constitute the situation. The second stage, which includes problematization, seeks to determine deeper structures. The longer the problematization occurs, the more the learners understand the problem. The generative words or themes are chosen from the learners’ environment to help problematize a situation, because apart from learning, the learners need to engage in a
critical analysis of the larger social framework. For example, the words *favela* in Brazil and *callampa* in Chile each represent nuances of the social, economic, and cultural reality of the slum dwellers in those countries. Thus, when *favela* and *callampa* are used as generative words, the codification represents the social situations in the slums of the respective countries (Freire, 1970/1998). The generative words evoke fundamental needs of people such as housing, food, employment, health and so forth, and all of these needs are contextualized within the person’s situation and daily experiences of life in a slum. When such a process is done iteratively using multiple generative words, the learners begin to critically examine their environment and their place within the society.

Thus, codification as a form of education helps adults learn the root causes of oppression. The learning circles are not designed to teach alphabets to adults who are illiterate; their purpose is instead to teach a way to code and decode situations using cultural referents including words, pictures and daily situations. Within a few months of training, the learners are not only able to be read newspapers and write simple letters, but have also developed a sense of confidence and dignity for themselves (Freire, 1970/1998). The Freireian approach to education for critical thinking can be understood as a process of empowerment; the ability of people to take control over their environment.

The following paraphrased excerpt from the work of Freire and his colleagues in Chile summarizes the process of conscientization, codification and generative words (Freire, 1970/2000). It explains that in learning circles, through the mastery of the generative words chosen from the learners’ existential experience and critical reflection,
the learners expand their vocabulary and creative imagination. Furthermore, the excerpt points to how education can result in liberation of the oppressed.

Freire asked a peasant in one of the adult literacy classes, “why he had not learned how to read and write before.” The peasant replied that before the agrarian reform, he and his friends did not think about learning because everybody carried out the orders given by the landlords. For Freire and his colleagues, the peasant’s analysis represented the “culture of silence” that most people experienced during that time. Another peasant said, when all the land belonged to a latifundio (landlord), there was no reason to read and write. We were not responsible for anything. The boss delegated the orders and everybody had to follow him. But now, after the agrarian reform, peasants like him are responsible for their work and also have other responsibilities that require them to travel to the city and deal with educated people.

The peasant had learned how to read and write after joining the adult literacy classes. The peasant had decided to continue going to the classes because he was afraid of being cheated in the city and had realized that words gave him the power to negotiate. For Freire and his colleagues, this revelation among the peasants that words meant power and the freedom to think was important demonstrated that the peasants were fighting for themselves to rid oppression through their education. (pp. 31-32)

The subsequent sections discuss how Freirean concepts are intrinsically linked to participatory communication and are in turn central to the present day discourse and practice of development.

Valuing Local Knowledge

Within the realm of participatory communication, Freirean thinking has been widely adopted because it values ordinary people’s knowledge. In essence, knowledge does not belong to or need to be transmitted by a handful of experts to a mass of illiterates; knowledge already exists among people (Freire, 1971). Freire (1970/1998) uses the term conscious beings to describe people as being aware of themselves and their
world. People exist in a dialectical relationship by negotiating the limits imposed by the world and the knowledge of their freedom.

Participatory communication recognizes that people fail to exercise their freedom because of prevailing social and political structures, which perpetuate a culture of silence. Chambers (1983) proposes valuing rural people’s knowledge, or local knowledge, as opposed to the centralized scientific knowledge owned and shared by elites or experts. Development efforts can make a meaningful impact only when practitioners reverse roles, learn from community members and value people’s active participation (Chambers, 1983).

Participatory communication for development emphasizes that knowledge is not the property of experts to be transmitted to beneficiaries. Through active participation and dialogue, communities can help identify their needs and address them with available resources, thus using and creating their own knowledge (Arnst, 1996). Knowledge is tapped by facilitating empowerment of communities, which leads to directed social change (Melkote & Steeves, 2001). People can only achieve their full potential when they are given the freedom to think and act in ways that overcomes oppression. For this reason, participatory communication recognizes ordinary peoples’ knowledge, capacity and potential to be involved in the development process.

**Empowerment**

Within development parlance, Freire’s idea of liberation is similar to empowerment, or the ability of people to have control over their lives through dialogic communication (Arole & Arole, 1999; Rogers & Singhal, 2003). “Only dialogue, which
requires critical thinking, is also capable of generating critical thinking. Without dialogue there is no communication, and without communication there can be no true education” (Freire, 1970/1998, pp. 73-74). For people to become liberated, they must be part of the knowledge generation process, which Freire believes occurs only through problem-posing, and not by giving information to people and treating them as empty vessels to be filled with knowledge.

Empowerment is usually understood within the context of power, as it refers to the ability to have control over decisions that affect people’s lives. In the field of social change, empowerment has been the goal of professionals in the fields of community organizing, education and community psychology, which development scholars and practitioners have borrowed and applied to larger national development objectives (Melkote & Steeves, 2001). Reviewing Freire’s work, Melkote & Steeves (2001) conclude that communication channels bring about dialogue and serve as a vehicle for liberation by overcoming the psychological and physical barriers that exist between people and the larger social structure.

Scholars have studied the process of empowerment of women in developing countries through social interventions that focus on income generation and provide women with the means to overcome an oppressive patriarchal social system (Papa, Auwal & Singhal, 1995; Shefer-Rogers, Rao, Rogers & Wayangankar, 1998; Wilkins, 2000). Freire’s (1970/1998) liberation theory states that humans are not born oppressed, but instead adapt to structures of domination. When oppressed people become conscious beings, they make oppression and its causes the object of reflection; this process helps
liberate the people through their struggle for freedom. For Freire, the oppressor and the
oppressed act as a duality. That is, one feeds into the other and only through the process
of liberation can oppressed people resist their oppressor and find freedom.

This research relies on concepts such as learning circles, people as conscious
beings, respect for local knowledge, empowerment and dialogic communication to pose
research questions. The following section discusses participatory communication models
influenced by Freirean thinking. These models have also guided the present research
process.

Participatory Communication Models

This section outlines those participatory communication for development models
that grew out of the intellectual debates spurred by the alternative paradigm and inspired
by the Freirean principle of education as liberation (Servaes, 1999; Servaes, Jacobson &
White, 1996; White, Nair & Ascroft, 1994). It focuses particularly on models that have
informed the practice of community development (White, Nair & Ascroft, 1994). Apart
from the Freirean principles such as learning circles and conscientization, concepts that
underpin participatory communication such as self-reliance, empowerment, facilitation,
change agents, local knowledge and dialogic communication theorizing also guide the
present research. Using a deductive logic and relying on existing theoretical constructs to
guide the research process, the research questions seek to understand the determinants of
communication for participation in development as operationalized by CRHP.

While Freire’s theory of liberation is central to theorizing participatory
communication for development, another factor that has influenced scholars to envision
participatory communication models is the two-way process of communication. Everett Rogers’ lasting contribution to development communication is his pioneering research on the diffusion of innovations and its application in international development. Early in his career, Rogers (1976) acknowledged the passing of the dominant paradigm, with which diffusion is associated, and proposed a “different role of communication than the usual top-down development approach of the past” (p. 112).

Rogers and Kincaid (1981) proposed a convergence model of communication that focused on the meaning making process of communication as opposed to mere information transfer. Communication was defined as a process in which participants create and share information with one another to reach a mutual understanding (Rogers & Kincaid, 1981). These two separate traditions, Freire’s emphasis on people’s participation in development and communication as a two-way process of meaning making, are central to the following models of participatory communication.

**Participatory Communication as a Dialogical Process**

Rahim (1994) characterizes development systems as being heterogeneous, or consisting of people and resources that are linked to each other by material and symbolic transactions. For Rahim, these transactions are not mental abstractions but are communication behaviors in the form of participation in the development process. The transactions produce meanings and values of development, and communication plays a major part in this process.

Drawing on Mikhail Bakhtin’s discourse theory, Rahim (1994) proposes a model of development communication that has three intersecting planes: the informational
plane, the ideological plane and the entertainment plane. The informational plane represents the knowledge and information that is shared by and among people using different channels of communication. The ideological plane represents the use of ideas, concepts, experiences, categories and images that people use to make sense of the information concerning their development. And the entertainment plane is the use of different cultural and popular forms of communication for the purpose of development.

*Dialogy*, a form of participatory communication, combines the three forms of communication – informational, ideological and entertainment – and therefore transcends the boundaries and differences between groups involved in the development process (Rahim, 1994). Dialogue is a conversation between two people, but dialogy is the recognition of and respect for the other speaker. Much like the Freirean notion of dialogic communication, “in dialogical participation everybody has an equal right to speak and to be heard, and to expect that his or her voice will not be suppressed by or merged with other voices” (p. 131). In essence, this model allows for the silenced voices of poor and oppressed people to become part of the development process. The model privileges communication across social, political and economic classes as a way to further the development process.

*Participatory Communication as Cultural Renewal*

Extending the link between communication and culture and recognizing that all cultures are dynamic and in a state of flux, cultural renewal lays out the participatory processes to accelerate progress towards equal human rights for all people (Nair & White, 1994). In the 1980s, development practice was caught between striving for universal
human rights and preserving cultural identity. Additionally, increased contact with other cultures; widespread access to mass media; decades of planned change; and a universal acceptance of equality, freedom and justice have made cultural change inevitable.

Cultural renewal is a participatory process to revitalize local cultures by “incorporating a universal framework which is egalitarian, equalitarian, less repressive, and adapted to the local ecosystem” (Nair & White, 1994, p. 140). The renewal process proposes a balance between reshaping old values and incorporating new cultural alternatives, and striving for universal values. Besides cultural context and universal values, self reliance and power relationships are integral to cultural renewal (Nair & White, 1994).

The fundamental tenet of participation is to help people and communities become self-reliant (White, Nair & Ascroft, 1994). Self-reliance as a development goal recognizes human potential whereby people can use local resources for change. And the existing capacity of people and communities serves as a catalyst for change. Nair & White (1994) term inherent human potential and people’s capacity as generative power. Generative power is “an ability to challenge cultural and structural deprivation or oppression” (Nair & White, 1994, p. 162). This concept is similar to empowerment in that it gives people a sense of control over their own lives.

The four concepts – self-reliance, power relationships, cultural context and universal values – need to be operationalized at the community level (periphery) and at the macro-societal level (center). Integration through cultural renewal, or relying on the local culture between these two levels, is important because changes at the community
level are dependent on state-level policies. An integration effort would facilitate communication between these two levels and has the potential to be culturally sensitive as opposed to imposing change on the communities. Lastly, the cultural renewal model recognizes the importance of dialogue among people who acknowledge that internal and external resources are necessary for change. Dialogic communication that integrates old knowledge with new information and understanding determines the outcome of the cultural renewal process.

*Communicator as a Facilitator*

Those who view development as social transformation agree that participatory communication, a two-way dialogic interaction aimed at transforming people to become self-reliant and empowered, is a necessary condition for change to occur (White, 1999, White, Nair & Ascroft, 1994). The communicator plays the role of a development facilitator by being the catalyst for the change process. Kiiti & Nelson (1999), inspired by Freire’s critical thinking approach to education, distinguish the role of facilitator from that of an advocate. “An advocate is often driven by an ‘external agenda’ while the facilitator seeks to understand and help people determine their own agenda” (p. 52). Facilitation ensures community accountability, locally driven solutions and sustainability of development interventions. Communication is the glue that binds people as a community, making effective communication a key element for facilitation. White and Nair (1999) use the term catalyst communicator to refer to a trained person whose role is “creating an environment for dialogue, learning and transformation” (p. 39).
The integrated model of communication for social change describes how community dialogue and collective action work together to produce social change including improved health and welfare, and suggests that the change process is initiated by a catalyst: “[The] catalyst leads to a dialogue within the community that when effective, leads to collective action and the resolution of a common problem” (Figueroa, Kincaid, Rani & Lewis, 2002, p. 6). There can be different kinds of catalysts, including an internal stimulus leading to a revelation of the problem; technological or policy change to overcome a problem; mass media to promote individual and collective action; and/or a change agent, a person or an organization that initiates a dialogue with the community. Within the context of community-based development interventions, the para-professional who is the change agent is the key catalyst.

Change Agents and Community Participation

A facilitator is usually from the community and is trained in organizing people to come together and engage in a critical dialogue leading to collective action, a practice inspired by Freire’s learning circles. Another person who can speed up the change process in a community by introducing new ideas is a change agent. Unlike the facilitator, who is from the community, the change agent is an outsider who works on behalf of the change agency, which is the organization or government agency implementing the development project. The role of the change agent and the characteristics of different change agents are described comprehensively in the literature on diffusion of innovations (Rogers, 2003). Although diffusion theory is not associated with participatory communication, the function of the change agent is central to
understanding the participatory development process, and in particular, how internal and external factors work together to influence people to change.

Rogers (2003) distinguishes between two kinds of change agents, a professional change agent and a para-professional aide, based on the degree to which the change agent is similar or dissimilar to the community. Rogers (2003) describes change agents as homophilous (socio-culturally similar to the community) or heterophilous (socio-culturally different to the community). The degree of similarity and dissimilarity is based on the socio-cultural and economic status of the change agent and the community members. Professional change agents tend to be different from community members, and thus despite their expertise, are not considered very credible (Rogers, 2003). For instance, a professional change agent such as an educated social worker promoting safe sex and providing counseling to commercial sex workers may not be perceived as being trustworthy by the sex workers. However, if a woman who used to be a sex worker and who is trained in counseling works as a para-professional aide, the sex workers would find her more credible than a professional change agent (Singhal & Rogers, 2003).

Within the context of participatory communication, the para-professional aides are most effective because they are homophilous, or perceived as being similar by the community (Rogers, 2003). Diffusion theory also suggests that because of their education, professional change agents have a higher social status and tend to interact with potential adopters who are similar in social status, thereby marginalizing poor people. Whereas a para-professional change agent may have less technical knowledge than a professional change agent, the para-professional agent actively seeks out people who are
similar to them to introduce new ideas. In essence, the role of the para-professional aides is to work with the community to facilitate the change process.

*Community Development Projects and Participatory Communication*

This section reviews several community development projects in light of the theoretical concepts of communication for participation in development. The projects are initiated by various change agents such as the government, private non-profit agencies and international development agencies, but are all grounded in principles of community participation. Most of the projects discussed are on public health and community development. Special attention is paid to communicative elements that are central to these community-based development interventions.

*Taking Health to the People*

The participatory communication model promotes communication as a dialogue with the community rather than the mere transmission of information from experts to community members (Figueroa, Kincaid, Rani & Lewis, 2002; Gumucio-Dagron, 2001; Servaes, Jacobson & White, 1996; White, 1999; White, Nair & Ascroft, 1994). Likewise, the community-based health and development approach is grounded in involving people in promoting change (Antia & Bhatia, 1993; Minkler, 1997; Minkler & Wallerstein, 2002; Rohde & Wyon, 2002; Tan-Torres, 2001; Taylor- Ide & Taylor, 2002). The first known experiment with community-based health, initiated in the 1920s by Dr. John Grant at Peking (now Beijing) Union Medical College, was based on the principles of going to rural areas and recruiting and training laypersons as para-professionals in preventive and promotive health practices (Taylor-Ide & Taylor, 2002; Wyon & Rohde, 2002).
A central principle in almost all successful community development projects aimed at improving poor people’s health is that doctors have to go to the people, so that even people in remote areas who are too poor to go to a health facility can enjoy good health (Arole & Arole, 1994; Kidder, 2003; Luecke, 1993). Many also believe that another unique feature of the community-based health care approach is the focus on prevention, achieved by training local people to become health promoters and educators and offering modest curative services to people with commonly occurring health problems (Wyon & Rohde, 2002). In order to prevent ill health, the root causes of diseases have to be tackled in the surroundings where people live, and not in the hospitals where they are treated (Antia & Bhatia, 1993; Taylor-Id & Taylor, 2002; Wyon & Rohde, 2002). Community members have to be made aware of the link between illness and what causes these illnesses. Thus, community participation is vital for projects that seek to improve the health and well being of poor communities.

Similarly, in the early 1970s, Mr. Mechai Viravaidya, the founding member of Thailand’s Community-based Family Planning Services program, realized through field experiments that village people used medical services only when somebody told them about such services and a doctor was available in a nearby clinic (Korten, 1980). Setting up medical facilities in urban centers does not motivate poor villagers to seek medical care, because of barriers such as time, money and lack of trust (Viravaidya, 1997).

The same is true of other projects, including those initiated in India. In the early 1970s, Dr. Antia, a surgeon, began working in Mandwa, a rural community about one hour away from Mumbai, in the State of Maharashtra (Antia, 1993). While treating
patients at his hospital in Mumbai, Antia realized that the underlying cause of most health problems experienced by rural people, even those in communities close to the cities, were linked to poverty. Aware that he could not reverse the desperate poverty of the villagers, Antia decided to do the next best thing; teach local residents how to treat commonly occurring medical conditions in the community. As a single doctor, he could not have reached many people, but by training villagers (mostly women) as para-professionals, he was able to contain most of the health problems in the community (Antia, 1993).

In Chimaltenango, Guatemala, Dr. Carroll Behrhorst, popularly known as the “good doc” by the Mayan Indians, did the same during his three decades of work with the poor. Dr. Behrhorst believed in the following philosophy: go to the people, live with them and help them find locally acceptable solutions to their health problems (Luecke, 1993). Similarly, Dr. Paul Farmer, a medical doctor-anthropologist who is known as the poor people’s doctor and lived with Haitians in the 1980s, worked with the local people and found ways to prevent communicable diseases such as tuberculosis by getting rid of the root causes of the illness (Kidder, 2003).

In sum, successful and sustainable community-based health and development projects have operationalized the concept of role reversals (Chambers, 1983). Skilled and highly trained doctors have made the effort to go to the poor people who need good healthcare services rather than waiting for them to come to hospitals and clinics that are usually inaccessible or too expensive.
Para-professionals as Facilitators and Change Agents

A change agent is native to the community or able to work closely with the community. She or he is trained as a para-professional to become a health promoter and educator, and is the link between the project staff or change agency and the community members (Rogers, 2003; White, 1999). Viravaidya (1997) explains the role of change agents in Thailand’s Community-based Family Planning Service (CBFPS). Established in 1974, CBFPS’s primary objective was to change people’s attitudes about contraceptives in order to contain the massive population growth. Apart from using local shopkeepers as distributors of contraceptives, CBFPS trained them as para-professionals to give information to potential clients on the importance of family planning and where to seek services. As part of the project, over 16,200 villagers in most regions of Thailand were trained as para-professional aides who sold condoms and birth control pills and gave advice to their customers on the importance of family planning (Korten, 1980). While the project gave a commission to these shopkeepers, money was not the primary incentive to join the project. Shopkeepers who were chosen as distributors and trained in providing information considered themselves to have a higher social status in the community (Viravaidya, 1997).

Consejo de Salud Rural Andino (CSRA) is a Bolivian non-governmental organization set up to provide healthcare for rural Andeans. CSRA’s mission is to save lives by knowing people and working with them to improve their health and well-being (Shanklin & Robison, 2002). Because medical practitioners in the capital La Paz, which is also the closest city for the community where CSRA worked, treated rural people with
disdain and were not sensitive to their cultural practices, the rural poor rarely used the health facilities. CSRA planned to demonstrate to the Ministry of Health a model program that would improve health care delivery for the rural poor, but officials at the ministry did not trust the auxiliary nurses, CSRA’s frontline health workers, because they were not highly skilled. Yet, at the same time, the Bolivian government had recognized the importance of non-governmental organizations in providing sustainable health services to rural areas. CSRA’s two decade old model program has proved successful, and one reason for its sustainability is the use of mid-level paid health workers from the communities (Shanklin & Robison, 2002). These auxiliary nurses are trained according to a government approved curriculum and provide the essential technical support and leadership in their rural communities.

BRAC, established in 1972 and formerly called the Bangladesh Rural Advancement Committee, was set up to help resettle refugees in the Sulla area of Northeast Bangladesh following the war of partition from Pakistan. Soon, BRAC expanded beyond providing emergency supplies and became involved in comprehensive development interventions such as health, income generation, education and vocational skills building, as well as in building people’s capacity to become involved in development projects. BRAC is therefore known for innovatively and continuously adapting its programming to bring about development (Abed & Chowdhury, 1997; Korten, 1980). Today, one of BRAC’s successful programs is in health. The four doctors working for BRAC realized that they could not meet the needs of thousands of people in hundreds of villages (Korten, 1980). Thus, BRAC trained villagers to treat commonly
occurring and fatal diseases such as cholera and diarrhea. This experiment proved successful as the trained health workers provided the communities with important information on preventing and curing the ailments. BRAC therefore used the physicians as trainers rather than as caregivers to expand the reach of the program. The health system was built around training villagers as paramedics so they could manage and prevent commonly occurring illnesses (Korten, 1980).

*Arogya doots* (health messengers) and *dais* (auxiliary nurses) are trained by SEARCH, a project established in 1986 in the Gadricholi district in the State of Maharashtra, to diagnose, treat and manage childhood pneumonia (Bang & Bang, 1993). The *arogya doots* and *dais* are ordinary people selected from the 58 villages that the project serves. These paramedical health workers are illiterate, but receive intensive training in diagnosing respiratory infections. In a two year trial experiment conducted in the late 1980s, the *dias* treated over 2,000 cases of pneumonia with a fatality rate of less than 1 percent, thus setting new standards for training local people. Equipping ordinary people with valuable knowledge to help their community has also resulted in a sustained change in local peoples’ attitudes toward managing children’s health.

Akin to SEARCH, the Foundation for Research in Community Health (FRCH) in Mumbai and Pune, India has learned from its ten-year long Mandwa experiment, outlined earlier, to train semi-literate women to handle almost 70 percent of health problems. Presently, FRCH trains village women in another rural community, Parinche, in the western part of Maharashtra, which has a population of about 20,000. The local women receive weekly training that equips them to deal with the majority of the health problems
in their communities. FRCH also runs a small hospital in a nearby town, which serves as a referral center for emergency cases. The aim of the project is to deliver a training program for women that would result in overall development in their villages (Gadkari & Vakil, 2003). These women, known as the *tais*, which in this context means women trained in doing development work, are responsible for much of the health and development improvement in this region.

*Respecting Local Knowledge*

Freire’s learning circles use local words and themes to stimulate discussions that lead to a critical examination of the existing problems faced by poor people. The use of socio-culturally appropriate words to sensitize people about health and to help improve people’s living conditions is demonstrated by a project in Boga, Zaire. A health team was working with local communities to undertake a needs assessment study and find ways for community action to achieve good health. Nickson (1993) explains that during a community meeting the discussion centered on the word *obusinge*, which when literally translated into English means health. However, the meaning of *obusinge* within the cultural context meant much more than health in the Western context, which is absence of disease (Leucke, 1993). The discussion, which was similar to a learning circle, was facilitated by the health team and revolved around social relationships including the family and the individual. These discussions raised questions about who should determine the health needs of the people in Boga. As a result of this process, various community needs were identified and pathways to overcome some of the problems were
discussed. Had the change agents imposed their view of health on the people of Boga the outcome would have been very different.

In certain community-development projects, the facilitators and para-professional aides can be much more than health promoters, as demonstrated by the following example. In the late 1960s, in the area around the Narangwal village in the Ludhiana district in the northern State of Punjab, India, pneumonia was the second largest cause of death among children under three years of age (Taylor-Ide & Taylor, 2002). A long-running field experiment implemented through the Ludhiana Christian Medical College trained laypersons to become family health workers (FHWs) to assist local doctors in identifying pneumonia cases and treating patients in the early stages of the infection. However, the FHWs were finding it hard to use a stethoscope and distinguish the breathing of a patient with pneumonia from a patient with a common cold.

One day, a family health worker (FHW) announced that it would be much easier to distinguish the breathing by watching the babies breathe rather than learning how to use a stethoscope. The doctors had never thought of this technique, but realized that the FHWs were correct; babies with pneumonia were breathing much more rapidly than other babies. Within a year after this field experiment, the mortality rate due to pneumonia dropped by 45 percent as compared to control villages (Taylor-Ide & Taylor, 2002). A few years later, health workers in New Guinea began observing and counting respirations. This led to the existing guidelines on identifying pneumonia cases based on the number of respirations per minute by age, a system endorsed globally by UNICEF,
the leading United Nations agency working for the improvement of children’s health and welfare.

Perhaps the most striking example of respecting local knowledge and incorporating it to improve people’s lives is the work of Dr. Carroll Behrhorst in Chimaltenanago, Guatemala. Dr. Behrhorst believed in learning about health from the Mayan people, with whom he lived and worked for three decades (Luecke, 1993). The Behrhorst program never dismissed local knowledge as primitive or unscientific; instead the program was built around people’s health care practices and perceptions about health. Building a relationship of trust and cooperation by respecting local people’s knowledge and culture was crucial for this project. Behrhorst (1993) explains: “Many health programs fail because they are designed solely by professionals. It is different when the indigenous people work on their own terms, learn from their own failures and build on what they themselves have done. That is what “development” is all about” (Luecke, 1993, p. 54).

Research Questions

Based on the review of participatory communication concepts, an understanding of how community development projects have operationalized these concepts and a reliance on inductively generated concepts from data collected in Jamkhed the following research questions were posed:

*RQ1:* How does the weekly training of the village health workers (VHWs) reflect the
Freireian concept of culture circles (learning circles)? What specific dialogic communication practices are used in these learning circles to facilitate the empowerment process of VHWs?

*RQ2*: How does the mobile health team (MHT) act as a change agent and work with the community members to improve health? What is MHT’s role in enabling community members to become self-reliant and improve their living conditions?

*RQ3*: What specific processes does CRHP employ that encourage the use of local knowledge and help create platforms for community members to actively participate in achieving good health for individuals and the community? How do these processes contribute toward conscientization of the community?

*RQ4*: How do the VHWs work as facilitators for their community? What contributes to organizing people in groups such as *mahila mandals* or Farmers’ Clubs? And how does the facilitator motivate the members of the *mahila mandals* and Farmers’ Clubs to engage in community dialogue and collective action?
CHAPTER 3: METHODOLOGY

Case Study Design

To address the overarching research question – how CRHP facilitates individual and community-level social change – this research employed a case study research design, using methods developed by Robert Yin and Robert Stake. Yin (1989) proposes that research design is dictated by three conditions: a) the type of research questions posed, b) the extent of control an investigator has on the events being studied, and c) the degree of focus on contemporary or historical events (Yin, 1989, p. 16). In addition, when a study is attempting to answer a “how” or “why” question about a contemporary set of events, over which the investigator has little or no control, a case study design may be the most suitable method. A case study is thus defined as an empirical method of inquiry that investigates a contemporary phenomenon when the boundaries between the phenomenon and the context are not clearly evident and multiple sources of evidence are used. Five components make up a case study research design: 1) study questions, 2) propositions, 3) unit(s) of analysis, 4) linking data to the propositions, and 5) criteria for interpreting the findings (Yin, 1989, p. 29).

Stake (1995), on the other hand, states that researchers conduct a case study when they are interested in understanding a particular case about a social phenomenon. “[W]e enter the scene with a sincere interest in learning how they (the phenomenon or interest) function in their ordinary pursuit and milieus and with a willingness to put aside many presumptions while we learn” (Stake, p. 1). The salient feature of case study is “particularization, not generalization” (Stake, p. 8) of the case. In case study research, the
investigator seeks to know the phenomenon being studied for the purposes of understanding its uniqueness. Stake (1995) believes that a phenomenon can have multiple meanings or realities; therefore, he suggests that the researcher should present more than one meaning about the observations they make. To allow multiple meanings to emerge, the researcher needs to provide a thick description that allows readers to draw their own generalizations based on their own position about the phenomenon. Thus, one of the most important decisions is to allow research questions to emerge from the case itself, which is an emic approach to doing research. These issues, according to Stake, are assertions or plausible reasons about why a particular phenomenon occurs. The assertions are then composed in the form of a narrative description, which can lead to naturalistic generalization of the phenomenon.

The concept of naturalistic generalization is the point of departure between Stake and Yin. Yin (1989) suggests that theoretically based propositions help in comparing the empirical results with previously developed theories, an etic approach to doing research and a process he terms “analytic generalization.” Thus, analytic generalizations are comparisons between case study findings and existing theories about the phenomenon that can extend or limit the theory’s explanatory power. But Stake (1995) suggests that case study researchers should present the findings in their most natural form, and the reader or user should decide how to generalize based on his or her theoretical stance about the phenomenon being studied. Despite these fundamental differences regarding how to identify research questions, both Stake (1995) and Yin (1989) follow the same
logic, which is to explain the uniqueness of the case once the specific issues or propositions about the phenomenon have been identified.

Stake (1998) also suggests different types of case study designs. An instrumental case study is an approach that uses a particular case to understand a broader phenomenon of interest. For instance, studying how participatory communication is accomplished within a given development project can help us understand how participation as a general strategy could be used in other communication projects. In this research, CRHP’s community-based health and development processes are studied to understand the larger concepts of using communication for participation in development. Additionally, Yin (1989) offers an embedded case study strategy; studying a single program by focusing on the specific roles of the different stakeholders or units. This study divides CRHP into multiple units by focusing on the different people that make up the organization and contribute toward improving the community members’ quality of life.

While the research questions are deductively derived from existing theories and models of communication, development and participation, the research seeks to uncover determinants of communication for participation based on information provided by the participants in Jamkhed. In doing so, a deductive-inductive approach is used to categorize and organize the data.

*Researcher’s Role and Nature of Inquiry*

The purpose of the present research is to describe the uniqueness of CRHP’s participatory development strategy. More specifically, the research seeks to understand how communication is used as a means to facilitate people’s participation in the project.
Thus, the nature of research inquiry is aligned with the methodological assumptions that guide interpretive research strategies. Stake (1995) explains how interpretive qualitative research design calls for researchers to be conscious of their own position and exercise subjective judgment while collecting, analyzing and synthesizing data. Moreover, the research questions that guide the present study are descriptive in nature and do not require the researcher to be value-free while collecting data. Instead the nature of research requires the researcher to build a close relationship with the participants. In order to fully answer the research questions, the researcher had to open up to the participants, reveal social status and explain how the participants’ openness to provide information would be beneficial to the research and also the project.

Despite the subjectivity embedded in the research design, the research relied on multiple sources of information (different stakeholders) and multiple methods of data collection (interviews, participant observations, etc) to triangulate the findings. Triangulation is an alternative to the validation of findings (Denzin & Lincoln, 1998; Kidder & Fine, 1987) in qualitative inquiry. The researcher uses multiple data sources, methods or theories to answer the same research questions. In this research, triangulation of methods was used to overcome the limits of individual methods. And gathering information from multiple sources provided a more holistic understanding of the research questions. Finally, because the researcher is fluent in the native language, Marathi, the interpretation of data collected during interviews and observations was not lost during translation. Thus, knowing the local language strengthened the research process of collecting, analyzing and synthesizing information.
Before discussing the data collection procedures, it is necessary to describe the physical characteristics of the research site, the social characteristics of the people of Jamkhed, CRHP’s organizational set up and how different participants or stakeholders were treated as separate units of analysis within the case study.

Description of the Case

Jamkhed is a small town at the heart of the community development block with a population of approximately 80,000. It is located 400 kilometers southeast of Mumbai in the Ahmednagar District in the State of Maharashtra. Figure 1 shows the location of Jamkhed on the map of India. Jamkhed is about 50 kilometers south of the district headquarters, Ahemdnagar, is accessible only by a small rural highway (similar to a county road in the U.S.). It borders four drought-prone districts. It has a government health center and at least half a dozen private medical facilities. Jamkhed is a corridor for migrant workers in the four neighboring districts to find work in industrial belts in western and northern Maharashtra. Being well connected by the rural highway, people often travel to Jamkhed for the weekly bazaar (market) to buy vegetables, grain, and other staples and to buy and sell farm animals (Arole & Arole, 1994).
The Comprehensive Rural Health Project (CRHP) was established in 1970 in the town of Jamkhed, a drought-prone and poor region 400 km southeast of Bombay (Mumbai) in the State of Maharashtra.

Figure 1: Map of India showing Jamkhed

This map of India does not show the recent changes in the political-administrative regions. Its purpose is to show where Jamkhed is located in India.
CRHP, with its hospital and health training center, is on the outskirts of Jamkhed, located on a two hectare plot of land donated by a local businessman in the early 1970s (Arole & Arole, 1994). But CRHP primarily works in villages within a 30 kilometer radius. By 2004, CRHP had worked with over 250 villages in the Jamkhed region and served over a quarter million people. Typically, each village has 200 to 300 households and a population of 1,000 to 2,000. Some of the villages or communities have a government health facility, called the sub-health center, which caters to a cluster of four or five surrounding villages. Sub-health centers, as described in Chapter 2, provide basic curative health services. Almost all villages have a primary school where children can study until the fourth grade. To complete their high school education, children have to travel to a nearby larger town, which requires a one hour walk or a twenty minute ride on a bus that runs only once a day.

The greatest development problem facing the Jamkhed region is water scarcity. The region is severely drought-prone and receives rainfall an average of only thirty days a year. The rainfall is spread over the three month monsoon season, June to August. The average yearly rainfall is only two to three inches. The summer season, which lasts for about six months, is very hot with temperatures averaging about 40 degrees Celsius. During the winters and the monsoons the temperatures are mild.

Most of the people in the region depend on agriculture for their livelihood. The majority of farmers grow food crops such as lentils, sorghum, and jowar, but a few grow cash crops such as oil seeds and cotton. Farmers depend entirely on the rainfall for their crops, as water is scarce and wells do not have much water. Thus, income for most
families is unstable, leading to economic insecurity. During severe droughts, farmers migrate to nearby cities in search of work. Aside from crops, animals also depend on rain water. If yearly rainfall is not sufficient then animals tend to die due to starvation and lack of water.

Majority of the people in the Jamkhed region are Hindus, the dominant religion in India. Much like the rest of the country, Jamkhed also has some Muslims, Christians and indigenous groups belonging to tribal and nomadic communities. Although CRHP is based on the Christian faith (Arole & Arole, 1994), the project works with all religious groups. For instance, every morning at the training center in Jamkhed, a short prayer service is organized by the Aroles. People of all religions are invited, but nobody is coerced into attending the service, and people with whom CRHP works are not discriminated against because of their religious affiliation.

The project’s biggest social challenge has been to empower and integrate lowest caste Hindus into development initiatives. In all the villages where CRHP works, the dominant caste Hindus (the Marathas, who are also the landlords) were historically an oppressive force that did not allow the lowest caste (Sudras) and the outcastes (Harijans or Dalits) to develop economically or socially. In the 1970s, in Jamkhed, like the rest of India, people strictly followed the caste hierarchy. Thus, the Sudras and Dalits that made up for about a third of the population were often ostracized and discriminated against by the dominant castes. CRHP decided to work with these lowest caste people, recruiting and training them to become village health workers and change agents. CRHP also
include the high castes to help alleviate the social discrimination that leads to a poor quality of life for the lowest castes (Arole & Arole, 1994).

Comprehensive Rural Health Project’s Organizational Set up

CRHP is organized in a three-tier system, with village health workers, a mobile health team and a health center or hospital. The village health workers are trained as para-professionals who live in the villages, the health center is in Jamkhed and the mobile health team is a multi-disciplinary group of seven women and men that links the health center with the village health workers and community members. This three-tiered system provides efficient and equitable access to the primary health care program because a village health worker is based in every village. These female village health workers identify and treat health problems in the village or refer patients to the health center through the mobile health team.

The mobile health team visits each village once a week or twice a month and organizes a clinic for community members. The clinic provides basic health services especially for women, children and the elderly, and preventive health practices are promoted through health education. The health team visits even remote villages where people have no access to other health facilities and is thus able to reach people who would otherwise be left out by the government health system. The health center in Jamkhed provides emergency medical and surgical services to people who cannot be treated at the village level. The next section describes the functions of the various stakeholders, and Figure 2 depicts CRHP’s organizational set up and the roles of stakeholders in each of the three tiers.
1. The Village Health Workers

Over the course of thirty five years, CRHP has trained at least 250 village health workers (VHWs), one or two for every village where CRHP has worked. In 2004, CRHP was actively working in 57 villages in three districts in the region. There are two village health workers in each village; therefore, approximately 100 village health workers are actively participating in weekly training and village-based community health activities.

The VHWs are all poor women and most belong to the lower castes. They are nominated by the village people and they work as volunteers for their community. These low caste women are illiterate or have had very little education, and no formal training in healthcare. The VHWs become the liaison between the community and the health center at Jamkhed. The Farmers’ Club, organized by CRHP in each village, calls a meeting and ensures that people belonging to all castes and social classes are present. By consensus, one socially conscious woman is chosen as the village health worker. The selection is deliberately made through an open voting system so that once selected, people do not oppose her. CRHP holds weekly training sessions for the VHWs on building self-esteem and self-confidence, enhancing communication skills, and providing treatment for basic diseases that affect women and children in the community. After their training in primary health care, the VHWs’ main task is to assess health and development problems in the village, promote preventive health practices and treat minor yet commonly occurring and potentially fatal health conditions such as diarrhea, pneumonia and malaria.

When the program began in 1970, the CRHP staff trained the VHWs in an effort to overcome caste and gender discrimination. VHWs were given the responsibility of
organizing women from all castes to come together and form *mahila mandals* (women’s groups). Even today, most of the VHWs are poor low caste women and work as volunteers. But CRHP ensures that the VHWs receive micro-credit from the local banks to help them become economically independent. Many VHWs have begun small business enterprises such as selling vegetables and raising farm animals, which has helped improve their social and economic position.

### 2. The Mobile Health Teams

The mobile health team (MHT) is comprised of seven para-professionals: one auxiliary nurse, two paramedics and four social workers. Presently, there are two women and five men on the health team; five of them have been working for CRHP since the 1970s (two senior members have retired since the fieldwork for this study was completed). During their weekly or bi-monthly visit to the villages, they provide technical support to the VHW. The team breaks into two groups; the one with the nurse sets up a small mobile clinic in the village square and the other makes house-to-house visits to identify people who need medical attention and to build rapport with the community. At the mobile clinic, the nurse and the paramedics immunize children, examine high-risk pregnancies identified by the VHW and give appropriate treatment or advice. The paramedics in the MHT treat patients with tuberculosis or other diseases.

The mobile health team also establishes regular contact with the Farmers’ Club, the *mahila mandal* (women’s group) and the newly formed self-help group (SHG) members in each community. In most villages, some of the *mahila mandal* women have come together to form the SHG that focuses on providing micro-credit to women so they
can become financially self-sufficient. Each SHG comprises six to eight women; a community can have many SHGs as long as all the women pay their monthly dues on time. Both the mahila mandal and SHGs work closely with the VHW, so it is important for the MHT to support the VHW by reassuring the community of her work. Along with the help of CRHP staff from the health center, each community is trained to assess, analyze and take action to solve community level problems. The open dialogue between community members and the health staff has resulted in increasing people’s self confidence and thus empowering them to engage in collective action. The MHT plays a crucial role in this process, and as the following remark from a member of a newly formed Farmers’ Club in Kharewadi suggests, it links the community and the VHW with the health center in Jamkhed: “The biggest change is that people are now willing to come together as a group and do work collectively. This did not happen in the past. Now we are confident that we can achieve many social objectives on our own, which can help everybody.”

3. The Health Center

CRHP’s health center and training institute are in Jamkhed. The health center, which has four doctors and half a dozen nurses, provides curative services and secondary medical care such as surgery and hospitalization to the community. The center conducts weekly training sessions for the village health workers and also provides periodic training to update the skills of the mobile health team. The emphasis is on enhancing communication skills and training the VHWs as health educators, promoters and change agents. The training institute also brings in national and international health professionals
In sum, the three-tier organizational system relies on VHWs, MHT and the health center’s senior staff to facilitate the social change process. However, the onus is on community members, who are empowered to begin a self-propagating participatory development process in their villages. Metaphorically, CRHP is a set of three concentric circles, with the health center representing the outer circle, the mobile health team comprising the middle circle, and the villages with VHWs trained as para-professional aides, comprising the core of the project. The MHT plays the important role of linking different communities and villages to the health center, with the help of the VHWs. Figure 2 describes the organizational set-up of and the different functions performed by the three key constituents.

For training purposes. By 1995, CRHP had trained over 4,000 grassroots workers, 3,400 health professionals and 1,200 social workers from other regions of India, and over 1,000 international trainees in community-based health and development (Arole & Arole, n.d.). Additionally, the health center is a liaison between government ministries, including the Ministry of Health and Family Welfare, Ministry of Social Development and the Ministry of Rural Development, and the communities.
Health Center in Jamkhed
- It has a 40-bed hospital with four doctors and provides surgical and emergency services.
- It trains and empowers VHWs in health promotion and education and empowers communities to manage local problems.
- It provides periodic skills-based training to community members.
- It trains professionals in primary health care delivery to expand CRHP’s model of equity, integration and empowerment.

Village Health Worker
- Each village has one to two VHWs, who are the liaison between the villagers and the CRHP staff.
- VHW is usually a poor or low-caste woman.
- She is a volunteer who is chosen by the community.
- She is trained as a para-professional and receives weekly training at the health center.
- The mobile health team provides her with technical support.
- She organizes community meetings to solve problems.

Mobile Health Team
- Consists of a nurse, paramedics and social workers.
- They provide basic health services in the villages.
- They make regular visits, along with the village health worker, to identify high-risk health problems in each community.
- They refer villagers to the health center if the problem cannot be solved locally.
- They organize Farmers’ Club and Women’s Groups and facilitate in community decision making and collective action.

The mobile health team is the liaison between village health workers and the health center.

Figure 2. CRHP’s three-tier organizational set-up
Comprehensive Rural Health Project as a Case

The present study will treat CRHP as a single case composed of multiple programs involving multiple stakeholders, and will thus use an embedded single-case design. A stakeholder is defined as a person or group of people who are included in the project process because they would be affected by the project outcome (Oakley & Kahssay, 1999). Thus, the VHWs, MHT, project staff, and the community members are all stakeholders in CRHP. Additionally, as described earlier, CRHP as a case is used to understand the broader concepts of communication and participation in order to extend the theory and practice of participatory communication for social change.

The three embedded cases comprising CRHP are: (1) the health center senior staff at Jamkhed, (2) the mobile health team, and (c) the communities, consisting of VHWs, women and men organized as Farmers’ Clubs, *mahila mandals* and women’s self-help groups. The levels of analysis in this case study are divided among these three stakeholder categories. The unit of analysis is not the organization or the overall program, but the various stakeholders in CRHP’s three-tier health and development system as shown in Table 4.
### Table 4

**The Stakeholders and their Activities in CRHP**

<table>
<thead>
<tr>
<th>Tiers</th>
<th>Activities and Roles Performed</th>
<th>Stakeholders involved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Health Center in</strong></td>
<td>1. Operate an outpatient clinic that provides medical, surgical and emergency obstetric care.</td>
<td>1. Project Director and Associate Director</td>
</tr>
<tr>
<td>Jamkhed</td>
<td>2. Train para-professionals in primary health care with a focus on prevention and health promotion.</td>
<td>2. Doctors and nurses</td>
</tr>
<tr>
<td></td>
<td>3. Conduct community workshops that provide skills in and information about farming, getting loans and vocational training.</td>
<td>3. Technical resource staff and trainers</td>
</tr>
<tr>
<td></td>
<td>4. Act as liaison between the villages and government ministries to ensure government programs reach the communities.</td>
<td>4. Administrative staff</td>
</tr>
<tr>
<td><strong>2. Mobile Health</strong></td>
<td>1. Make regular visits to build rapport between the health center, village health workers, and community members.</td>
<td>1. Auxiliary Nurse Midwives</td>
</tr>
<tr>
<td>Teams</td>
<td>2. Provide curative services and referrals to the health center.</td>
<td>2. Paramedics</td>
</tr>
<tr>
<td></td>
<td>3. Promote health prevention through health education.</td>
<td>3. Social worker</td>
</tr>
<tr>
<td></td>
<td>4. Provide assistance for the assessment, analysis and action of problems.</td>
<td>4. Development worker</td>
</tr>
</tbody>
</table>
### Table 4 (continued).

<table>
<thead>
<tr>
<th>Tiers</th>
<th>Activities and Roles Performed</th>
<th>Stakeholders involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Communities</td>
<td>1. All collective activities performed in the village.</td>
<td>1. Health workers and community members</td>
</tr>
<tr>
<td></td>
<td>3.1. Village Health Workers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Serve as a para-professional aide and change agent.</td>
<td>1. Mostly low caste poor women</td>
</tr>
<tr>
<td></td>
<td>2. Work as a health educator and health promoter.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Provide basic healthcare to community members.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Act as a liaison between the health center and the community.</td>
<td></td>
</tr>
<tr>
<td>Villagers or community members</td>
<td>1. Women organized as <em>mahila mandal</em> (MM) engage in community development and promote preventive health.</td>
<td>1. Women and men organized in groups such as MM, SHG or FC</td>
</tr>
<tr>
<td></td>
<td>2. Women organized as self-help groups (SHG) engaged in income generation projects.</td>
<td>2. Marginalized groups such as lower caste groups</td>
</tr>
<tr>
<td></td>
<td>3. Men organized in Farmers’ Clubs (FC) take on community projects.</td>
<td></td>
</tr>
</tbody>
</table>
Units of Analysis

While CRHP is treated as a single case, the embedded cases within the program are the different stakeholders that comprise the three-tiered organizational set-up of CRHP. Therefore, the villages that are part of the study were categorized based on the duration of project activities. Also, the CRHP staff provided outcome indicators for the different villages as measured by the number of active Farmers’ Clubs, *mahila mandals* and self-help groups. A list of community activities such as building wells and soakpits, organizing cleaning drives and mobilizing women from self-help groups to begin small income generation projects was provided by CRHP. Once the villages were segmented based on duration and level of community activities, the village health workers from these villages, who had come to Jamkhed for their weekly training sessions, were asked whether they would be willing to participate in the study. About a dozen VHWs from 12 villages agreed to participate in the study. Six villages were chosen based on the number of active Farmers’ Clubs, *mahila mandal* and self-help groups, the willingness of community members to participate in the study, and their accessibility.

Of the six villages that were not studied, two were left out based on CRHP’s rapport with the community. The MHT and VHWs, the key informants in introducing the researcher to the community, warned that the people from these two villages may not willingly participate in research. The researcher had to rely on the key informants’ perception in order to maintain a good relationship with them and CRHP. Data was not officially collected from the remaining four villages, but the researcher informally collected observational and interview data during field visits. The six villages that are
central to the study were divided into three groups of two as described in Table 5. The first group consists of two villages where the project had been working for over twenty-five years. CRHP has been active between ten and fifteen years in the second two villages, and in the final two villages the project has been working for less than five years.
Table 5

*Villages Studied in the Jamkhed Region*

<table>
<thead>
<tr>
<th>Group</th>
<th>Name of the Village, District</th>
<th>CRHP’s Presence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pimperkhed, Jamkhed</td>
<td>More than 25 years</td>
</tr>
<tr>
<td></td>
<td>Ghodegaon, Jamkhed</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Sharadwadi, Jamkhed</td>
<td>Between 10 and 15 years</td>
</tr>
<tr>
<td></td>
<td>Jawalka, Jamkhed</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Kahrewadi, Asthi</td>
<td>Less than 5 years</td>
</tr>
<tr>
<td></td>
<td>Pangulghavan, Ashti</td>
<td></td>
</tr>
</tbody>
</table>
Following Yin’s definition of an embedded case study design, the specific cases studied within CRHP were defined based on the role of the stakeholders. Therefore, although the villages were divided into three groups, they together comprise one case within the larger case study. The other two cases are senior health center staff and the VHWs, as described below in Table 6.
Table 6

*The Embedded Case-Study Design of CRHP*

<table>
<thead>
<tr>
<th>Case</th>
<th>Profile of Participants</th>
<th>Units of analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 1: Para-professional aides</td>
<td>Village Health Workers (VHWs)</td>
<td>1. VHWs in the six study villages</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Senior VHWs who are peer educators in the training center</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. VHWs from other project villages</td>
</tr>
<tr>
<td>Case 2: Key informants</td>
<td>Senior health center staff</td>
<td>1. Project Director</td>
</tr>
<tr>
<td></td>
<td>Mobile health team</td>
<td>2. Associate Director</td>
</tr>
<tr>
<td></td>
<td>Health educators</td>
<td>3. Mobile Health Team</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Communications Team</td>
</tr>
<tr>
<td>Case 3: Community members</td>
<td>Men and women from the six study villages that are actively involved in CRHP activities</td>
<td>1. Farmers’ Clubs members</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. <em>Mahila mandal</em> members</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Self-help group members</td>
</tr>
</tbody>
</table>
Data Collection Procedures

Following Yin’s (1989) approach, the study relies on multiple ethnographic data sources including participant observations, individual in-depth and group interviews, participatory tools such as transect walks and participatory rural appraisals and secondary data. Although the research relies primarily on qualitative data collected during the two-month field work to understand communication practices for community organizing, secondary data on CRHP including strategy documents, past surveys and past research from disciplines such as public health and nursing are used to validate the findings.

This research design was shared with CRHP senior staff for their comments, and certain data collection methods and sampling techniques were modified based on their feedback. For instance, many interviews with community members were conducted in Jamkhed when they came for training instead of in the villages, in order to better use the participants’ time. Also, all the fieldwork was done either between 7:30 and 10:30 in the morning or after seven in the evening so that participants did not lose their daily wages by participating in a few hours of interviews. Participants were also consulted during the research design and data collection process to ensure that participant observation during community meetings and training would not make them uncomfortable.

Additionally, the research incorporated the needs of CRHP staff by asking questions that may help to enhance the project and allow the participants to become part of the research process. For instance, while interviews were being conducted in some communities, the MHT made use of the opportunity to fill out household surveys. Although it was not part of this research agenda, participants and the MHT used the
opportunity to discuss logistical issues about the project such as the next training session or community meeting. Finally, some VHWs that were working as staff at Jamkhed accompanied the researcher to learn how to conduct interviews.

The field work was conducted in July 2004, and after a two week break, from the middle of August until mid September 2004. A total of eight weeks was spent living in Jamkhed at the training center. The data was collected in Jamkhed, the six study villages and from four more villages that were visited on a regular basis during the eight week stay in the region. All the interviews were conducted in Marathi, the local language, which is also the researcher’s mother tongue. Field notes were typed up or handwritten after each day’s field visits and observations. Upon return to Athens, Ohio in October 2004, the researcher translated and transcribed the interviews into English. The sampling procedure, sample size and data collection methods are explained in the following sections.

Gaining Entrée

Gaining entrée to the community in order to establish trust and build a relationship with the participants is an important aspect of the research process (Chambers, 1983). Even though the researcher is native to the region and speaks the local language, not living in the community and belonging to a different socio-economic group immediately marks the researcher as an outsider. While this difference can never be completely overcome, in order to reduce the distance from the community members, the researcher decided to spend the first month learning about the different communities and getting acquainted with the project staff and key informants in Jamkhed.
Every summer, CRHP offers a month-long course on community health and development. In July 2004, the researcher enrolled in the course, which is taught by the senior staff of CRHP and the mobile health team members. As part of the course, the researcher visited a dozen project villages and got an opportunity to get to know some of the health workers and community members. Thus, the course was a way to gain entrée to the community and build a good rapport with the key informants and some of the community members who would later participate in the study. Through this course, the researcher was able to learn about CRHP’s process of development and gain the trust of senior staff members and other key informants.

Moreover, participation in the course allowed the researcher to learn from the VHWs and MHT members, rather than merely collecting data from these stakeholders. This reversal of roles is a process of co-research, when the researcher shares knowledge with the community and learns from the participants (Chambers, 1983). This also helped the researcher build rapport with the stakeholders and observe how community members communicate, participate and organize for collective action. In addition, after a few weeks, participants began recognizing the researcher and opened up easily during interviews. The researcher made a conscious attempt not to pose as an expert and instead showed interest in learning from the participants. On many occasions, the researcher explained the purpose of the field visit to the participants using the opportunity to informally glean how community members participate in the development projects in their village. In sum, inspired by Chambers’ (1983) idea of role reversal, the researcher showed genuine interest in learning from the participants.
Participants in the Study and Selection Criteria

Key informants. The health center senior staff, consisting of two project directors, including the co-founder of the project and a resource person from the U.S. who is in charge of coordinating the training offered in community health and development to local and international professionals, were the researcher’s first point of contact. Six months before doing the fieldwork, the researcher contacted Ms. Connie Gates, the CRHP resource person, and through her, established contact with Dr. Rajanikant Arole, founder and director of CRHP. The research proposal was shared with Dr. Arole to seek his permission to conduct fieldwork while based at CRHP.

These three participants, along with the seven members of the mobile health team, are the key informants for the present research. Five of the nine key informants have been actively involved in the project since its inception in 1970. Another key informant is the associate director, Dr. Shobha Arole, who is responsible for all operational decisions. The associate director is also the doctor in charge of CRHP’s hospital. In addition, because the mobile health team members know all of the VHWs and most of the community members personally, their recommendations were useful in purposefully selecting participants based on their active involvement in the project.

Village health workers. To identify the VHWs to be interviewed, the key informants were asked who would provide the richest and most insightful information on communication and community participation. In addition, during the participant observations of the health worker training, the researcher introduced himself and sought voluntary participation from the health workers. The researcher also asked the health
workers to further identify typical cases (Miles & Huberman, 1994), who were the community members that regularly engaged in collective action in the villages. Once a group of actively involved men and women was identified, a snowball sampling technique (Patton, 1990) was used to identify other participants, primarily men and women who participated regularly in the Farmer’s Club, *mahila mandal* and self-help group activities.

Sampling continued until the data reached a point of saturation: a point when participants were sharing information that was already told by other participants and no new themes were emerging. In sum, the research used triangulation of sampling methods, data sources and data collection procedures to gain perspective from the different stakeholders. Table 7 summarizes the total number of participants in the study. Further, data were collected by engaging in 30 hours of participant observation and direct observation during the VHW training sessions, and an additional 12 hours of observations of the communication troupe performances in six villages.
Table 7

*Participants from Villages and CRHP*

<table>
<thead>
<tr>
<th>Sampling Frame</th>
<th>Total Participants Interviewed/Observed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 1: Village Health Workers</td>
<td>6 (Peer-facilitators)</td>
</tr>
<tr>
<td></td>
<td>12 (from the six study villages)</td>
</tr>
<tr>
<td></td>
<td>10 (from other project villages)</td>
</tr>
<tr>
<td>Case 2: Health Center staff</td>
<td>3 (Director, Associate Director and training resource person)</td>
</tr>
<tr>
<td>Mobile Health Team members</td>
<td>6 (Two females and four males)</td>
</tr>
<tr>
<td>Communication troupe performers</td>
<td>8 (Seven females and one male)</td>
</tr>
<tr>
<td>Case 3: <em>Mahila mandal</em> members</td>
<td>15 (Four to five members from three study villages, all females)</td>
</tr>
<tr>
<td>Self-help group members</td>
<td>20 (Three to four in each of the six study villages, all females)</td>
</tr>
<tr>
<td>Farmers’ Club members</td>
<td>24 (Four in each of the six villages, all males)</td>
</tr>
<tr>
<td>Total participants</td>
<td>112</td>
</tr>
</tbody>
</table>
Data Collection Methods

*Secondary Data: Research and Organizational Reports*

Before visiting Jamkhed and beginning the fieldwork, the researcher studied and analyzed documents that synthesized the communication and project implementation processes implemented by CRHP. Organizational documents were obtained from the CRHP staff, and published papers were accessed through the university library and the Internet. The purpose of analyzing the secondary reports before doing fieldwork was to help identify key strategies used to organize community members and specific communication activities carried out by the CRHP staff and VHWs. This analysis helped the researcher gain a cursory understanding of the case study and provided an empirical framework to design the study.

After arriving in Jamkhed, during the first month in July 2004, the researcher continued studying more secondary data and gathered primary information from key informants during their month long training. The researcher found research articles; book chapters; organizational reports; evaluation studies; and past academic research, theses and dissertations on the project in CRHP’s library in Jamkhed. The researcher also studied the results of the periodic household surveys conducted by CRHP. The information collected and analyzed from the secondary data and acquired during the training was used to refine the research design and to prepare the question guides used during in-depth and group interviews. Also, the secondary data was used to validate some of the primary research findings while analyzing the data, as explained in Chapter 4.
Benefits and Drawbacks of Using Documented Information

The advantage of using documented evidence about CRHP is to identify practices and processes that would not emerge during interviews and participant observations. For instance, certain practices like community kitchens in the villages are no longer practiced and thus people may not talk about it. Or at times, participants may cover up or forget certain events, since the project has been operating for many decades. This is a common occurrence when interviews are a primary source of data collection. However, the documents about CRHP did not provide all the information needed to understand the communication practices at work in Jamkhed. Hence, participating in the training course, in-depth and group interviews, participant observations and participatory methods are used as the primary sources of data.

Participant Observations

The researcher gained entrée to the community with the help of the senior health center staff and the MHT members during the one-month training course. In the first week, the researcher was introduced to the VHWs who act as peer facilitators during the weekly training sessions of the health workers. In the second week, the researcher asked the mobile health team and the peer facilitators whether he could observe the weekly training and get to know some other VHWs. With their consent, the first participant observation was conducted in the second week of July; subsequently the researcher attended five more VHW training sessions.

The main purpose of the participant observation was to understand how these training sessions contribute to the VHWs empowerment process. Using Freire’s
(1970/1998) approach of researcher as a co-learner and Chambers’ (1983) concept of an outsider (researcher) learning from the community, the participant observation helped show how the VHWs approach health and development problems in their communities.

Benefits and Drawbacks of Participant Observation

Participant observation allowed the researcher to be active and reflexive (Mason, 2002). It made available non-verbal data that could not be accessed through other forms of data collection, and thereby strengthened the study (Adler & Adler, 1998). Participant observation allowed the researcher to observe first hand how trainings were conducted, how group interactions were facilitated and the nature of communication between VHWs and the trainers. This information could not be elicited through interviews, secondary data or participatory methods. Also, this method allowed the researcher to participate in training sessions by raising questions and learning from the participants and the facilitators.

In addition, the researcher made half a dozen visits to the communities with the MHT before beginning the formal interviews. During these visits, the MHT organized community meetings as part of their regular agenda. Participant observation was conducted at these community meetings, during which time the researcher was introduced to key members in the villages. This helped establish credibility among the potential participants. These visits also helped establish trust among the community members as the researcher was accompanied by the project staff.
Direct Observational Data

Observing the training sessions helped the researcher understand the critical role that communication practices play in organizing and empowering community members. Apart from observing and participating in the health workers’ weekly training, the researcher also observed meetings organized by the mobile health team and village health workers with community members who were part of the self-help groups, mahila mandals and Farmers’ Clubs. Observing the meetings helped the researcher understand how community members engage in dialogue and critical thinking. Also, the researcher could learn how the MHT and VHWs use different communication strategies to discuss the community’s health and development needs and promote preventive health information.

Additionally, the researcher followed six village health workers from the six study villages over a period of one week as they interacted with community members. The researcher also engaged in participatory research such as transect walks and asking people to draw or give examples of how their life has changed over the past few years as a result of CRHP. Through this engagement, it was possible to explore how health promotion and health information methods have improved people’s lives and how community members have participated in collective action.

Benefits and Drawbacks of Observational Techniques

Observation is one of most unobtrusive methods of data collection, and hence it allows issues and problems to emerge naturally in what is called the emic, or the insider’s approach to data collection. Through this method of inquiry, research questions emerged...
that were not anticipated (Adler & Adler, 1998). For instance, during training sessions it was observed that apart from health information, the VHWs are also responsible for resolving social problems such as dowry related harassments or finding a home for orphans. As a result, in the interviews, the VHWs were asked how CRHP facilitates and empowers them to manage social problems in the community. Yet, one of the biggest drawbacks of observations is the ethical concern raised by the nature of inquiry. Community members may not be comfortable with the researcher attending their regular meetings. This was partially overcome by building a rapport with the community during field visits and also by seeking participants’ consent before the interviews.

**In-depth and Group Interviews**

In-depth and group interviews were used as a primary source of data collection with all the stakeholders ranging from the staff at the health center to the VHWs and community members. The *mahila mandal* is active in organizing poor women to improve the health of women and children, and to address harmful socio-cultural beliefs and practices such as dowry and discrimination against people from lower castes. In many communities in the past five years, *mahila mandals* have split into self-help groups comprising six to eight women. These self-help groups are organized to provide micro-credit to poor women. With the appropriate co-facilitation of local female researchers (MHT members or senior VHWs), group interviews were conducted with the women members in all six villages. The information from these sessions helped reveal the problems faced by women due to the prevailing social structure. Also, these interviews
provided an avenue to understand how CRHP consciously makes an effort to include women in the development process.

The drama, song and dance clubs and the puppet show performers commonly known as the Communication Troupe are part of CRHP’s efforts to promote health using entertainment-education. Entertainment-education is a strategy in which pro-social messages and educational issues are intentionally incorporated into entertainment programs delivered through communication channels (Singhal & Rogers, 1999). At CRHP there are about a dozen members who perform songs, dances, and dramas that have an educational purpose. The researcher attended four of these four-hour long performances in four different villages. Each performance was attended by almost three-quarters of the population from the community, which translates into about 750 to 1,000 audience members. Six lead performers, including the person who introduced puppetry as a mode of health promotion, were interviewed in-depth.

Benefits and Drawbacks of Using Interviews

In-depth qualitative interviews have the advantage of eliciting rich and insightful information from the participants. First, the interview allows the participant to re-live an experience that may have happened some time back, a process of constructing or reconstructing experiences (Mason, 2002). This allows the participant enough space and time to think about a phenomenon that they are being interviewed about and give a thoughtful complete explanation. In the case of CRHP, some members such as the dance, drama or puppetry performers and even Farmers’ Club and mahila mandal members were
able to think back and share their vast experiences in the challenges and the strategies
employed in community organizing and implementing the communication programs.

Second, the interview allows for creation of a social interaction between the
researcher and the participants (Fontana & Frey, 1998). This puts the participants at ease
and provides them the freedom to pace the interview depending upon their level of
confidence. Being an outsider to the region, the non-threatening notion of being
interviewed helped gain trust and establish a rapport with the participants. Third,
interviews allow the participants to provide a rich and in-depth description of the
phenomenon that other methods did not offer. Also, it allows a chance to go back and
seek clarification about what the participants said in the interview. This interactive and
social nature allowed for rich and insightful data to be generated in a non-threatening and
conversational environment.

A major drawback of interviews is that people may cover up or forget to discuss
important events. An attempt was made to overcome this bias by cross checking the
information through multiple interviews and group interviews. Also, as discussed above,
information from secondary sources and key informants was used to pose some of the
questions and to cross check whether what the participants revealed during the interview
had actually happened.

Participatory Methods

In collaboration with CRHP staff and VHWs, a rapid assessment of what
participation means to the community members in the six study villages was conducted.
Farmers’ Club and mahila mandal members were given a list, compiled from CRHP
records, of community activities that were organized over the past few years in various villages in the region. The list included building a community well, village cleaning drives, helping VHWs to monitor child growth, and so forth. As a second step, the researcher asked the participants to rate the items on a participation continuum.

Farmers’ Club members from three of the six villages were also engaged in participatory rural appraisals. These men decided to use community mapping to illustrate changes that had occurred over the past few years in their villages. The participants told the researcher that these changes had occurred either due to the active involvement of community members or with assistance from CRHP or other development agencies. Participants used maps to illustrate changes in socio-economic status of community members, infrastructure development, and to a lesser extent, the diseases occurring in the village by season.

Also, ten participants from one of the six villages used participatory photography (Singhal, Harter, Chitnis & Sharma, 2004; Wang, 2003) as a tool to assess community perceptions about health and development. The researcher distributed six cameras to ten members of the Farmers’ Club and mahila mandal and asked them to take pictures about situations that they felt represented positive change in the community. Participants were asked to give particular attention to areas of community development which was either facilitated by CRHP or occurred because of the community’s own initiative. Also, the participants were asked to take pictures of situations that they felt needed to be improved in their community.
From over 100 photographs, each participant was asked to choose six that they felt represented either the most positive change or a situation that needed urgent attention. Each of the ten participants was interviewed based on the photographs they chose and asked to explain what they hoped to communicate through these pictures. The accompanying narratives that guided the selected pictures were used to understand community perceptions of positive change and areas that need improvement (Lykes, 1997, 2001; Wang & Burris, 1994). These interviews were conducted in a group setting as participatory photography is often used to elicit community level dialogue to foster social change (Wang & Burris, 1994).

Benefits and Drawbacks of Using Participatory Methods

Participatory methods allow participants to actively engage in the research process and help demystify it (Chambers, 1983; Singhal, 2001). In particular, rapid assessments and participatory rural appraisals are commonly used in many community-based development projects because they are not complex or time intensive and so make research accessible to people from different socio-economic backgrounds (Chambers, 1983). Also, these two methods allow local knowledge and information to be incorporated within the traditional ethnographic research methods such as interviews and observations.

Much like rapid assessments and participatory rural appraisals, participatory photography enables people to record and reflect on their community’s strengths and concerns and can stimulate and promote dialogue between participants and researchers about community issues (Wang, 2003). Also, by taking pictures, participants are given
another mode of expressing their views rather than simply providing information orally. The researcher has little control over the kind of information that the participants want to share as the tool for knowledge creation is handed over to the participants. This method fits in with Chambers’ (1983) idea of the researcher learning from the participants in order to minimize the biases that outsiders may have.

The drawback of the participatory method is that the participants may often stray from the main research topic which was participation, communication, and collective action. However, the advantages of allowing issues that are central to the participants to emerge during the research process help explain how participation is achieved and sustained as part of the various collective actions.

Data Categorization and Analysis

During the two months of fieldwork and the three months following the fieldwork, all the taped interviews and group interviews were translated and transcribed into English. Additionally, participant and direct observations and field notes were transcribed. The two months of fieldwork generated 20 individual interviews, 20 group interviews, over 32 hours of participant observation and field notes from visits to dozen project villages and the training center. Additionally, the participatory tools generated village maps and ranked lists of community activities from six study villages and over 100 participatory photographs from one of the communities.

All the data were then categorized into different themes based on the research questions (Yin, 1989). Following Stake’s (1995) idea of writing a thick and detailed description of the case study out of the concepts emerging from the case, new categories
that did not fit the original constructs were separated and thematized. The findings and discussion are presented so that readers can draw their own generalizations in addition to the researcher’s analysis. This combination of deductive and inductive data analysis and presentation of the findings makes this study richer. The findings describe how communication facilitates participation, which can benefit future development projects that seek to achieve community participation and empowerment of the poor.

Yin (1989) proposes two strategies for analyzing data from case studies. The first is to rely on the theoretical constructs that guide the research questions in order to focus on certain data and ignore the other data that does not speak to the constructs; this technique is useful in organizing the case study based on the constructs and providing alternative explanations that need to be explored. The second strategy relies on describing the case in the form of narratives, not privileging the theoretical constructs, but allowing for the whole data set to speak about the case.

The present research begins with the former method of focusing on the theoretical constructs but also integrates an analytic strategy that allows new constructs to emerge. In addition, using Miles & Huberman’s (1994) analytic techniques, the data was categorized into different patterns or themes and clustered around particular research questions. These themes were compared and contrasted in order to ensure that the constructs are well explicated by the data. Finally, all the data was arranged logically to make conceptual and theoretical sense with respect to the central research question – how communication processes helped facilitate participation and what determinants of communication are necessary to foster community participation on a sustainable basis.
CHAPTER 4: RESULTS

This chapter presents data about how CRHP uses various communicative practices to facilitate community participation. The data is organized around the four research questions that guide this study. Furthermore, the data is presented according to the role of and the activities performed by the different stakeholders. Case 1 describes how communication is used to empower the village health workers. Case 2 describes the role of change agents in linking the communities with the project in Jamkhed. Finally, Case 3 describes how CRHP uses communicative strategies to facilitate collective action by the community members.

Case 1: Empowering Village Health Workers

This section addresses how the CRHP operationalizes the Freirean principle of conscientization using participatory and dialogic communicative practices. More specifically, the various communicative practices are thematized under one overarching research question.

RQ1 asked: How does the weekly training of village health workers (VHWs) reflect the Freirean concept of culture circles (learning circles)? What specific dialogic communication practices are used in these learning circles to facilitate the empowerment of VHWs?

The data revealed several themes that support Freirean principles such as the participatory selection and training of VHWs, dialogue and critical thinking to overcome barriers such as caste and gender roles and respect for people’s capacities and knowledge.
These practices result in empowering the women to become para-professional aides to serve their communities.

Selection and Training of Village Health Workers

In 1970, CRHP and some village leaders realized that the project needed to have a person who would talk to and educate women about various health topics. Drs. Raj and Mabelle Arole, the two surgeons and public health specialists who founded CRHP, decided to train village women as health workers. They thought that women, despite their low educational status, were constantly learning and taking on new responsibilities such as care giving, working in the house and in the fields. Moreover, women were especially concerned about their family’s health (especially the children’s health) and were more eager than men to improve it. Thus, the doctors persuaded the Farmers’ Clubs in four villages where the project began its work to identify women who could be trained as village health workers.

Education or social class was not a criterion to become a health worker; instead the health worker must be willing to volunteer her time, learn new knowledge and develop skills she could use to help others. Making the job a volunteer position was important to ensuring that women would be dedicated to serving the community and not lured only by the prospect of money. This screening strategy gave poor and lower caste women an opportunity to break out of their oppressive daily routines.

The principal challenge, however, was to convince men that women should be allowed to take on a job that traditionally was for men. Arole & Arole (1994) describe how difficult it was 35 years ago for women in Jamkhed to perform work outside the
domestic sphere. In the 1970s (and even today), women in most of rural India rarely attended public meetings or come in contact with strangers. Women did not go to community places in the village, especially if men were around. Women were mostly confined to their homes or fields. More specifically, Arole & Arole (1994) state:

Serving others was considered a demeaning job; nurses and other hospital workers were looked down on by people, especially the high caste. A health worker had to be willing to go from house to house to promote health. But women who walked freely in the streets and talked to strangers were looked upon with contempt. (p. 147)

**Overcoming Caste Barriers**

CRHP, however, believed in training women, especially the most marginalized women, to become VHWs. CRHP predominantly chose VHWs from the lower caste, because, as in the rest of rural India, discrimination against the low caste resulted in ill health and poor living conditions for most poor people in the Jamkhed region. Poor health was directly linked to caste, as lower caste families had limited access to safe water or healthcare, and their children were not allowed in schools attended by high caste children. CRHP was committed to overcoming this social practice and used VHW training as an entry point.

Once the VHWs were nominated by the leaders in their communities, CRHP invited them to Jamkhed for a preliminary training. Initially, some of the VHWs belonging to the dominant caste found it very difficult to sit, eat, and stay with the low caste VHWs for several days. At the training center, the Aroles were committed to overcoming caste barriers by demonstrating to the dominant caste VHWs that the caste system is socially constructed. Most VHWs recall that “the doctors and the mobile health
team members would repeatedly tell the dominant caste people that everybody has the same blood irrespective of the caste.” While it took time, slowly people began to realize that caste discrimination was a harmful practice.

Apart from talking to people about caste and purposely asking VHWs from different castes to share food, several other communicative strategies were used to overcome the caste barrier. For instance, VHWs were asked to stitch a patchwork quilt. While both the dominant and low caste women were skilled in stitching a quilt, the purpose of this strategy was twofold. First, it demonstrated a respect for the skills women possessed before they were trained as health workers. Second, at night the VHWs were asked to share this big quilt and thus instill a sense of unity and sharing, irrespective of caste differences (Arole & Arole, 1994).

*Communication for Personal Development*

Despite the hurdles in convincing men to allow women to be trained as health workers, nine women were selected from four villages by 1971, within the first year of the project (Arole & Arole, 1994). Dr. Raj Arole recounts that “many of these women who became health workers faced severe problems in their community and had very low self-esteem and self-confidence and therefore our training sought to improve their confidence in themselves.” CRHP believes that if people are given an opportunity and education then, irrespective of their social class, they have an innate ability to improve their status. Arole continues, “the VHW training is as much about transforming the lives of these women as it is about training primary health care workers.” And much like the
Freirean concept of using learning circles to stimulate critical thinking, CRHP helps transform people’s lives and allows them a path toward self-development and liberation.

The trainers who facilitate the weekly training sessions are sensitive to this goal and thus respect all VHWs and other poor and marginalized community members by listening to them and allowing them to express their feelings and desires. For instance, new health workers are given a mirror and asked to look at their reflection and speak to the group about who the person in the mirror is and what qualities she possesses. “During this exercise, most of us would consider dogs to be more respected than us, because of the way we were treated at home and by the community,” says Muktabai, a health worker since 1971. She adds,

My husband abandoned me when he realized I had tuberculosis (TB) and that my brother had died of TB. I returned to my parents’ village only to face more stigma and discrimination as a TB survivor…. But at CRHP, I got love and respect that every individual deserves, that motivated me to want to be a health worker.

Lalanbai, another health worker from the early years who now acts as a peer facilitator during the weekly VHW training sessions recalls: “People would throw food at me as I am a Dalit. But the training process, which is focused on respecting women as capable human beings, transformed me completely and as a VHW people began treating me with dignity.” Similarly, Yamunabai, a very loquacious and friendly health worker, remembers how initially she lacked the confidence to take on the job of promoting health. Through training, she was able to recognize her strengths and realize how she could be of use to the community. Today, after 30 years as a health worker, Yamunabai says, “people, men and women, young and old, come to me from early morning until late at
night to seek my advice on health or social matters…. I feel good that I can help people
and that they realize my role as a health promoter, caregiver and community organizer.”

Empowering the VHWs as Voices of Change

CRHP was able to transform village women into voices of change by focusing on
empowering them (Arole, 1999). As mentioned in Chapter 1, every Tuesday morning, a
stream of women in brightly colored sarees find their way, either by bus, on foot or by
hitching a ride in a jeep to CRHP’s training center in Jamkhed. Typically, about 50
VHWs from twenty five to thirty villages make this journey on a weekly basis. For over
twenty years, about a dozen women have been coming to Jamkhed every week for their
refresher training. A half-a-dozen of them have been coming for the past 35 years. The
weekly VHW training is unique to CRHP and is one of the most critical elements of the
empowerment process. The themes below exemplify the process of empowerment, a
central concept of communication for participatory development and a key principle for
training local people as catalysts for change.

Collective knowledge creation. The weekly VHW training begins after the women
enjoy lunch with their co-workers and ends the next day with a similar meal. During the
training, all women gather in a big room and sit cross-legged on the floor in concentric
circles. The facilitators also sit cross-legged on the floor, as their being part of the circle
suggests that everyone in the group is equal. Every week, depending on the group’s
needs, there is a different facilitator. It could be the nurse, the senior VHWs, Drs. Arole
or the social worker from the mobile health team. However, the role of the facilitator,
whatever it may be, is always the same: to listen to the village women, to engage in a
dialogue that leads to problem posing and to treat the women with dignity and compassion. Songs are composed and sung by VHWs to motivate other women in the community to join them.

Let’s go to Jamkhed for the weekly training.
Let’s learn about health.
Let’s spread that knowledge. And let’s help our community.
Let’s go to Jamkhed for the weekly meeting.
Let’s learn how to form women’s groups.
Let’s learn about micro-credit. And let’s help our community.

The VHWs sing during the training sessions and village community meetings to create a conducive learning environment and promote knowledge about health and social issues.

The facilitator goes around the circle, asking the women to share the previous week’s experiences with the group. Sharing information helps other health workers learn and helps the facilitators understand how the health worker manages problems in her village. The health workers get into a habit of repeating information, which is useful when they promote such knowledge in their community. Also, sharing information results in confidence building and allows the health workers to learn from their peers. As Sarubai says, “this would put a lot of pressure on us, but slowly we got the confidence to tell whatever we could remember. It was useful because our training was paced according to what we could understand and remember and not dependent on what the trainers felt we knew.” It takes about two hours before each health worker has shared her story. Thus, collective sharing results in new learning and serves as a needs assessment exercise in which all can participate.
Self efficacy through dialogue. Every week, the facilitator and group members collectively decide on four to five topics for further discussion based on the issues raised by the health workers. These are usually related to women’s and children’s health, general health topics such as malaria and snakebite, and social health topics such as domestic violence and suicide. The health workers break into groups consisting of six to eight women. To encourage peer learning and sharing of knowledge, each group consists of new and old VHWs. This helps the new health workers learn how, in the past, older VHWs worked with the communities and what communicative strategies and skills they used to diffuse knowledge and organize people for community action. Also, the new health workers share the experiences and challenges of working in their villages. The key issue is facilitating dialogue among the health workers and ensuring their self-efficacy is raised. Self-efficacy is an individual’s perception of their capacity to do something (Bandura, 1997). During group work, the women realize that they have the knowledge and skills to find solutions to problems. By discussing what they know and how they feel about a particular problem such as malaria prevention in their community with the larger group, they gain self confidence. The facilitator ensures that all women volunteer to be the leader at least once each month.

Peer learning. The collaborative group discussion allows women from different villages to share their experiences. Doing this on a weekly basis ensures the women gain confidence to discuss issues, which eases the process of diffusing information about health to other villagers. Peer learning also occurs when the older VHWs interact with new VHWs. Sarubai from Jawalka explains;
The older VHWs would provide encouragement and say you can do it. Lalanbai came and lived with me for few days in my home. She talked to my husband and mother in law about the importance of a VHW in a community. Lalan would teach me skills and help reinforce what I had already learnt in Jamkhed. After a few weeks, I went and stayed with Lalan in her house of a few days. She would take me with her when she went on house-to-house visits. Thus, slowly I gained confidence in becoming a good health worker.

Therefore, peer learning at the weekly training sessions, reinforced by pairing VHWs to stay with each other, becomes a component of the empowerment process.

*Challenging social norms.* In the evening, the women seek half-a-dozen volunteers to cook a meal for the entire group of about 50 VHWs. Every week different women cook the meal, ensuring that everybody participates. In the early days of the project, when caste discrimination among the women was strong, upper caste health workers did not want to eat with the lower caste women.

Cooking and sharing meals together symbolically indicates to health workers that all castes are valued equally. The analogy often used is that people of all castes have the same color of blood, which means all people are the same and caste is merely a social construction. Another way to overcome caste discrimination, as mentioned earlier, was to encourage the health workers to stitch a big patchwork quilt and share it at night. Today, the health workers who used to be part of this process find it amusing that they had to resort to such measures to overcome caste barriers. Similarly, Vilas Kulkarni and Shahji Patil, veteran Farmers’ Club members, remember how difficult it was in the 1970s and 80s for upper caste and lower caste people to work together. “We did not allow the lower caste people to come near our neighborhood or let their children play with ours. When
CRHP came to our village, the Aroles explained to us repeatedly that caste is socially created and deep down all of us are the same,” explains Shahji Patil.

Arole & Arole (1994) note that as people began interacting with each other, either through sports or working collectively to build a well, caste distinctions between upper and lower caste people were slowly blurred. Through dialogue and working together, people began openly criticizing the boundaries based on caste differences. Thus, among the VHWs and community members, and due to CRHP’s conscious efforts and the government’s laws for mainstreaming the lower castes, caste discrimination is not nearly as evident today as it was in the 1970s.

Demystification of health. During the evening and at night, the 40-bed hospital at CRHP headquarters in Jamkhed serves as a site for observation, demonstration and the practice of certain health-related skills. For instance, health workers actively help in emergency cases such as childbirth and snakebites. This learning-by-doing technique is an excellent method of teaching as well as demystifying health. Demystification is the process of making something transparent. Every week, the women get to observe and practice their skills, and new health workers can learn new skills at the hospital. Thus, the weekly refresher training provides health education and promotion lessons, as well as knowledge on key medical emergencies.

On the second day, the health workers’ training continues. More detailed information and skills are provided on the health and social issues that were discussed the previous day. The training is conducted by Drs. Arole or other senior staff who are experienced in dealing with medical or technical issues. However, the goal is to
demystify health, ensuring that the VHWs are able to manage health problems at the community level. Following this half-day training, the women return to their villages equipped with new information to work as health promoters and community organizers.

In sum, CRHP invests heavily in training VHWs once they are nominated by the villagers. Moreover, each element in the training process represents CRHP’s efforts to ensure that the VHWs do not simply learn about preventive health; the emphasis is on valuing women for who they are and giving them an opportunity to participate in the development process. The learning circles allow VHWs a chance to reflect upon and find ways to understand and deal with the root causes of oppression and poverty. Simple practices such as participants and trainers sitting on the floor in a circle as opposed to the trainer sitting on a chair, the participants’ ability to dialogue with the trainer through the use of key words that stimulate discussions, and the forming of small groups among participants and asking them to discuss a problem and propose possible solutions, allow VHWs to talk freely with the CRHP staff. As a result of such horizontal communication, lay women gain the confidence and self-efficacy they did not previously realize that they possessed.

Case 2: Change Agents and Platforms for Social Change

VHWs are the local representatives who spread health information and organize community members for social change. The project also uses another set of people, the mobile health team (MHT), to create and sustain a strong link between the CRHP headquarters in Jamkhed and people in the communities. The research questions in this
section address the role of linkers in facilitating participation and how communication is used to facilitate people’s participation in development activities.

RQ2 asked: How does the mobile health team (MHT) act as a change agent and work with the community members to improve health? What is MHT’s role in enabling community members to become self reliant and improve their living conditions?

**Linking the Project to People**

The MHT members are employees of CRHP and the principal link between the villages and the training center and hospital in Jamkhed. The team, being a change agent, therefore introduces new ideas and information to community members. The MHT also sets up a small mobile clinic which provides curative services when it visits the villages. Through this clinic the MHT has established credibility and trust among the community members.

Five of the seven members of the present-day MHT have been with the project for over thirty years. Thus, for the purposes of this research, the MHT is an extension of the senior project directors and is treated as part of the principal project team. In addition, six of the seven members are social workers and did not have any formal training in providing para-professional health services when they joined CRHP as described in Table 8.
Table 8

*Profile of Mobile Health Team Members*

<table>
<thead>
<tr>
<th>Name</th>
<th>Joined CRHP</th>
<th>Expertise/Role Performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. Jhadav</td>
<td>1971</td>
<td>Leprosy extension worker/Coordinator of the mobile health team</td>
</tr>
<tr>
<td>(retired January 2005)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms. Jerus</td>
<td>1971</td>
<td>Principal trainer of VHWs/Nurse</td>
</tr>
<tr>
<td>Mr. Londhe</td>
<td>1972</td>
<td>Water management co-ordinator/Social worker</td>
</tr>
<tr>
<td>(left July 2004)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr. Thorat</td>
<td>1970</td>
<td>Clerical tasks/Survey researcher</td>
</tr>
<tr>
<td>Mr. Pandit</td>
<td>1978</td>
<td>Paramedical worker/Survey researcher</td>
</tr>
<tr>
<td>Ms. Renuka</td>
<td>2002</td>
<td>Social worker/In charge of income generation activities</td>
</tr>
<tr>
<td>Mr. Dhotray</td>
<td>2002</td>
<td>Social worker/Survey researcher</td>
</tr>
</tbody>
</table>
The multi-disciplinary expertise of the MHT reinforces CRHP’s strategy of intervening at the societal and individual level to improve quality of life of poor people. Dr. Raj Arole explains, “merely providing health services to the poor is not going to improve the poor people’s lives on a sustainable basis; people have to become empowered to take control over their lives and surroundings.” CRHP strives to achieve this, and according to Mr. Vasant Jhadav, one of the most senior MHT members: “Primary health care is always focused on prevention and secondary health care deals with curative. We need to have both systems so that people can enjoy holistic health. CRHP begins with primary health care as this system seeks to overcome root causes of ill health.”

**Mobile Health Team as Change Agents**

The MHT is the principal change agent representing CRHP in promoting preventive health. The team is responsible for establishing trust and building relationships with community members, and spreads the information needed to change behaviors that lead to ill health. Mr. Jhadav describes how transparency and good communication are central to achieving this objective:

In any village when we are just beginning our program, the MHT organizes training sessions for a group of five to six VHWs who live in neighboring villages. We train the VHWs in front of the other community members so that people realize that we are transparent with our training agenda. In addition, people from surrounding villages where we do not work also come and attend these sessions. Mostly women attend these sessions. It is not unusual for 50 women to observe our training of VHWs. After these sessions, many times people from these new villages invite us to work in their community. We use simple terms to explain our purpose and use this opportunity to give health education and promote simple preventive health practices. In this way our program gets more visibility and it helps us diffuse it in more communities.
Once the program is active in a community, the MHT instills the principle of sharing information that the community has gained. People are encouraged to describe how their lives have improved as a result of new knowledge, the adoption of preventive health practices, and the undertaking of collective action. People also share the problems that they face in bringing about the change. The senior MHT members explain how communication is central to sharing information and for CRHP’s expansion into over 250 villages in 35 years:

The basic principle of expansion of CRHP from one village to another is through word of mouth. Every village we work in has people who have relatives in nearby villages. When we are doing something with the people that is helping them and bringing about a positive change in their lives, naturally these people share that with their relatives and friends in the neighboring village. It is human nature to talk and share both good and bad things. We encourage people to share CRHP’s principles of preventive health and community participation. In this way our project becomes more visible and it gains credibility because people are talking about us. In turn, we are invited to work in new villages.

The MHT therefore relies considerably on community members to spread CRHP’s agenda and on VHWs for spreading information on preventive health practice. Yet, the most important role of the MHT is to serve as a link between CRHP and the participating communities. The MHT members are socio-economically different from the client community members. Based on the diffusion of innovations literature, the MHT is highly heterophilous to the community whose attitudes and behavior CRHP seeks to influence (Rogers, 2003). Heterophily is the degree to which people who communicate differ from each other with respect to their beliefs, socio-economic status, education and so forth (Rogers, 2003). Communication between heterophilous people helps spread new information widely across different sections of the population as opposed to
communication between homophilous people. This occurs because new ideas get introduced when people are different from each other (Rogers, 2003). Thus, change agents, by definition, are dissimilar from the community. But in the case of CRHP, the MHT is only partially heterophilous to the community, because many members belong to the same region as the community members. The most heterophilous group that introduces new ideas is the project directors, Drs. Raj and Shobha Arole. Thus, CRHP has two kinds of change agents – the MHT and Drs. Aroles – because the project believes in reducing the social difference between the staff and community members.

The MHT and the project directors treat the community members as their peers. The MHT and the doctors strive to build a relationship with the community members. A conscious attempt is made to ensure that villagers do not feel inferior to the project staff despite the heterophily between them. Pandit, another veteran MHT member who conducts the yearly household surveys in the project villages, describes how relationships are built:

> The importance of regular village visits and visiting different households when we are there is to build a relationship with the community. This is done by merely talking to them and, finding out what problems they have and by being genuinely interested in peoples’ lives. Over time, people begin appreciating our role. On many occasions even the poorest people offer us tea and ask us to visit their house. These people can barely afford two meals a day for their family but they invite us to share what they have. We need to understand the purpose behind offering us tea. And that is the best way to have close relations with the people with whom we work.

Jerus, the VHW trainer and nurse who joined Drs. Arole the day CRHP began its operations, concurs with Pandit and recalls their early years: “In the 1970s and 1980s, the poorest families and those who were most in need of CRHP’s services, tended to be Dalit
or the lowest caste families who were not allowed to interact with the dominant 
(Maratha) and other higher caste groups.” But by consciously interacting with the 
Dalits, the CRHP staff challenged the existing social pattern and set a new practice. Jerus 
recounts:

I used to take the VHWs like Sarubai or Muktabai who are Dalits, to visit upper 
caste patients. Whenever the family would offer me tea, I used to pass that cup to 
the VHW and ask her to drink from it. And I used to drink from the broken cup 
that was meant for the low caste people. The family members did not like my 
behavior but they were hesitant to complain as I was providing them health 
services. But over time, people realized that low caste or Dalit people are no 
different from others. CRHP played a big role in it and as the MHT we had to 
practice what we preached.

Dr. Raj Arole explains how CRHP’s work fundamentally hinges on challenging 
harmful social practices such as untouchablility (upper caste people not touching or 
sharing items used by lower caste people). In the early years of the project, he and his 
wife, Mabelle, would visit stigmatized people such as Dalits or even upper caste people 
who had diseases such as leprosy or tuberculosis. Lalanbai, a senior village health 
worker, underscores what the Aroles used to do: “The doctors would not only provide 
care and support to these sick patients but they also shared food by eating out of the same 
plate from a person who was suffering from leprosy.” Lalanbai adds:

We as VHWs would also initially hesitate to touch a leper. However, once we saw 
that educated people like dada and bai (Drs. Raj and Mabelle Arole) eat from the 
same plate of a person who has leprosy and they touch, love and care for these 
people our fear of getting sick was overcome. Also, the doctors treated low caste 
people like me with dignity and respect, nobody had ever treated me the way the 
doctors and MHT treated me. For the first time in my life I felt I was valued as a 
human being. Thus slowly, even I began to behave differently toward other 
people.
Therefore being heterophilous does not limit the MHT and the doctors from communicating with people who are different from them. In fact, using MHT as the change agent and the VHWs as the para-professional aides, CRHP has been able to bridge the homophily-heterophily gap. The VHWs help greatly in reducing the socio-cultural, economic and educational gap between the MHT, project directors and the community members. The heterophily between the change agents and the community members is balanced by the homophily between the VHWs and the community. For instance, the MHT members (namely Mr. Pandit, Mr. Thorat and Mr. Dhotray) who regularly conduct household visits and surveys among the communities clarify how the VHWs help gain entrée in households that they have never been to in new project villages:

We do not make surprise visits to the community. The VHW prepares the community in advance that the MHT would be visiting the village. She is ready with the names and list of people who may need immediate medical attention when we visit the village. These people are taken care of by Jerus akka (the nurse). The social workers in the MHT break into two groups and each is accompanied by a VHW or the local Farmers’ Club or mahila mandal member as we make house-to-house visits and collect information on children’s and maternal health conditions of the household. We also seek out for leprosy and TB patients and if there is a pregnant woman then the nurse checks such women and provides ante-natal care. Having a local person guide you makes it easier for us to be accepted by family members.

The use of VHWs and change agents helps us understand the multiple roles of the different project stakeholders and the community. The regular village visits by the MHT and by VHWs build relationships with the community, which helps when new information and ideas are introduced. People are more likely to listen and change their behaviors when new information comes from people they know and trust. Also, the
weekly or bi-monthly visits of the MHT to communities help establish trust and rapport with the community members. Despite being change agents, the continuous contact with the community lends credibility to the MHT and makes it a stronger link between the CRHP headquarters and the VHWs.

The MHT thus helps ensure that the project in Jamkhed has regular contact with community members. The weekly or monthly visits by the MHT and by the doctors are part of CRHP’s vision of going to the people who need the project the most. Without the MHT, it would be difficult to maintain the sustainable relationship with the communities. The MHT is the principal player in introducing new ideas and information among community members.

*Providing Platforms and Respecting Local Knowledge*

CRHP believes in providing opportunities to all people, and in doing so it respects people for their capacities. The following question is posed to answer how CRHP orchestrates change and creates an environment whereby ordinary people have the freedom and the opportunity to become involved in activities aimed at improving their lives.

RQ3 asked: What specific processes does CRHP employ that encourage use of local knowledge and help create platforms for community members to actively participate in achieving good health for individuals and the community? How do these processes contribute toward conscientization of the community?

The following themes describe how CRHP uses various communication and community organizing strategies to bring heterogeneous communities together and
participate in development projects. It also describes how improving the quality of health has led to improvement in social change indicators such as status of women and low caste people. Finally, this section describes the efforts to provide the marginalized and the poor with a voice and an opportunity.

Linking Poverty with Ill-Health and Development

When the Aroles arrived in Jamkhed in 1970, the biggest problems facing the people in the region were water scarcity and hunger. To understand the link between poverty and health, the Aroles decided to live on the same amount of money that an average village family earned – the equivalent of U.S. $7.00 per month (Arole & Arole, 2002). In this context, lecturing people on eating nutritious food, boiling their water, and washing hands with soap was futile. Realizing that accessing food and water was a far greater need for Jamkhed residents than the practice of good public health, the Aroles approached donor agencies that funded food-for-work programs, especially those that supported the building of small check dams to conserve water. Men and women of Jamkhed were employed as daily wage laborers to build the dams and were paid a bag of grain per week (Arole & Arole, 1972, 1994).

Health and wellness lessons were incorporated in these construction projects. For instance, the Aroles convinced workers to assemble an hour or two before the work began to discuss how to implement home-based, low cost prevention and care programs to enhance children’s nutrition, prevent diarrhea, and control pneumonia (Arole & Arole, 1972, 1994). By providing basic medical care to workers and their children, the Aroles established initial trust with the residents of the Jamkhed region. Even today, after years
of working with different communities in the region, Dr. Arole points out that 80% of the illnesses among poor people are primarily due to two reasons: lack of food and lack of education.

Most problems in poor communities are related to food and the surroundings. Firstly, there is not enough food for children and even adults. We say malnutrition, but it is essentially starvation. They don’t have enough food. And secondly due to poverty and lack of education, they are not able to take care of their environment, which results in unclean water and unclean environment. Together these account for 80 percent of the illnesses. And the victims of these illnesses are always the young children; therefore the infant mortality is very high.

Dr. Arole adds that fortunately these illnesses – such as diarrhea and pneumonia (the two leading causes of infant mortality) – are easily preventable. Thus, CRHP has focused on finding ways to prevent illnesses. Prevention is done through health education and communication using entertainment as well as interpersonal channels. CRHP used a two-pronged strategy – one to find appropriate entry points for bringing people together, and the other to train local men and women to become health promoters and change agents.

**Valuing Local Knowledge**

To train community members as para-professional aides and as informal health and development communicators, CRHP directors and the mobile health team staff had to be receptive to local and traditional health practices. But the respect for local knowledge came naturally as Dr. Arole explains:

We [in India] have historically had *Ayurveda*, a decentralized health system. Each 10-15 mile area had local people who identified local herbs and local remedies so the practice of medicine changed from place to place and they practiced what they knew in that area.

In developing countries, the colonists brought with them western medicine. Over time the rulers’ health system took precedence over the local health system. But,
in every society there are doctors, their methods of diagnosis may be different but it is still science. So it’s not that only modern medicine is true medicine. Each society has its own medical theory. Modern medicine has its own theory and it was started in the 16th century by British physicians. It is based on the premise that body is like a machine. This theory works but we have also realized that this theory has limitations. There is no theory that answers all the questions completely. For example the Chinese, the Indian, the Greek, and the Arab medical practice all have their differences and limitations.

Therefore, CRHP’s vision values different knowledge because there is no single approach to attaining a good quality of life. CRHP has promoted western medicine and trained VHWs as para-professionals to diagnose and treat common illnesses with antibiotics, but at the same time encouraged local knowledge about herbal medicines and home remedies.

Shobha, who used to be a VHW and now works in Jamkhed’s training center, belongs to a tribal community that collects and uses medicinal herbs and plants from the forests. With her help, CRHP has planted over 50 varieties of plants and herbs in Jamkhed. Some plants such as papaya, drumsticks and holy basil are common while others are not so common yet very useful to treat conditions ranging from jaundice to burns. Shobha explains how she learned about herbal medicines and how her knowledge is used by CRHP:

In the past decade we have began promoting alternative medicine at CRHP. My maternal grand father had extensive knowledge about Ayurveda. My mother learned from him and I learned from her how to identify medicinal plants and herbs and how to use them for treating different ailments. We brought back 145 different kinds of plants that we collected in Bhandardara, (a remote community 200 miles away from Jamkhed). We told the doctors about our knowledge and they encouraged us to share it with other VHWs and the mobile health team. We have planted more than 50 plants at CRHP which we use for demonstration during VHWs training and also to cure some patients at the hospital.
Finding Entry Points for Health

When CRHP was setting up and building trust with communities, the Aroles realized that farmers in Jamkhed were more interested in improving their crop yields and their animals’ health than in improving their family’s well-being and health. Realizing it would be difficult to convince villagers right away to launch village sanitation drives or build soak pits (a low-cost locally built drainage system that uses a 3’ x 3’ x 3’ ditch filled with bricks and stones to absorb waste water), the CRHP established Farmers’ Clubs (Arole & Arole, 1994). These Farmers’ Clubs brought together local farmers on a regular basis to discuss farming and animal husbandry topics and to talk about other community issues. Local bankers, agricultural experts, and local government officials were invited to these meetings. These Farmers’ Club seminars provided a forum for villagers to voice their concerns to local authorities and identify possible solutions (Arole & Arole, 2002).

CRHP also used these Farmers’ Club meetings to promote basic health education among community members. For instance, while talking about the importance of immunizing dairy animals against foot-and-mouth disease, the need for immunizing children against measles and tetanus was discussed.

From the mid-1980s, however, organizing men into Farmers’ Clubs has not been the primary focus of the project. There was a conscious effort to focus on women and organize women into groups. The primary reason for concentrating on women was because of the commitment women showed to improving children’s health and their family’s well being. Dr. Shobha Arole, the associate director of the project explains:
Generally [over the past two decades] women have been more empowered by the project. One of the reasons was this problem that in the 1970s a lot of effort was made to get men together. Soon it was realized that their reason for getting together was for political reasons or how they could get personal gain rather than improving the health of their family or giving back to the community. If we gave them loans they would use it for self growth. Therefore after the 1980s we didn’t focus much on men’s groups except to sensitize them on why it was important for the women to come forward.

Further, Shobha explains how men’s groups are more informal in present day project villages and community participation is spearheaded by women’s groups:

So what we are saying now is that it is good to organize and empower women and work with them on community issues. Because women are the caregivers who give it back to the family or the community. With the men it is important to have community participation through informal groups rather than formal groups.

These women’s groups (translated as mahila mandals in Marathi), organized by the project and coordinated by the VHWs, provide women with knowledge about prevention of communicable and fatal, yet easily avoidable, illnesses. The project also focuses on self development and self efficacy as part of the health promotion activities. By meeting the needs of the local residents through Farmers’ Clubs, mahila mandals, and self-help groups (micro-credit groups for women to become financially self-reliant), CRHP has been able to create appropriate entry points for promoting good health in the Jamkhed region, boosting its health indicators over the past several decades (see Table 9).
### Table 9

Changing Health Indicators in Jamkhed Region with CRHP’s Presence

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Jamkhed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Villages surveyed</td>
<td>9</td>
</tr>
<tr>
<td>Infant Mortality Rate(^1)</td>
<td>176</td>
</tr>
<tr>
<td>Crude Birth Rate(^2)</td>
<td>40</td>
</tr>
<tr>
<td>Basic Immunization(^3)</td>
<td>0.5%</td>
</tr>
<tr>
<td>Malnutrition – weight for age</td>
<td>40%</td>
</tr>
<tr>
<td>Antenatal care(^4)</td>
<td>0.5%</td>
</tr>
<tr>
<td>Deliveries by trained attendants</td>
<td>&lt;0.5%</td>
</tr>
<tr>
<td>Couples practicing family planning</td>
<td>&lt;0.1%</td>
</tr>
</tbody>
</table>

Note. \(^1\) Infant mortality rate is number of children dying per 1,000 live births before they reach the age of one. \(^2\) Crude birth rate is the number of children born per 1,000 women in the child-bearing age. \(^3\) For children under five years of age. \(^4\) Percentage of women aged 15 to 49 years who were attended at least once during pregnancy by skilled health personnel (doctors, nurses or midwives).

Source: Comprehensive Rural Health Project (2003)
The success in achieving improved health, primarily children’s and women’s health, in Jamkhed can be better understood when compared with the average health indicators in the rest of India available from UNICEF (2004). For instance, the infant mortality rate in Jamkhed is 26/1000 live births compared to the national average of 67/1000 live births. While only 5 percent of the children in Jamkhed are malnourished, nationally almost 47 percent of children are malnourished. Likewise, nationally only about 67 percent of the children under five years of age are fully immunized, but in Jamkhed almost all children are immunized. Also, in Jamkhed almost 97 percent of the pregnant women receive antenatal care, and nationally only about 60 percent of the women receive antenatal care.

Jamkhed’s health indicators demonstrate how a holistic health and development project has improved the overall quality of life and changed the priorities of people from meeting basic health needs (mortality and morbidity due to fatal yet preventable illnesses) to higher level health needs (diseases afflicting any community that has good primary health standards) (see Table 10). While all these changes cannot be attributed solely to CRHP’s activities, given the remoteness of most villages and looking at hospital records, CRHP has played a considerable role in facilitating these changes.
<table>
<thead>
<tr>
<th>1970s scenario</th>
<th>Present day scenario</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital visits</strong></td>
<td></td>
</tr>
<tr>
<td>Over 50% outpatients at the CRHP hospital were children</td>
<td>Only 2% or 3% outpatients at CRHP hospital are children</td>
</tr>
<tr>
<td>Tetanus patients came in daily at CRHP hospital</td>
<td>Tetanus has almost disappeared as children and pregnant women are immunized</td>
</tr>
<tr>
<td>Chronic diseases were mostly simple communicable diseases that could be prevented through education</td>
<td>As health has improved, new health problems such as diabetes, hypertension and cancer are more common</td>
</tr>
<tr>
<td><strong>Community level changes</strong></td>
<td></td>
</tr>
<tr>
<td>MHT visited villages once a week as people needed health services and did not know of preventive measures</td>
<td>MHT visits the villages where CRHP is working for over ten years only once a month, as morbidity in villages is reduced</td>
</tr>
<tr>
<td>Less than 1% of eligible couples would use contraceptives</td>
<td>The small family is a norm in the region, with 60% couples using contraceptives</td>
</tr>
<tr>
<td>Infant mortality was due to diarrhea and acute respiratory infections</td>
<td>Infant deaths are rare, and those that happen are due to accidents such as snake bites</td>
</tr>
<tr>
<td>Focus on empowerment of women</td>
<td>Focus is now on health and development of adolescent girls</td>
</tr>
</tbody>
</table>
Table 10 (continued).

<table>
<thead>
<tr>
<th>1970s scenario</th>
<th>Present day scenario</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leprosy and TB were priority programs in all villages</td>
<td>HIV/AIDS is a new threat and thus a priority program in the villages</td>
</tr>
<tr>
<td>VHW were trained in treating diarrhea, pneumonia and identifying emergency signs among pregnant women</td>
<td>VHWs are now trained to take blood pressure and test blood for diabetes.</td>
</tr>
</tbody>
</table>

Overall, CRHP had to overcome many social barriers and economic inequalities among the communities before beginning to promote preventive health. This was achieved by integrating health with larger development problems such as lack of water and food. Also, regular monitoring of health indicators (as seen in Table 10) and pointing out that fewer children are dying or malnourished than before helped CRHP convince the villagers that even poor people can enjoy good health. It is important to note that CRHP achieved its goal of lowering mortality and morbidity through a combination of social and medical approaches and by respecting local peoples’ knowledge and practices. CRHP found a way to challenge harmful practices, while at the same time being sensitive to the local culture and traditional wisdom of the community.

*Focusing on the Most Vulnerable and Providing Platforms for the Poor*

CRHP began a process of dialogue with community members from all castes to gauge their perception of health problems. The Aroles realized that most villagers were unaware that most children in Jamkhed were malnourished, or that pregnant women were anemic. Sarubai, a VHW who has served her community for over 20 years, remembers:

> The doctors would come and sit with us and ask us about the problems facing our (the Dalit) community. We had no idea about the problems we had. The doctors showed us malnourished children or pregnant women with swollen feet and asked us whether there are similar people in our village. This was a common occurrence but we never paid attention to it. Slowly we started understanding how to identify health and social problems in our villages.

While malnutrition was a problem among most families, it was worst among the low caste. The lower caste families – who were the poorest, the most exploited, and the most vulnerable – lived on the village periphery, were not allowed to enter the village temple
or draw water from the village well, and had the lowest health status (Arole & Arole, 1994; 2002). Shunned by the high caste, they were the least likely to have access to drinking water, adequate food, or medical services and thus had the worst health. Drs. Arole wished to establish a children’s nutrition program in a way that also reduced local caste distinctions.

CRHP requested each student in the local school, who came from different caste groups, to bring a handful of rice. In school, each student put their rice contribution in the pot in which the meal was prepared. Once cooked, the meal was shared by everyone, irrespective of caste. This practice, conducted on a daily basis in front of students and their parents, helped inculcate a new behavior – sharing food irrespective of caste. Once this practice was legitimized, the intervention was replicated at the larger community level by organizing community weddings. Shahji Patil, a CRHP Farmers’ Club member since 1971 recalls: “The whole village would participate, cooking for and hosting the wedding guests. It did not matter what caste you were.”

CRHP believes in providing the poor and the vulnerable with a voice. Organizing men and women in formal and informal groups such as Farmers’ Clubs and mahila mandals is central to CRHP’s strategy because the project believes that poor people bring about changes by themselves. The project engages in advocacy on behalf of the communities such as lobbying the state and national governments. For instance, CRHP has invited local bureaucrats and technocrats to the training center in Jamkhed so that community members can engage in a dialogue with them, learn about new policies, and gain the confidence to approach the officials. “We, the Farmers’ Club and the mahila
mandal from my village have gone to the zilla parishad (local government) and demanded that they clean our village and provide water by water tankers during a drought,” explains VHWs like Rambhabai and Yamunabai. But more importantly, the project believes that the poor and marginalized need to be heard. Therefore, VHWs are selected to speak at conferences or during meetings with local, national and even international policy makers.

Shobha, a former VHW who now trains other health workers and para-medical staff in alternative medicine, says, “I was taken to Australia to show the rest of the world how ordinary women like myself can be trained to become good health workers and become promoters of preventive health.” Lalanbai, a veteran VHW and now a peer-facilitator during the weekly health worker training, adds that she has accompanied the project directors to many meetings and conferences where high-level ministers and industrialists were present. Lalanbai believes that facing the outside world is not only useful to build the community members’ confidence, but shows the policy makers what poor women are capable of doing for their communities.

In summary, creative strategies had to be used to reach out to the most vulnerable and involve them in the community. Participation by community members belonging to different castes helped reduce the social divide that was also the cause of ill health and unequal access to community resources such as safe water. Additionally, giving the VHWs and community members an opportunity to participate in local or national seminars contributed toward increasing the community’s confidence. These platforms
allow people access to policy makers, and at the same time, legitimize CRHP’s efforts among the community members.

Case 3: Communication, Facilitation and Collective Action

This section describes the communicative process and the role played by local women trained as facilitators. It also explains how community members are motivated by the VHWs to engage in community activities and collective action on a sustainable basis. The following research question helped address how communication and collective action is accomplished by CRHP.

RQ4 asked: How do the VHWs work as facilitators for their community? What contributes to organizing people in groups such as mahila mandals or Farmers’ Clubs? And how does the facilitator motivate the members of the mahila mandals and Farmers’ Clubs to engage in community dialogue and collective action?

Para-professional Aides as Facilitators

Through repeated training and managing health issues, the VHWs are trained to become facilitators in their communities. The weekly training, conducted in the form of learning circles, helps empower these ordinary women to become community-based change agents. As a result, VHWs are the health promoters and health communicators as well as community organizers responsible for mobilizing people.

The CRHP staff plays a key role in training and supporting the health workers themselves, but the responsibility of organizing community members lies with the health workers. Mr. Jadhav, a veteran MHT member says: “The VHWs have freedom to diagnose and treat patients and to mobilize women to form a mahila mandal. We provide
moral and technical support to the VHWs by allowing the VHWs to take charge of problems in their community.” The relevance of the VHWs’ work is reflected in how men and women in the villages perceive them. The community members realize the important tasks performed by the VHWs when they see what the health workers do to help different families. It is through demonstration, trial and above all, building a trusting relationship in which the community members listen to the health worker and engage in collective action. Sunita, a VHW from Kharewadi, one of the new project villages where CRHP has been working for less than five years, says:

Initially only a few women were willing to come for weekly health education sessions but they would still not listen to me. With a lot of patience, I slowly convinced some of these women to come and attend our weekly training in Jamkhed. When some of these women came here and listened to the senior doctors, nurses, trainers and other VHWs they realized that what I am promoting in the village is the same as what is taught here at CRHP. This reinforced their belief in me and convinced them that what I am trying to do, organize women to form a mahila mandal so that I can promote health is the same as what CRHP is doing in other villages to help communities become healthier.

Surekha, a former health worker who is now one of the lead performers in the song and dance troupe that uses entertainment-education to promote health and development, adds:

There is a lot of difference between simply giving information versus doing something and showing the effect of practicing a new behavior. We don’t just talk about oral rehydration solution (ORS) but help prepare it and give it to a child suffering from diarrhea and show the family that it can indeed manage diarrhea. Of course, before we can demonstrate we have to build a strong relationship with the people; we have to love them and care for them before they begin trusting us and practicing the new behaviors that we promote.

In addition to being a credible source of health information, VHWs are also trained to be effective facilitators and skilled communicators. VHWs recognize how communication is key to facilitating participation, and that an effective communicator is
one who can repeatedly dispense health information at any given opportunity in the village. Also, to become a respected VHW, the woman needs good listening skills and dedication to involve as many people as she can in community meetings. Sarubai, a VHW from Jawalka, repeatedly told this story about the hurdles she faced in facilitating community participation:

When I was told to form a mahila mandal. I was under a lot of pressure and tension. I am from the lowest caste, Dalit and the maratha women (dominant caste in the village) would not come out and talk to me. So how can I organize women in my village, where the marathas dominate? I asked some of my family members and friends and some older women to help me. These women and I would go and sit in the center of the village. I would then talk about preventing common illnesses that plagued our village based on what I learnt at CRHP. I would talk about treating diarrhea with homemade oral rehydration solution, and malaria by keeping the environment clean. Some high caste women used to overhear what we were talking. They liked what we were discussing and realized that it was important for their family. But the men in the maratha community did not allow their women to come and sit with us. They would lock the women in. I felt frustrated, but I did not talk back and antagonize the community. I persisted and slowly I began visiting the maratha women who had shown interest when their husbands were away at work. I told the women about different health issues and how to prevent their children from getting sick.

Likewise, Yamunabai, a very enthusiastic and cheerful VHW from Ghodegoan who has been working since the mid-1970s, narrates:

I would organize a meeting by going house-to-house and persuading the women to come for one meeting at a time. It was difficult but when I told the women that I will provide health information which would benefit their family some women began participating. I also told them information about loans specifically given to women by government programs and local banks, and how CRHP can also provide small amounts of credit to women to become self reliant. The money can be used to begin a small business such as raising goats or selling bangles or even opening a local grocery store. But most important thing that helped me facilitate participation was when community members realized my credibility as a trained health worker. I used to bring pregnant women in a bullock cart to Jamkhed the moment I identified a complication. Bai (the late Dr. Mabelle Arole) would say
that she completely trusts Yamunabai’s diagnosis and that there is no need to re-confirm the diagnosis if it’s an emergency.

Thus, relying on different communication practices was an important aspect for VHWs like Sarubai and Yamunabai to overcome the barriers to participation. While helping villagers with health problems was an important part of establishing trust, the VHWs also believe that because of their skills as facilitators and communicators, community participation is possible in their respective villages.

**Processes of Communication for Participation**

The VHWs are trained as health communicators and community organizers, and the MHT is a multi-faceted team of para-medics and social workers; yet, both groups of change agents rely on various communicative processes that result in facilitating the participation of community members. Specific communicative activities used by the VHWs are:

*Diffusing knowledge for improved health.* The health workers seek out opportunities to share their acquired knowledge during the weekly training sessions. Health workers unanimously concurred that they tell most of the new information to other women and men in our village within the first two days of their training. They do this so that they do not forget what they have learnt during the training. The health workers organize a meeting of women who are in the *mahila mandal*, self-help group members and those who are interested in improving their family’s well-being. Any formal and informal opportunity is used to promote health information. Therefore, VHWs are encouraged to talk about social problems such as not sending girls to school and how
to deal with maternal health problems due to poor nutrition. The VHWs talk about these problems when they are working on the farm, fetching water at the well or in the evening when they meet at the temple.

Lalanbai, a veteran village health worker, explains how she used to spread the information she learned in the training sessions:

Any opportunity I got, be it at a well or working in the field or visiting a neighbor, I would start talking about preventive health and how we as villagers can do something about the problems facing us. I did not wait to hold a meeting. But when we did hold our regular meetings, we used to discuss in-depth the various topics that we informally talked about every day such as promotion of good health and prevention of diseases, being self sufficient by taking small loans from CRHP or the bank and not going to money lenders and different livelihood options such as raising chicken or goats. Also as a VHW, I used to visit four to five houses every day to learn and assess the situation of health in the community. In this manner, I would provide health information to the family members and build a relationship.

Repetition of information. CRHP values the principle of repeating information. The various participant observations and informal interviews with the project staff in Jamkhed revealed how repetition is key to training VHWs to become good communicators. Repetition is built into the weekly training programs as well as the regular meetings organized by the health workers, MHT or local groups such as the Farmers’ Club and mahila mandals. Additionally, repetition is designed to occur at various levels of the project. For instance, when the doctors and the nurses train VHWs, the same information is given irrespective of the person doing the training.

Thus, whether it is Drs. Raj and Shobha Arole, Jerus the nurse, or even Renuka, the social worker, during the training of health workers or community meetings, the same information is repeated by all the project staff. Likewise, it was observed during the
multiple training sessions, and also later in the communities, that different VHWs give the same information to community members.

The CRHP project staff underscores the importance of repetition. Jerus, the nurse and master trainer who has worked for CRHP since 1971, says:

Repetition of information is extremely important. These women (VHWs) are not literate and therefore, the way they remember is by repeating the same information over and over. In fact, it is a actually a good thing that the VHWs don’t write down what they learn at the training. Because many times what we write in a notebook remains there and we never practice it. But repetition of information motivates VHWs to use the knowledge they learn in their community. Also, observing how we manage cases in the hospital helps. Later, when the VHWs are confronted with a case in their community, then they remember what they had seen, heard and what is to be done.

Facilitating Community Groups and Engaging in Collective Action

CRHP’s goal is to promote preventive health by empowering people to become involved in community action (Arole & Arole, 1999). While different communicative processes, as described above, are central to facilitate participation, the VHWs are also responsible for organizing community members to engage in dialogue and collective action. Once the community realizes what it can achieve by working collectively, community participation becomes sustainable.

Community groups. All the VHWs, irrespective of their seniority, are responsible for organizing women to come together on a regular basis to discuss issues facing themselves and their families. Different techniques have been used over the past thirty years, and the challenges encountered have differed as the social characteristics in the communities have changed. Nonetheless, the VHWs play the same role; talking to women and men about the importance of community organizing, promoting health and
development information, and demonstrating what people can do when they collectively take on a community betterment project.

The senior VHWs share similar stories of how they faced resistance from their family members and men in the community; most also share experiences of male and female community members that actually helped them in their tasks. In the 1970s and 80s, CRHP concentrated on organizing men into Farmers’ Clubs. These men, who came together to learn about new farming techniques (or were employed by CRHP through the food-for-work program), realized the importance of good health and helped to identify VHWs from their village.

Once VHWs were nominated in each village, CRHP asked the VHWs to organize women into groups to discuss preventive health practices. It was certainly difficult to organize women of different castes to come together, but VHWs nevertheless prevailed in forming *mahila mandals* or women’s groups in all the communities. By 1995, there were approximately 195 *mahila mandals* in the 200 villages where the project was implemented (Arole & Arole, n.d.). Rambhabai, a health worker in Sharadwadi for the last ten years says: “It took a lot of time to convince women to form groups in our village. We did not have a Farmers’ Club to help us set up the *mahila mandal*. Three of us began the group, and in three years over 40 women joined us.” These women’s groups are important from CRHP’s perspective because once women begin to come together and share experiences and problems they face in the home and over a period of time, they identify a solution for their problems. Dr. Raj Arole says that *mahila mandals* are a form
of liberating women and empowering them to take action to improve their lives and those of their family members through dialogue and discussion:

Women’s status has shown a tremendous change in these villages. By organizing them and providing them information and opportunities, women are able to earn money and are thus able to provide better food for their family. As a result, the birth weight has gone up; in the Jamkhed region we have an average birth weight of 3.25 kilograms, which is more than the average weight of children in rural India. The delivery practices have improved too, as the woman gets medical attention either from a VHW or local women trained by us and VHWs.

Collective action. Community groups engage people in collective action. In all villages where the health workers live, there are numerous instances of members of the community coming together to improve their situation. Table 11 explains some of activities the people engaged in as a result of CRHP’s facilitation.
Table 11

*Collective Action by Community Members (since 2000)*

<table>
<thead>
<tr>
<th>Villages where CRHP has been working for less than 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Names</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>2. Kharewadi</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Villages where CRHP has been working for 10-20 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Names</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>3. Sharadwadi</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Villages where CRHP has been working for over 25 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Names</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>5. Pimperkhed</td>
</tr>
<tr>
<td>6. Ghodegaon</td>
</tr>
</tbody>
</table>

F is Farmers' Club, M is *mahila mandal* and S is Self-help Groups

*Key to Collective action and community activities:*

1. adolescent girls’ seminars
2. self-help group weekly or monthly meetings
3. *mahila mandals* weekly or monthly meetings
4. cultural program
Table 11 (continued).

5. sanitation drive
6. village meeting
7. economic assistance by government
8. emergency hospital assistance
9. safe drinking water supply from the government
10. vermiculture program
11. kitchen garden
12. educational trip
13. agriculture development
14. promoting awareness of violence against women
15. income generation program
16. health education
17. training for other groups such as adolescent girls
The Farmers’ Clubs’ and *mahila mandal* members engage in separate or collaborative action. “Every rainy season, we (the Farmers’ Club members) come together and decide to clean up the village, especially the grass which tends to be the breeding ground for mosquitoes and snakes,” says 21-year-old Raju from Sharadwadi. Raju said that his club took action because of the knowledge gained from VHWs, discussions with the CRHP staff, and from the educational programs organized by CRHP.

In another instance of collective action, CRHP convinced the people to organize community weddings for 10 to 20 couples to get married at the same time in order to save money for each family and to deter families from performing child marriages. Community weddings put pressure on families not to marry off their daughters before they are 18 years old. Vilas Kulkarni, a veteran Farmers’ Club member from Ghodegaon, a village of about 2,000 people that conducted many mass weddings in the 1970s and 80s, shares a story with great enthusiasm:

> Our village has been instrumental in coming together as one force and helping out families, especially during marriages. In villages, during a wedding the bride’s family has to invite the entire village and host the groom’s family. This tends to be very expensive. Over the years, we have figured out that if the entire village participates in hosting then the burden is less. If we have a couple of weddings at the same time then community weddings can bring the cost down considerably. This makes everybody happy.

These ideas were instilled by CRHP during the health workers’ training sessions or when Farmers’ Club members were invited for informational seminars on farming techniques, animal husbandry and government schemes. CRHP would engage in an open dialogue to encourage men and women to think of ways to overcome problems. Through
problem posing and listening to everybody’s views, solutions such as the ones discussed above would emerge.

In addition to the Farmers’ Club members engaging in community action, women are also motivated to help with the overall development of the community. The VHWs and CRHP staff would repeatedly explain to women that one way to save money is to prevent illnesses in the household. For instance, malaria is a common problem in the rainy season, which can last for three to four months of the year. Sarubai and Babai, the VHWs from Jawalka explain:

During our weekly meetings, we used to tell them why we have problems like malaria in our village. I (Sarubai) would explain it is due to stagnant water. Furthermore, I would tell them that we are spending a lot of money on treating the patients. Every week when the doctor makes a visit, we spend hundreds and thousands of rupees and we lose a day’s wage plus we have to spend our savings. If we can instead prevent malaria in our community then we can save that money and use it for other expenses like weddings. We would tell the women that since we don’t have a sewer system, we can prevent malaria by building simple soak pits for drainage.

The women and even young men who would be present during our meeting would ask us how to build a soak pit. Babai and I immediately told them what we were taught at CRHP. We don’t understand feet and inches, so I told them we have to dig a ditch up to our waist and it should be as broad. Thus, I told them how to build a 3’ x 3’ x 3’ pit. I told the people that we should fill the pit with small stones, then slightly bigger stones and finally the large stones on top. I said, we can use coconut rusk as at the opening so that it can strain out large pieces of waste. This would help us get rid of the stagnant water.

Women were excited with this prospect. I told each mahila mandal member to build a soak pit in front of their house and later we can build a few more in the common places in the village where water tends to stagnate. Some of the high caste women said they would not help dig the ditch in the day time, as they feared people would mock them. But they agreed to build these soak pits after sundown. Babai and I said that’s fine. Whatever suits people’s convenience was fine, as we needed to get their support first.
So the Maratha women mostly built the soak pits at night, and the rest of us from the lower castes, *chambar*, *sonar*, *harijan* and even Muslims build the pits during the day. People began noticing what we were doing. They asked us and we explained the purpose of building soak pits. Soon after we built a few soak pits, people realized that there was little stagnant water in the village and incidences of malaria had gone down. The community realized the importance of our work and began supporting us in other collective activities.

Sarubai and Babai’s stories resonate with the experiences of other VHWs. In the newer communities where CRHP works, these same problems with respect to community participation are common. In the villages of Pangulgawhan and Karewadi, where CRHP began working less than five years ago, the Farmers’ Club and *mahila mandal* members listed similar barriers to participation. But slowly, community activities are becoming more common even in these new communities. For instance, the young Farmers’ Club members in Karewadi have come together to ban local brewers as alcoholism is a problem among many men and affecting families. Rajendra, a 19-year-old college-bound Farmers’ Club member explains:

For a few years now, we have talked to many people in the community about the evils of alcohol and *gutka* (chewing tobacco). Our college has youth groups that are engaged in bringing about different positive changes in their respective villages. We felt *gutka* and alcohol were the biggest problems in our village. In the past year or so, we collected money and bought all the *gutka* from the local shop and burned it in the middle of the village. We did the same thing about alcohol and we were finally able to shut down the local brewer. Likewise, after learning from CRHP and other groups about sanitation and hygiene, we organized a few men to help clean our village, mostly to clean the wild grass that grows during monsoons. We have learned that it is a breeding place for mosquitoes, so we organize such cleaning drives. We also have learnt how to build soak pits. We have built four to five soak pits to dispose of the sewage water and thus prevent illnesses.

*Creating and sustaining community participation.* CRHP, as an institution that facilitates change, has been wary of the inherent problem faced in all community
organizing work: how to mobilize people with diverse backgrounds such as caste and religious affiliations into a cohesive community (Arole & Arole, 1999). Before community action could occur, CRHP invested in creative ways to get people to come together and later mobilized them for community action. Dr. Raj Arole recounts: “We began by organizing sports for the entire community and after the game we would discuss issues that were important to the people, be it health, agriculture or social problems.” Such events led to people coming together and discussing community problems. Dada Pawar, the headman of Bawi, where CRHP has been working for over two decades, underscores what Dr. Arole says about participation:

When the project begins work in any new community, it is very difficult to organize people to come together for any community action or work. Thus, CRHP organized many events or found ways to get us young people together. For instance, they gave us sports equipment so that we could play in the village, and to the women, CRHP provided small musical instruments as they already had bhajan (devotional songs) groups. So games and songs brought people from diverse social and economic status together. Once we came together as a group, CRHP decided to inform us about their main interest in working in the village – they wanted to help improve the situation of health in our community and they believed it was possible only if we participate and work with them.

While community participation is the cornerstone for collective action, there are certain barriers that CRHP is facing today that it did not have to deal with in the 1970s and 80s. People are much more exposed to information and have become more mobile and thus they are not willing to invest as much time in community action. New strategies are therefore needed to sustain community participation than relying on sports and community kitchens. Associate director Dr. Shobha Arole’s response captures this
problem and the complexities that present day community-based development projects in
general have to deal with:

The whole thing about the grassroots participation is a good thing because that is what brings about sustainability of the project. But what I would like to say is that today people are affected a lot by the media and also by the rising levels of unemployment, which lead to high levels of frustration. Thus, people are a little harder to deal with and the scenario today is very different from the 1970s and 80s when people’s needs and self-interests could be met. Today that is not the case. Especially among the youth; the boys and the young men are very frustrated. Sometimes they politicize issues and tend to get destructive. Therefore, one of the things I am concerned about in the near future is how one continues a good level of participation.

It is a challenge to get people, especially young men, to understanding the power of participation, without being motivated by self-centered goals. I think this is a challenge in the future. Some issues we can manage, like organizing women, empowering them and giving them loans and such things. Women’s organizing is not going to be that difficult. But working with men is not going to be easy because men already have it in their head that they have to have ownership of the issues. It’s not that we don’t want them to have ownership, but sometimes the attitude because of the media, politics and the general frustration is really not lending itself to work for others. There are some men who are socially minded and very dedicated to helping others, therefore it’s not a lost cause. But at the same time, one has to think of keeping participation alive and genuinely active in the interest of the people.

For 35 years, CRHP has experimented with various ways to overcome hurdles to achieve community-based development. However, the challenge to sustain participation and use of communication to facilitate the change process is the key issue for CRHP in the future.

Summary

The three separate cases suggest that facilitating sustained participation in development requires multiple strategies. Many of the strategies are communicative and are effective when linked to services and motivating people to come together and work collectively. An important element in facilitating participation is the use of
communication for empowerment as explained in Case 1. CRHP’s efforts in training and empowering lay women as VHWs results in social change at the individual and the community level. The women become empowered and enjoy a new social status among the community; and seeing the transformation of women as VHWs, men and women in the community realize that even lay people can bring about positive change and have a better quality of life. Also, empowering women to become VHWs provides CRHP with a contact person through which they can reach the larger community and the community can reach CRHP.

Case 2 points out the role of change agents in helping the CRHP link with the community and in diffusing new information among the community members. The MHT, which is the principal change agent, bridges the gap in information by reaching out to the most marginalized and ensuring that the project caters to the needs of people. The MHT provides new information during community meetings in the village and during the training sessions in Jamkhed. Moreover, the MHT also trains the members of Farmers’ Clubs or mahila mandals to monitor the changes in the community through research such as village mapping and understanding the importance of growth monitoring of children. Farmers’ Club members in some of the communities map their village every one or two years to understand if households have moved up or down the socio-economic ladder. Likewise, the VHWs explain to mothers and fathers how to read the children’s growth chart based on weight, height and age. Lastly, with the help of CRHP, the MHT demonstrates and builds the capacity of community members to do collective action such
as building soak pits or check dams. Thus, the MHT members are information diffusers, linkers and facilitators who train the community members in becoming self-reliant.

Case 3, which is about facilitating collective action, informs us that development projects can introduce new ideas and challenge social norms as well as capitalize on the knowledge and resources that exist in a community. Collective action is linked to reducing morbidity and mortality and to making people efficacious and self-reliant. CRHP provides assistance, especially health care services, but the primary goal of the project is to ensure that commonly occurring illnesses are prevented or treated at the village level. For instance, today children are healthier as reflected by the low morbidity rates, which has an impact on the family’s economic status as less money is spent on treating otherwise commonly occurring illnesses. Also, families are having fewer children as infant mortality has been declining over the past three decades. These changes in children’s health have an indirect impact on people’s socio-economic status.

Overall, CRHP’s efforts have helped improve people’s well-being and allowed them a chance to break out of extreme poverty. A survey conducted among 930 families in 12 villages in the 1990s revealed that lower caste families that had only one meal in day dropped from 50% in 1971 to 0.28% in 1990, and during the same period upper caste families having one meal a day dropped from 32% to 0%. Likewise, the number of families living in thatched huts dropped from 42% to 5.6% among lower castes and from 15% to 2.6% among the upper castes (Arole & Arole, n.d.).

Based on the lessons learned from the past and by analyzing the problems faced and solutions provided by the VHWs, MHT members, Drs. Arole and the community
members in catalyzing change, CRHP provides a unique model for understanding how communication can help facilitate participation on an ongoing basis. The next chapter discusses and synthesizes the key findings from the three separate cases presented in this section and proposes how present and future communication for social change initiatives can apply principles underpinning Jamkhed’s successful participatory development initiative.
CHAPTER 5: DISCUSSION, SYNTHESIS AND RECOMMENDATIONS

Revisiting Communication for Participatory Development

This chapter revisits the theoretical constructs guiding the present research by interpreting the stories and experiences of the participants presented in the three cases in Chapter 4: (1) empowering village health workers, (2) change agents and creating platforms for social change, and (3) communication, facilitation and collective action. These cases describe how CRHP has managed the complexities, challenges and successes in facilitating community participation. The multiple methods used to elicit the data coupled with the participants’ experiences suggest several points of convergence, contradictions and new ways to understand how communication facilitates participation in development initiatives. The themes that underscore the existing theoretical constructs include dialogue and reflection, critical thinking, respect for people’s knowledge, empowerment, facilitation and collective action. Several new themes also emerged, such as the nature of participation depending on community needs and seasonality, catering to people’s self-interest, challenging social and cultural norms and the multiple roles of change agents and facilitators in achieving community participation. The findings synthesize the themes, particularly the new themes, in light of processes of communication to facilitate participation.

The synthesis presented in the form of matrices analyzes how CRHP integrates various communicative processes to operationalize the three principles of equity, integration and empowerment that guide its programs. The purpose here is to explain how the theory of participatory communication is put into practice by CRHP. The matrices use...
participatory processes, communication activities that support these processes, and social change indicators as outcomes of participatory development to explain how equity, integration and empowerment are achieved by CRHP.

By linking the data to the constructs this chapter seeks to answer the questions posed in Chapter 1. It describes how CRHP and its stakeholders transform the lives of the poor by introducing new knowledge and motivating people to come together and engage in collective action. It also explains how CRHP overcomes barriers of caste and class and uses strategic communication to ensure on-going participation by the community members. Before analyzing each case and its relationship to communication for participatory development, Table 12 provides a summary of the findings.
<table>
<thead>
<tr>
<th>Cases/Stakeholders</th>
<th>Participation in CRHP and Community Activities</th>
<th>Social change (individual or community level)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Communication for Empowerment/VHWs</td>
<td>Training to become VHWs</td>
<td>Self and group efficacy</td>
</tr>
<tr>
<td></td>
<td>Health communicators</td>
<td>Respect in the community</td>
</tr>
<tr>
<td></td>
<td>Information diffusers</td>
<td>Knowledgeability</td>
</tr>
<tr>
<td></td>
<td>Community organizers</td>
<td>Self reliant</td>
</tr>
<tr>
<td>2. Change Agents/MHT and CRHP Directors</td>
<td>Trainers</td>
<td>Contributed toward:</td>
</tr>
<tr>
<td></td>
<td>Facilitators</td>
<td>Improved health of children</td>
</tr>
<tr>
<td></td>
<td>Service providers</td>
<td>and women</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Girls’ education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social harmony</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Overall human development</td>
</tr>
<tr>
<td>3. Collective Action/Farmers’ Club, <em>mahila mandal</em> and self help group members</td>
<td>Attending meetings</td>
<td>Knowledgeable</td>
</tr>
<tr>
<td></td>
<td>Collaborative work</td>
<td>Collective efficacy</td>
</tr>
<tr>
<td></td>
<td>Organizing people</td>
<td>Respect for poor</td>
</tr>
<tr>
<td></td>
<td>Approaching officials</td>
<td>Self development</td>
</tr>
</tbody>
</table>
Analyzing Case 1: Mainstreaming Empowerment through Communication

Empowerment is a theoretical construct that is central to participatory development. Empowerment is defined as having enough confidence to demand one’s rights which is achieved by gaining control over resources by a group of marginalized people (White, 1994). When development programs effectively work toward empowering people, then people are capable of managing their own problems and learning skills through their experiences (Melkote & Steeves, 2001). Having said this, participatory development does not always result in empowering the people as it sets out to do (Melkote & Steeves, 2001; Servaes, Jacobson & White, 1996).

The literature on participatory communication for development overwhelmingly indicates that “while the practice of participatory communication has stressed collaboration between the people and experts, a co-equal knowledge sharing between the people and experts, and a local context and cultural proximity (all of which fall under the empowerment model), the outcome in most cases has not been true empowerment of the people, but attainment of some indicators of development as articulated in the modernization paradigm” (Melkote & Steeves, 2001, pp. 350-351).

Other theorists and practitioners concur with Melkote & Steeves’ (2001) assessment. As a result, development programs have failed to allow people to become empowered or gain control over resources and structures. For instance, Bordenave (1994) and White (1994, 1999) point to the token use of the phrase “participation in development,” when in reality development projects are planned, managed and executed without any active participation by and consultation with the community. Likewise,
Jacobson (1994, 1996) argues that while participatory communication for development has empirical support, it is under-theorized because of the limitations in understanding what processes of communication can support and lead to participation. In essence, there is a need both theoretically and empirically to understand how outcomes such as empowerment can be adequately attained as a result of development interventions.

Another issue with practicing participatory communication and development is to understand how projects fare on the continuum of community participation. Deshler and Sock’s study (as cited in White, 1994) on elements that determine participation in development, delineates two levels – pseudo and genuine participation. Pseudo participation is of two types, one in which people are manipulated to participate, and second, includes consultation of the people but not allowing people to take control (White, 1994). Genuine participation consists of cooperation, which refers to partnership and delegation of power and citizen control (White, 1994). The consensus among critical development scholars is that since the 1990s, the rhetoric of participation has been used by most development practitioners and theorists, yet few projects have the commitment to translate the rhetoric into practice and in turn focus on empowerment of people (Jacobson, 1994, 1996; Melkote & Steeves, 2001; Singhal, 2001; Singhal & Rogers, 2003; White, 1999).

An additional problem with operationalizing participation for empowerment deals with measurement of outcomes. Social change indicators are not adequately developed to capture the process of empowerment across a multitude of development initiatives (Jacobson, 1996). However, a recent model of communication for social change posits it
as the result of empowerment, achieved via community dialogue and collective action, triggered by internal or external stimuli such as communication messages, change agents, policies or new innovations (Figueroa, Kincaid, Rani & Lewis, 2002). In effect, empowerment is embedded in the various processes that trigger dialogue and action leading to individual and societal change. And change is meant to be sustainable because the process is owned by the community (Figueroa et al., 2002).

In sum, participatory development and communication are grounded in principles of empowerment, which means people gain more control over the resources and policies that affect their lives. But at the same time, scholars find it difficult to identify what specific communication process can lead to empowerment and what indicators can adequately measure communication leading to social change. Given this dilemma, CRHP provides examples of processes and outcomes that can inform how future participatory communication processes can contribute toward empowerment of community members. Table 13 describes how CRHP uses communication for participation as an integral element in the empowerment process.
Table 13

*Case 1: Mainstreaming Empowerment of Women as Village Health Workers*

<table>
<thead>
<tr>
<th>Participatory Processes</th>
<th>Communicative Activities</th>
<th>Social Change Indicators as Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Training and Selection of Village Health Workers (VHWs)</td>
<td>a. Learning Circles</td>
<td>Empowerment of women as:</td>
</tr>
<tr>
<td></td>
<td>b. Critical thinking</td>
<td>- para-professional aides</td>
</tr>
<tr>
<td>2. Personal Development of VHWs</td>
<td>c. Dialogue leading to self-efficacy</td>
<td>- diffusers of information</td>
</tr>
<tr>
<td></td>
<td>d. Valuing people’s knowledge</td>
<td>- health educators</td>
</tr>
<tr>
<td></td>
<td>e. Respecting people’s capacities</td>
<td>- community organizers</td>
</tr>
<tr>
<td></td>
<td>f. Collective knowledge creation</td>
<td>- representatives of CRHP</td>
</tr>
<tr>
<td></td>
<td>g. Self efficacy through dialogue</td>
<td></td>
</tr>
<tr>
<td></td>
<td>h. Peer learning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>i. Challenging social norms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>j. Demystification of health</td>
<td></td>
</tr>
</tbody>
</table>
Communication for Empowerment at CRHP

As summarized in Table 13, CRHP uses various participatory processes and communication activities that result in empowering the most marginalized group in the Jamkhed region – poor and illiterate women. An important practice is co-creating knowledge and demystifying technical and complex information so that community members can understand it, use it and spread it. To do this, the first step is to identify and train local women as VHWs. The second is to focus on personal development so that ordinary women who have never been respected and valued by society begin to realize their potential and become self efficacious. VHWs report that before they became health workers they were treated worse than dogs, but now after years of training and working as para-professional aides, they are treated as “doctors” by their community. This change is indicative of a self-reported measure of empowerment and social change among the poor lay women.

Personal development at CRHP uses participatory communication principles by investing in dialogue with VHWs rather than giving information to them. The Freirean idea of using learning circles is used by CRHP during its weekly training sessions and community meetings. The dialogue empowers VHWs to think critically, gain self efficacy and become self reliant. Thus, the VHWs embody how communication based on dialogue and critical thinking can indeed result in empowerment. Training Farmers’ Club members in participatory rural appraisals (PRAs) such as village mapping and seasonal calendars are used to identify which communicable diseases are prevalent, and which can be prevented is another element of empowerment.
There is a two-fold benefit to involving community members in participatory research. First, lay people gain new knowledge and feel valued in doing research, an activity that is usually conducted by educated, urban outsiders. Engaging and empowering community members to do research also results in demystifying knowledge. Second, once people realize the value of research that is relevant to their needs, over a period of time the community moves toward self-reliance. As a result, sustainability is naturally built into the project that aims at empowering community members.

Participatory communication values local knowledge. CRHP practices this principle by listening to people about local health management practices and promoting ideas that are useful, such as use of herbal medicines or prayers when someone is ill. Nonetheless, CRHP also challenges local practices that are harmful to people, such as under-nourishing a neo-natal mother so that the child will be small and hence easy to deliver. Once people are knowledgeable and empowered, they understand the good and harmful cultural practices.

Analyzing Case 2: Change Agents and Integrated Development

There is a movement in international public health and development that maintains that attaining sustainable good health is not merely a function of building state-of-the-art hospitals, but is achieved when people are free from poverty and provided with opportunities to improve their lives (Perry, 1996; Rohde & Wyon, 2002; World Health Organization, 2005). Grounded in these principles of health and social development is the assumption that improving people’s health is not a stand-alone development program, but instead needs to be integrated with other programs. Good health is a function of proper
nutrition, education of men and women, adequate access to clean drinking water, good sanitation, promoting preventive health practices and above all, empowering people to take control of their health. People’s participation, as evidenced by community-based primary health care, is the foundation for achieving these social determinants of health (Minkler, 1997; Minker & Wallterstein, 2002; Rohde & Wyon, 2002; Tan-Torres, 2001).

In addition to mainstreaming people’s participation, the social determinants of health make a case for a multi-sectoral approach to health and development. Arole (1999) points out that agriculture, education and environment are the three major development sectors that impact the attainment of sustainable health among poor communities. Perry (1996) recommends that social sciences supplement the bio-medical sciences in order to achieve global health and development goals. He concludes that inter-disciplinary efforts are needed to promote empowerment of poor people and to translate successes of medical science into sustainable practices and behaviors by people. Empowering poor people through education, access to food and nutrition and clean environmental surroundings is necessary if common health problems among children and women such as diarrhea, pneumonia and maternal mortality are to be overcome.

Another reason why public health and development experts strive for multi-sectoral approaches is because the root causes of most communicable illnesses are complex and inter-dependent. For instance Paul Farmer, a medical doctor-anthropologist, has dedicated his life to helping poor communities in Haiti, Russia and Peru to get rid of multi-drug resistant tuberculosis (Kidder, 2003). Farmer, who is based in Boston, lives with the poor communities in different countries and deals with the root causes of
illnesses by using a combination of disciplines such as pathology, social medicine, politics and anthropology. Because poverty is the root cause of many illnesses such as tuberculosis, Farmer believes in finding solutions such as employment for the poor, transportation to take the sick to the hospitals, as well as ensuring that medical supplies reach the people who need them the most (Kidder, 2003).

In sum, primary health care as an approach emphasizes equity and a multi-sectoral approach to ensure that people enjoy good health. Thus, community-based health projects, much like participatory development, need to focus on larger structural problems such as sanitation, clean drinking water, land reforms, education and so forth. Community-based health also needs to focus on individual needs such as empowerment and efficacy, information and dialogue, and opportunities to participate in social and political arenas.

At CRHP, inter-sectoral development achieved via integration of different aspects of development is central to achieving the other two principles, equity and empowerment. Table 14 describes how the multi-functional MHT is used to integrate various development practices into CRHP’s vision of holistic development.
Table 14

Case 2: Change Agents and Integrated Development

<table>
<thead>
<tr>
<th>Participatory Processes</th>
<th>Communicative Activities</th>
<th>Social Change Indicators as Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mobilizing Change Agents to</td>
<td>a. Establishing trust and credibility through dialogue and demonstration</td>
<td>Holistic development through integration of services and expertise</td>
</tr>
<tr>
<td>- Link the project to people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Form a multi-functional health team</td>
<td>b. Building long-term relationships</td>
<td>1. multi-disciplinary project staff</td>
</tr>
<tr>
<td>2. Creating Platforms for Change</td>
<td>c. Regular contact with the community</td>
<td>2. sharing individual expertise with team members and community (demystifying health)</td>
</tr>
<tr>
<td>- Linking poverty with ill-health and development</td>
<td>d. Dialogue with the community</td>
<td></td>
</tr>
<tr>
<td>- Finding entry points for health</td>
<td>e. Learning from the community (valuing local knowledge)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>f. Disseminating information during community meetings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>g. Disseminating information during informal meetings and events such as sports and religious ceremonies</td>
<td></td>
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</tbody>
</table>

Communication, Change Agents and Integrated Development at CRHP

Arole (1999) explains that in order to accomplish the goals of community-based primary health care, projects need to begin with an understanding of the basic principles guiding development. Good health is achieved when the impact of economic and political development – the production and distribution of goods and services and policies that ensure basic needs are met – reaches all. In order to ensure that even the poor have access to food, medical services and education, CRHP believes in promoting poor people’s economic capacity. To this end, CRHP trains small farmers on improved farming techniques such as crop rotation and use of hybrid seeds and empowers people to approach banks and local government officials for loans. Women are provided micro-credit so that they are no longer dependent on the men, but are self-reliant and provide for the family (Arole & Arole, 1994).

Linked to the economic sustainability of the poor is the association between health and agriculture. While working with the poor communities in Jamkhed, CRHP soon realized that children are not only under-nourished but are often starving. Communities had little access to food partly because of poverty and partly because of the lack of rainfall in the region, which resulted in famines. CRHP therefore focused on finding ways to provide water to the people so that poor farmers could at least produce enough food for their families. Building check dams as part of the food-for-work programs became an entry point to promote health and development. CRHP thus began their project by providing water to poor farmers, giving information to improve farming
techniques and providing veterinary health services for the animals. All these allied services had a synergistic positive effect on the health of the children and women.

CRHP also heavily invests in community development with the goal of improving people’s living conditions and overall well being. While holistic development necessitates integration and inter-sectoral cooperation, at the community level it also requires organizing which can lead to social change. Formation of *mahila mandals*, self-help groups and Farmers’ Clubs has helped to build communities out of segregated groups or factions based on caste or socio-economic class. Arole (1999) explains:

> The first problem is that no community exists. Villages are heterogeneous, being divided by class and caste, political and traditional factions, and religions. People have to be organized if they have to act collectively for the good of all. Organization of communities is therefore the first step in achieving community participation (Arole, 1999, p. 3).

Once people are organized and realize the potential of working in groups, CRHP provides local or community level opportunities. These include asset creation by engaging in watershed development or cash crop farming, providing micro-credit to women and men to start small income generation projects, and seminars that open new employment options for youth. Different strategies are used for people who belong to different economic classes. For instance, landless families are encouraged and given opportunities to buy milk animals such as goats and cows. People who have land but cannot produce enough crops because of water scarcity are given options to invest in appropriate technology such as building small bund dams or a community well that would be used by a group of farmers. Different strategies are used to help meet different
people’s needs; multi-sectoral cooperation results in achieving meaningful and sustainable change that is appropriate to the community needs.

CRHP operationalizes integration into its primary health care approach by using a multi-disciplinary MHT and by openly sharing information with all members and seeking their cooperation before implementing any project. The Aroles had a plan for improving the health status of the people in the Jamkhed region, but they wanted to explain their purpose and work only with those people who would willingly co-operate with the project staff. The MHT, who are the change agents, work closely with the community ensuring that people understand the social and cultural determinants of attaining good health. Also, CRHP’s values of transparency and establishing trust with the community resulted in people understanding the need for integration and participation in bringing about holistic development.

Additionally, CRHP found creative ways to involve people in efforts to help themselves. So, for instance, if lack of food and water was a problem, then a food-for-work program resulted in people contributing their time and effort to build dams, which in turn helped both the community and the individuals who were paid in food grains. While this project was run by an outside organization, CRHP was the facilitator, connecting the community with the food-for-work project. Once people realized that CRHP was helping them meet their needs, then people began cooperating with CRHP and took interest in learning about preventive health practices.
Analyzing Case 3: Equity in Participatory Development

Chambers (1983) puts forth the idea of “putting the last first” in development, a strategy that requires reanalyzing the focus of development programs. This thesis suggests that if development managers and change agents want to realistically and meaningfully facilitate a process of change, then development practitioners need to base their projects on community needs rather than global agendas or needs of policy makers. Equity, a principle in community-based development, is akin to Chambers’ (1983) putting the last first. Equity means consciously and strategically designing projects based on the needs of people and ensuring that projects deliver what is needed to those who need it the most (Rohde, 2002).

The problem with development theory and practice, including participatory development, has been the insufficient focus on equity. Chambers (1983) suggests that when development projects begin with the community as the focus, then it is possible to identify two dimensions that determine the root cause of poverty. First, identify whether entire communities are poor due to their isolation and lack of access to information and resources or whether there are pockets of poverty with a few wealthy people in the communities. And second, identify the disadvantages of being a female in a community and the disadvantages faced by women as a group, in most cases from the moment of birth (Chambers, 1983). Both these are universal conditions.

Chambers (1983) suggests that if we understand how the cycle of deprivation is perpetrated among certain groups of people, such as low caste, ethnic groups, women, children and so forth, then in order to make a difference we need to begin developing
programs that aim to overcome the root causes. For development programs to be equitable, they need to devise different strategies for different groups of people depending on their needs.

Chambers (1983) reexamines the problem with equity by contrasting how professional values compartmentalize the world as first (urban, industrial, modern, affluent, educated) and last (rural, agricultural, traditional, poor, illiterate). Chambers makes the point that if we continue to value people as “first” or “last” then the poor and the marginalized, who are always the “last,” will never be able to break out of their poverty and under-development trap. Hence, he suggests that development theoreticians and practitioners need to reverse their roles and focus on the problems, issues and needs of the poor. This in effect would lead to more equitable development strategies and thereby involve and cater to those people whose needs are the most pressing.

CRHP has achieved equity in its programming by moving away from the traditional medical model that values curative health services and instead embracing a primary health care approach that values human development and good health as universal human rights. Table 15 describes the difference between these two approaches. Where as Table 16, which follows, summarizes how CRHP integrates equity in its programming through participatory processes and communication activities.
Table 15

*Comparison of Curative versus Primary Health Care Models of Health*

<table>
<thead>
<tr>
<th>Medical Care Model</th>
<th>Primary Health Care Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Emphasizes care of the sick</td>
<td>Emphasizes health</td>
</tr>
<tr>
<td>2. Treats individuals</td>
<td>Treats communities</td>
</tr>
<tr>
<td>3. Relies on drugs, doctors and hospitals</td>
<td>Focuses on proper nutrition, a good environment and preventive health practices</td>
</tr>
<tr>
<td>4. Works in isolation from other human development activities</td>
<td>Values inter-sectoral cooperation with education, agriculture, etc.</td>
</tr>
<tr>
<td>5. Depends on imported technology</td>
<td>Builds people’s capacity and empowers local people</td>
</tr>
<tr>
<td>6. Mystifies medicine</td>
<td>Demystifies health</td>
</tr>
<tr>
<td>7. Is biased in favor of the rich, and is unjust</td>
<td>Is available to all</td>
</tr>
<tr>
<td>8. Produces its own culture and ignores the culture and value system of the poor</td>
<td>Adapts to culturally acceptable practices</td>
</tr>
<tr>
<td>9. Is expensive</td>
<td>Is suited to the human and material resources of the community</td>
</tr>
<tr>
<td>10. Encourages dependence on doctors and medical institutions</td>
<td>Encourages self-reliance and motivates people to manage problems locally</td>
</tr>
</tbody>
</table>

### Table 16

**Case 3: Involving the Marginalized in Development Practice**

<table>
<thead>
<tr>
<th>Participatory Processes</th>
<th>Communicative Activities</th>
<th>Social Change Indicators as Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Facilitators as community mobilizers</td>
<td>a. Diffusing information from training center to community</td>
<td>Equity (reaching out to the most vulnerable)</td>
</tr>
<tr>
<td>- use of para-professional aides</td>
<td></td>
<td>- low caste VHWs as facilitators</td>
</tr>
<tr>
<td>- identifying people to form Farmers’ Clubs and <em>mahila mandals</em></td>
<td>b. Regular contact with community and facilitators</td>
<td>- involving all, especially the poor, in community activities</td>
</tr>
<tr>
<td>2. Organizing Community Groups</td>
<td>c. Repetition of information with facilitators</td>
<td>Collective action</td>
</tr>
<tr>
<td>- men and women improving the community (digging wells)</td>
<td>d. Training community to do participatory action research</td>
<td>- community meetings to resolve problems</td>
</tr>
<tr>
<td>- collaborative partnerships among men (helping other farmers)</td>
<td>e. Promoting information exchange among local network of people</td>
<td>- community partnerships to improve living conditions</td>
</tr>
<tr>
<td>- collaborative partnerships among women (formation of micro-credit groups for income generation)</td>
<td>f. Using local communication channels to reach a mass audience</td>
<td>- collective efficacy to approach local government for development projects</td>
</tr>
</tbody>
</table>
Communication for Participation and Achieving Equity at CRHP

CRHP accomplishes equity in its programming by concentrating on the most vulnerable and the poorest of the poor. This is why the project invests in training marginalized women as VHWs. Also, in order to reach out to the most needy, CRHP ensures that it develops a rapport with the economically and socially marginalized groups in the communities. Therefore, the project staff consciously seeks out low caste, Dalits or indigenous people such as the scheduled castes and scheduled tribes who are not allowed to participate in the mainstream community.

Another strategy is to organize people to form groups irrespective of class and caste. The Farmers’ Clubs, mahila mandals and self-help groups, each formed for a different purpose, are unified by the goal of involving all people in improving the community. As a result, most Farmers’ Clubs have upper-caste Brahmins and Marathas working with Dalit farmers and laborers. While blurring these caste distinctions was not easy, CRHP invested a lot of resources and creative efforts to achieve it. Organizing community kitchens where children from all castes contribute food grains or firewood toward a meal and using sports and religious ceremonies for dialogue with the community members are some of the important communicative and participation strategies. The purpose of these activities was to consciously involve the poor in the development activities in their villages.

Yet another strategy used by CRHP was to reach out to stigmatized people. In the 1970s and 80s, when leprosy and tuberculosis were major problems faced by the poor (and also at times by the rich) in the region, CRHP decided to tackle cultural practices
that shunned people with these diseases. This was achieved by demonstrating to the community through touching and caring for patients that leprosy is not a communicable disease, and neither is tuberculosis, as long as the sputum is disposed of properly. CRHP also took the initiative to help overcome harmful cultural practices such as discrimination against girl children and women. This was accomplished by providing information, engaging in dialogue and showing through the example of VHWs that women can take on roles outside of the domestic sphere if they are given an opportunity to learn.

Before involving the marginalized groups, CRHP first gained the confidence of leaders in the community to avoid internal conflicts. Over time however any group of people that was marginalized was consciously involved in CRHP’s community development activities. This resulted in gaining poor people’s trust and in empowering them to demand basic services such as access to water and good health. Furthermore, gaining the confidence of the poor helped CRHP understand their real needs rather than providing pre-determined services and information. The Aroles note that for the poor in Jamkhed food and water, not health, were the basic needs. CRHP was interested in improving the overall quality of life of the communities. Instead of simply building a well in a community, CRHP insisted on community involvement and used this occasion to promote preventive health. Through demonstration and repetition of information, people understood the relationship between quality of water and sanitation with health. As a result, CRHP was able to involve the community in improving their situation, and the needs of the poor and those of the project coincided (Arole & Arole, n.d.).
Lessons Learned: Communication Practices for Facilitating Participation

1. Participation occurs at various levels within communities and across the project.

Based on the continuum of participation in development, we know that projects fall between two poles: titular or pseudo participation at one end and genuine participation on the other (White, 1994). In addition, there are three levels of genuine participation – low, medium and high – as shown in Figure 3.

<table>
<thead>
<tr>
<th>High</th>
<th>Medium</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaboration, Cooperation</td>
<td>Consultation, Compliance</td>
<td>Cooption, Coercion</td>
</tr>
</tbody>
</table>

*Figure 3. Degrees of participation and level of control by community (White, 1994)*

CRHP provides another perspective for understanding the degrees of participation even when projects fall on the genuine participatory side of the continuum. Table 17 explains how different activities demand different levels of participation ranging from high to low from different stakeholders. High participation occurs when community members have a high degree of control and are collaborators with the change agency in designing and implementing a program. Medium participation occurs when the change agency consults the community about its needs but the projects are implemented with little collaboration from the community members. Finally, low participation refers to project staff planning and implementing activities without seeking community input.
CRHP’s experience reinforces the challenge faced by many community-based development projects that value participation as a necessary condition for change. Table 17 illustrates how certain project activities demand more involvement from the project staff, while other activities can be carried out entirely by the community members with very little involvement of the staff.
Table 17

**CRHP Activities as Plotted on a Community Participation Continuum**

<table>
<thead>
<tr>
<th>Stakeholder(s)</th>
<th>Activities</th>
<th>Participation of community members</th>
</tr>
</thead>
<tbody>
<tr>
<td>VHWs</td>
<td>- household visits&lt;br&gt;- health promotion and prevention&lt;br&gt;- mobilizing women in groups&lt;br&gt;- mobilizing men to engage in collective action&lt;br&gt;- providing basic healthcare and referring people to the hospital</td>
<td>High&lt;br&gt;- VHWs perform the activities with little supervision from staff&lt;br&gt;- Community members help VHWs with the tasks</td>
</tr>
<tr>
<td><em>Mahila mandals</em></td>
<td>- helping the VHWs, organizing community meetings&lt;br&gt;- discussing preventive health practices&lt;br&gt;- working collectively to solve community issues&lt;br&gt;- encouraging girls to join the adolescent group</td>
<td>Medium to high (depending on the communities)&lt;br&gt;- VHWs/MHT facilitates and motivates MM to join and meet weekly or monthly</td>
</tr>
<tr>
<td>Farmers’ Club (FC)</td>
<td>- mobilizing people for collective action e.g. building check dams, community well or lake, building soak pits, village cleaning, etc.&lt;br&gt;- organizing community meetings&lt;br&gt;- cooperating with the VHWs and help them conduct surveys</td>
<td>Medium to High&lt;br&gt;- FCs facilitated by CRHP but each FC evolves based on the leaders from the community&lt;br&gt;- Collective action is decided without CRHP intervention and executed with partial or no help from CRHP</td>
</tr>
<tr>
<td><em>Mahila mandals</em> and Farmers’ Clubs</td>
<td>- collaborating to bring major change in the village e.g. approaching the local government, community weddings, community kitchens, etc.</td>
<td>Medium to High&lt;br&gt;- CRHP provides the impetus and guidance on government schemes&lt;br&gt;- gradually community takes over</td>
</tr>
<tr>
<td>Self-help groups</td>
<td>- forming a group of five to six women to start a savings group&lt;br&gt;- working collaboratively and helping members who are most in need&lt;br&gt;- learning about income generation&lt;br&gt;- taking financial decisions for the family</td>
<td>Medium (initially)/High (later)&lt;br&gt;- CRHP helps organize SHGs Community chooses its members&lt;br&gt;- Groups decide what to do with the funds&lt;br&gt;- Groups can also join government schemes where participation is difficult to assess</td>
</tr>
</tbody>
</table>
Table 17 (continued).

<table>
<thead>
<tr>
<th>Stakeholder(s)</th>
<th>Activities</th>
<th>Participation of community members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training of VHWs</td>
<td>- learning new preventive and curative practices</td>
<td>Low to medium</td>
</tr>
<tr>
<td></td>
<td>- sharing information from the villages</td>
<td>- VHWs are trained to become effective communicators, health promoters and community organizers by CRHP staff</td>
</tr>
<tr>
<td></td>
<td>- VHWs are trained to become effective communicators, health promoters and community organizers by CRHP staff</td>
<td>- Older VHWs become peer facilitators</td>
</tr>
<tr>
<td>Adolescent girls</td>
<td>- organized by VHW to learn about health, hygiene, nutrition</td>
<td>Low</td>
</tr>
<tr>
<td>groups</td>
<td>- trained in vocational skills such as tailoring at CRHP</td>
<td>- MHT gives information and training</td>
</tr>
<tr>
<td></td>
<td>- trained to protect themselves from men</td>
<td>- VHWs organize girls to come together and motivate them to come to CRHP</td>
</tr>
<tr>
<td></td>
<td>- motivated by peers to join the group</td>
<td>- <em>Mahila mandal</em> members encourage girls to become active learners</td>
</tr>
</tbody>
</table>
2. Communication is essential for community participation and sustainability.

The Aroles emphasize that being accepted by community members is the most important step in starting a development project. CRHP’s experiences inform us that gaining acceptance is a slow and difficult process. For instance, the most effective strategy is to use the first few meetings to build trust with the people. A meeting is organized to discuss the community’s needs and what CRHP can do. The project staff also shares the problems they face such as transport, lack of trust and co-operation and so forth while working with the community. Yet, the Aroles caution that at times there is a thin line between gaining trust and losing credibility. Thus, at the beginning the doctors had to provide curative services to demonstrate what they can do before the community trusted them and began learning about preventive health practices.

Communication grounded in principles of trust, respect, dialogue and critical thinking is fundamental to gaining peoples’ confidence and motivating them to engage in collective action. Moreover, CRHP uses different communicative processes to meet the information needs of different groups involved in the project. For instance, during the formative years of the project, the emphasis was mostly on dialogue to understand the needs of the community. Once the project has a VHW and a few community groups, the project staff uses these people to promote new information and seek community participation to implement programs such as growth monitoring of children, ante-natal and post-natal check ups for women, village cleaning drives and so forth. Table 18 explains the various activities and communicative processes employed to facilitate participation.
Table 18

*Key Activities in Facilitating Participation by CRHP in the Villages*

<table>
<thead>
<tr>
<th>Activities for Participation</th>
<th>Communicative processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Build rapport and trust</td>
<td>- Meet leaders, organize community meetings</td>
</tr>
<tr>
<td>2. Community organizing</td>
<td>- Ensure all groups are contacted and represented</td>
</tr>
<tr>
<td>3. Build a platform for dialogue</td>
<td>- Use local leaders to form Farmers’ Clubs (FC)</td>
</tr>
<tr>
<td>4. Provide work (e.g. building bund dams, veterinary training, new farming techniques, building community wells, farm lakes)</td>
<td>- Motivate and facilitate FCs to have regular meetings to discuss local issues</td>
</tr>
<tr>
<td>5. VHWs (chosen by villagers and thus accepted by the community)</td>
<td>- Use games, religious gatherings and festivals to discuss local issues</td>
</tr>
<tr>
<td>6. Motivate Farmers’ Clubs to form <em>mahila mandals</em></td>
<td>- Mobilize socially active people to facilitate discussions</td>
</tr>
<tr>
<td>7. <em>Mahila mandals</em> and VHWs form adolescent girls group</td>
<td>- Facilitate the community to learn new skills and tackle its own problems</td>
</tr>
<tr>
<td>8. MHT trains the community to assess problems, analyze problems and implement programs whenever feasible</td>
<td>- Use work as an entry point to promote health and development</td>
</tr>
<tr>
<td>9. <em>Mahila mandals</em> transformed into self-help groups</td>
<td>- FC meetings used to initiate discussion about the need for a VHW</td>
</tr>
<tr>
<td></td>
<td>- Being a voluntary job, only genuinely interested women become VHWs</td>
</tr>
<tr>
<td></td>
<td>- FC members wives asked to form a MM to learn about health to take better care of their families</td>
</tr>
<tr>
<td></td>
<td>- VHW (during her home visits) given the task of identifying MM members</td>
</tr>
<tr>
<td></td>
<td>- Young girls are encouraged to learn about health and motivated to go to CRHP for weekly training</td>
</tr>
<tr>
<td></td>
<td>- Provide an opportunity for girls to learn vocational skills</td>
</tr>
<tr>
<td></td>
<td>- Regular visit by MHT helps build trust and provides an opportunity to learn about village issues and facilitate PRAs</td>
</tr>
<tr>
<td></td>
<td>- Micro-credit provides women independence</td>
</tr>
<tr>
<td></td>
<td>- Empowers women as they make choices for the family</td>
</tr>
</tbody>
</table>
3. Communicator as a facilitator helps achieve participation.

The two key communicators at CRHP are the MHT members who deliver the training and the VHWs who are trained to become para-professional aides. As described earlier, the MHT is a multi-purpose team which includes paramedics and social workers. This group of seven people is trained on an on-going basis by the project directors to become master trainers for the VHWs. During the weekly VHW trainings, they facilitate discussion through critical thinking and dialogue. The training is based on effective facilitation which is “the art that engages the creative forces within persons which energize thinking and doing” (White, 1999, pp. 19-20). Therefore, communication which is essential for participation is achieved through effective facilitation and the role of the communicator thus is to be an effective facilitator.

Not only does the MHT play the role of a facilitator-communicator, but the VHWs are trained as communicators, too. CRHP invests heavily in the VHWs to become information diffusers and facilitators. The role of the VHWs as para-professional aides is to help spread new information and motivate people to change their existing attitudes and take on new behaviors. Communication is central to this process and VHWs are trained to facilitate the change process.

As facilitators and communicators, the VHWs become the focal persons in the community to stimulate dialogue and mobilize people to work collectively. This is achieved by organizing women into mahila mandals and conducting regular meetings in the village as well as inviting the women to Jamkhed for a meeting with the MHT. The purpose of these meetings is to ensure regular contact between the VHWs, MHT, mahila
mandals, Farmers’ Clubs and others as well as to provide information on a repetitive basis. MHT and VHWs repeat the information to ensure consistency of messages about preventive health practices and social issues. For instance, it is not sufficient to talk about the importance of adequate nutrition for children, especially the girl child, only once during a monthly meeting. The facilitators need to keep reminding the community how certain social practices, such as discriminating against a girl child by ignoring her nutrition, can perpetrate a cycle of malnutrition and morbidity. In order to do so, the VHWs and the MHT use any occasion they find to spread preventive health and social practices.

4. Change agents and para-professional aides are central to the diffusion of CRHP’s programs

At the heart of CRHP’s activities lies promotion of preventive health practices. Preventive health uses a multi-sectoral and integrated approach and is closely tied to communication, education, and environmental sanitation as well as political activism. CRHP promotes preventive health practices by concentrating on providing information for attitude and behavior change, and empowering people to gain control over their lives.

Rogers (2003) outlines four factors in change agent success: (1) The effort made by the change agent in contacting the potential adopters, (2) the closer rapport and higher credibility that the change agent has with adopters, (3) the compatibility between the information and the adopters’ needs, and (4) the change agent’s empathy with the adopters. All of these qualities are operationalized by CRHP in its programming and by the MHT and VHWs during their interactions with the community. For instance, building
rapport and trust is the first step for CRHP. Likewise, the MHT and VHWs both ensure that they reach out to the people who need their services the most. This effort to contact all people is part of the principle of equity that guides CRHP’s programs.

Empathy was not measured as a characteristic of change agents in the present research. But based on the evidence from the interviews and participant observations, one can fairly conclude that empathy is part of a set of values such as love, caring and respect inculcated by the project amongst the staff, VHWs and even community members. Almost all VHWs repeatedly talked about the love and respect they received from the Aroles and the MHT when they began working for CRHP. And the VHWs also noted that when they work with their community, their work is influenced by the values that are instilled in them by CRHP.

Additionally, CRHP uses an innovative strategy of using both change agents and para-professional aides in order to bridge the homophily-heterophily gap. Homophily is the degree to which the adopters and the change agent are similar and heterophily is the degree of dissimilarity. The VHWs as para-professional aides are homophilous to the community as they belong to it, and though MHT is heterophilous they are not as different as the project directors. The MHT members are semi-skilled and many of them belong to the different villages in the region, therefore they are perceived to be similar by the community. However, because they are trained by CRHP, the MHT members are also able to introduce new ideas and information that otherwise would not become available to the community.
5. Communication is integral to CRHP’s vision of development.

Communication for participation guides almost all activities that CRHP plans and implements. CRHP uses traditional media such as theater, song and dance and puppets, in an entertainment-education format. And, it also uses locally produced health education materials such as flip-charts to give information during house visits and community meetings. But these communication channels are not central to CRHP’s use of communication. The project’s key communication practices are building a relationship through community dialogue and uplifting marginalized women to become empowered through critical thinking and problem posing. Therefore, Freirean principles of dialogic communication and conscientization (Freire, 1970/1998) are used as a means of achieving the project goals: sustainable and positive change among individuals and the community.

Additionally, information is delivered using culturally relevant channels such as village elders, religious songs and popular entertainment. Particularly the traditional entertainment channels, such as song and dance performances, are easily accessible to all and substitute for mass media as they have the potential to reach large number of people. Today, despite access to and limited ownership of radio and television sets, traditional channels are still popular. For instance, the song, dance and dramas organized by CRHP on various community development topics are attended by almost a quarter of the village population (250 to 500 people). Not only is there a mass appeal for these communication programs but these programs allow people to actively participate as performers.
Participation by the people has at least two distinct advantages: (1) the messages are co-created with the community during community meetings or VHW training sessions, as a result people’s information needs are met, and, (2) the transparency with which the messages are delivered enhance their credibility. The consistency also helps establish the credibility. The doctors and the MHT give the same information as the VHWs and thus reinforce the preventive health practices. There is a lot of repetition of information during the training sessions and community meetings. This is done intentionally so that people begin practicing what they learn.

Another important aspect of communication as a means to achieve participation and sustainable development is demystifying technical knowledge. The Aroles believe that doctors have a tendency to keep information about good health away from people, especially the poor. CRHP on the other hand makes knowledge about preventive health comprehensible and easy to understand through training, health education and demonstrations. At CRHP, knowledge is not a prerogative of the privileged but is to be shared among people. Thus, demystification of knowledge is linked to empowering people to become health promoters and health educators. And communication is used to share the knowledge and also ensure that lay people gain the necessary self efficacy and self esteem to learn about preventive and social health.

Implications for Theory and Practice of Communication for Participatory Development

This section briefly summarizes how the theory and practice of participatory development can benefit from the present research. This is achieved by explaining the
lessons learned from studying how communication for participation is mainstreamed by
CRHP. Moreover, this section provides evidence of how communication for participatory
development can be attained and sustained when empowerment of the communities is the
end goal of the projects. The seven generalizations that follow are: (1) participation is
tidal in nature, (2) community participation and outside change agents can co-exist, (3)
dialogue can stimulate collective action, (4) para-professional can be trained to become
effective communicators, (5) people’s self interests need to be accounted for, (6)
participation necessitates social change and political will, and (7) participation and social
change are slow processes.

1. Participation is tidal in nature and depends on community’s priorities.

The literature mentions levels of participation and also the goal of participation; as a
means to an end or an end in itself (Servaes, Jacobson & White, 1996; White, Nair &
Ascroft, 1994). Yet, there is overwhelming evidence from this research that suggests
another important element, frequency of participation. CRHP’s prolonged engagement
with facilitating participation suggests that once people are convinced of the value of
coming together, then participation occurs whenever there is a need. A project like
CRHP, which is steeped in community participation, can rely on some of the people like
the Farmers’ Club or mahila mandal members to either initiate collective action on their
own or when the project requests people to invest in the project.

Cohen (1996) argues that problems with development interventions are not
merely restricted to overcoming lack of knowledge and resources among poor
communities, but also the need to invest in human development. By human development,
Cohen means people need to be empowered so that they can make decisions about whether or not to participate in programs that affect their lives. The barriers to participation are due to internalized oppression as a result of deep rooted dependence of poor communities on leaders, which is due to low social status, low self esteem, and no political power (Chambers, 1983; Cohen, 1996). All these barriers can be overcome if poor communities are allowed to take control over their lives.

However, in Jamkhed, it was observed that even among groups that are empowered participation in community development occurs only when communities are convinced that their participation can indeed make a difference. Moreover, many people simply do not have the time to participate as they are working long hours to earn their livelihood. In agrarian communities people’s work is seasonal. Despite the importance of participation for the community’s well being, during sowing and harvesting season most men and women are too busy to participate in any additional activity. Nonetheless, there are other times when a facilitator can mobilize the community to participate in collective action. Participation is tidal, it ebbs and flows depending on the community and their needs.

CRHP’s experience also points to the fact that each community has a cohort of people who are naturally inclined to work for the community and volunteer their time and even resources for the larger social good. As a change agency, CRHP invests in such people by identifying them, training them and keeping them motivated by making them role models for other community members. In most instances, these people who the project calls “socially minded,” are willing to take on responsibilities and ownership of
the community projects. Once again, whenever a community has a group of men and women that are willing to participate then they can be called upon whenever there is a need. For instance, CRHP uses these people as demonstrators or even facilitators when the project begins working with a new community.

In sum, participation is determined not only by the level of autonomy that people have but by the characteristics of the people who participate, their social environment and the community needs.

2. Community participation and outside change agents can co-exist.

While participation is central to CRHP’s activities, it is important to realize that CRHP is an outside agency that seek to improve the lives of the poor. CRHP, like most outside change agencies, faced many hurdles from the community members before it could begin motivating and organizing community members to practice preventive health practices. The Aroles, through effective communication, built a relationship with the community members based on trust, respect and transparency, yet at the beginning the staff faced resistance from the people.

This tension between the role of the change agency (CRHP) and the community members is consistent with the literature on the dialectic nature of organizing for social change (Papa, Singhal & Papa, in press). Based on their investigation of long-running social change projects, the authors propose four dialectics – control and emancipation, oppression and empowerment, dissemination and dialogue and fragmentation and unity – that are in play when communities experience change. These dialectical tensions exist because changing the status quo in a system is a highly complex and non-linear process.
Furthermore, the role of experts or an outsider need not render a project anti-participatory because new information and ideas from someone outside the community can become the source for dialogue that can trigger social change (Papa, Singhal, Papa, in press).

CRHP provides a unique site for such dialectical change processes. In particular, this research uncovered how the dialectic of control and emancipation is embedded in CRHP’s project activities. For instance, the weekly training of VHWs allows women to become empowered and gain freedom, something they had never experienced before, but at the same time, the VHWs have to follow the rules laid down by CRHP. The VHWs have to convince their families to allow them to travel to Jamkhed on a weekly basis. And at the training center, VHWs have the freedom to pursue their passion but they also have to practice certain collective behaviors such as cooking for the entire group or training new VHWs.

Another dialectic that is central to CRHP is the use of dissemination or giving information, especially during the training of VHWs. There is little room for dialogue when VHWs are learning about treating particular diseases or promoting knowledge to prevent ill-health in the communities. Once the VHWs learn the factual information, then they are encouraged to be engaged in a critical dialogue so that community members understand how to prevent or treat commonly occurring health problems.

In sum, participation is promoted and is central to CRHP but the role of outside change agents is not undervalued either by the project staff or the community members.
3. *Dialogue with appropriate facilitation can stimulate collective action.*

Figueroa, Kincaid, Rani and Lewis (2002) propose an integrated model of communication for social change, at the heart of which is community dialogue and collective action. This model proposes that a catalyst triggers dialogue which leads to action and individual and societal change. According to Figueroa et al. (2002), community dialogue occurs when people go through iterative steps which can lead to a community generated solution. These processes can be used to recommend future programs on how to effectively use participation. For instance, the model proposes that as a first step people need to recognize a problem and then share it with others including those who would take the responsibility of finding a solution. Once an action plan is developed, then the people can find a solution through community mobilizing.

CRHP, with its emphasis on training lay people, organizing communities to form groups and collaboratively working with communities to overcome problems, operationalizes many aspects of the integrated model of communication for social change. However, the model does not overtly discuss the role of the facilitator or the change agent in stimulating community dialogue and action. The model notes that change agents can serve as a catalyst but it does not specifically describe their role. In Jamkhed, it is evident that the facilitators, who could be either from the community such as VHWs or heads of the Farmers’ Clubs or external to the community such as the MHT, play the critical role of catalyzing the community to dialogue, deliberation and action.

Communication is a means through which community mobilization is orchestrated by CRHP. Communicative processes such as establishing a relationship and
credibility with the community, providing an opportunity where people can talk freely, and encouraging people to act collectively, result in community dialogue leading to action. Moreover, dialogue occurs when people are empowered to talk about their problems.

In sum, participation by community members occurs when people are allowed a chance to freely and openly discuss and deliberate problems, and they are given an opportunity to come together and find local solutions to the problems. The role of the communicator as a facilitator is central to this process of community mobilization.

4. Para-professional aides and change agents can be trained to become effective communicators.

An important function of mass media to reach communities with new information is the consistency of messages. If messages are appropriate for the community, then group listening to the media along with a facilitator can stimulate dialogue and action. However, in the absence of widespread access to radio and television, the low level of literacy and lack of local media such as community radio, CRHP has been successful in using change agents and para-professional aides as the principal communication channels.

The weekly training helps VHWs become effective communicators. Repetition of information and peer-facilitation allows VHWs to practice how to disseminate information in their communities. The frequency of sharing information with community members cannot be compared to the frequency with which information can be repeated over mass media. Yet, there are at least two distinct advantages of using para-
professional aides as communicators; first, information is shared whenever there is an opportunity, especially during house visits and meetings when people are most receptive to new information. Second, sharing information face to face allows for immediate feedback and the ability to modify the message according to people’s needs. Thus CRHP’s model of information sharing and use of para-professional aides reinforces the efficacy of training lay people. Lastly, the MHT and the doctors serve as important intermediaries because they introduce new ideas to the communities. Therefore, CRHP provides a model that uses local facilitators and change agents who are in regular contact with the communities as an effective channel for communication.

5. *Participatory development projects need to account for people’s self interest.*

In the alternative model of development, projects have a positive impact in improving people’s lives if programs are designed on the basis of community needs (Servaes, 1999; Servaes, Jacobson & White, 1996; White, Nair & Ascroft, 1994). There is enough empirical evidence to conclude that development projects that cater to poor people’s needs have a sustainable and meaningful impact on improving the situation of the people who need development the most (Chambers, 1983, 1997). While fulfilling community needs is important, not all participatory projects can do so because of economic, social and political constraints. However, CRHP accounts for people’s self-interest before implementing health prevention programs.

As explained previously, social change programs cannot be implemented in isolation from other sectors that impact people’s lives. As a result, CRHP uses the primary health care approach to deal with the root causes of ill health, which are usually
social and economic in nature. As a result, some community participation efforts are not linked solely to preventive health. In addition, to deal with poverty as a root cause of ill health, CRHP’s approach demonstrates how small community based development projects can invest in local solutions as opposed to relying on the larger policy level changes. To this end, CRHP promotes micro-credit groups to help poor communities to become self reliant. Another strategy is to provide people information and guidance to make use of existing government subsidies. In essence, participatory community-based projects can find ways to meet the needs of people even when the needs are beyond the immediate scope of the project.

6. Participation necessitates social change and political will.

Servaes (1996) states that a major hindrance to using participation more widely in development is its challenge to existing hierarchies. In other words, the status quo within a social system with regards to people who wield power and control over economic, political and social resources needs to be reevaluated if development projects allow poor communities to genuinely participate. This point was made earlier in relation to the concept of equity, which is ensuring that people who need certain basic services the most should have access and the opportunity to receive them. And Chambers (1983) recommends that the last, who are always the poor communities in any society, need to be put first; that is, development projects should give priority to fulfilling poor people’s needs irrespective of what policy makers want.

As one can imagine, destabilizing existing hierarchies can cause conflict and create resistance from people who are in power. Yet, CRHP demonstrates that without
challenging some of the existing oppressive practices, the poor and the marginalized cannot be empowered. For instance, without overcoming caste and class barriers, heterogeneous communities would not have organized into groups to engage in collective action. Likewise, unless gender roles were challenged, lay women would not have been trained as health workers and empowered to become change agents. However, CRHP did not challenge the existing hierarchies by creating new groups. The project staff built a trusting relationship with the community leaders and through dialogue the community agreed to change certain discriminatory social practices.

7. Participation is a slow process and social change even slower.

For at least the past two decades, the theory and practice of development have embraced participation as a necessary condition for projects aimed at improving peoples lives (White, 1994). More recently, it has been recognized that sustainable development occurs only when people become agents of their own development, i.e. participating fully in the development process (White, 1999). This ideological stance cannot be questioned because there is plenty of evidence which points to the efficacy of participatory development (Krishna, Uphoff & Esman, 1997; Rohde & Wyon, 2002; Servaes, Jacobson & White, 1994; Taylor-Ide & Taylor, 2002; White, Nair and Ascroft, 1994; Uphoff, Esman & Krishna, 1998; Yunus, 2003).

However, few theorists mention the time involved in making projects genuinely participatory, especially those that use participation as a means for empowerment. CRHP staff and community members point out that ensuring that all people, especially the poor, participate is a very slow process. In 1970, it took CRHP a year to get eight communities
to select and allow nine women to be trained as VHWs. In addition, it took a couple more years to begin organizing people for collective action. Overall, the project staff works with a community for at least eight to ten years before community members feel they can manage their problems on their own.

Limitations

As descriptive research, this study explains how communication is a means to participatory development. In particular, the cases explain how communication is integral to empowering people, diffusing information and organizing people for collective action. However, given the multi-sectoral approach and longevity of the project, it is hard to pinpoint when the communicative processes begin, how they evolve and when they are replaced by new communicative processes. For instance, learning circles to improve self-efficacy have worked to empower people but it is hard to tell whether the same activities that are performed today would work in the future. And it is even more difficult to extend these findings to other communities, as all projects are run differently. Therefore, the validity of the findings reported should be understood within the boundaries set by CRHP as an organization, the leadership qualities of the Aroles and the project’s relationship with the communities.

The research used multiple data collection methods, which were useful to gain different perspectives from the participants and to validate some findings that were consistent across methods. However, another commonly used method to validate the findings is doing a member check. In this method, participants are asked to cross-check the interpretations of the data. The researcher could not achieve this while in the field due
to lack of time, primarily on the part of the participants. A member check of this sort requires going back to the research site, looking up the participants and in this case, translating the interpretations into the participants' language, Marathi. The cost involved in doing this kind of data validation was prohibitive.

Another limitation is the difficulty in isolating time as a contributing factor to social change. In other words, due to many participants’ prolonged engagement with CRHP, it was almost impossible to distinguish when particular events had occurred and how these events changed over a period of time. For example, older participants talked about community organizing and collective action that was common twenty years ago as though they were still practicing it today. And among the newer communities, participants found it difficult to explain what changes have occurred, as some of the efforts are yet to have an impact on people’s lives. However, at times the reverse was also true; older communities reported that nothing new happens in their village because people have become accustomed to being involved in community action. On the contrary, new communities report everything that is different in their lives since they began collaborating with CRHP.

In addition, over a period of three decades there have been many changes in these communities as in other villages across India. For instance, roads have been built, villages have been electrified and there is access to modern communication such as media and telephones. These changes have impacted individuals and communities, but the impact cannot be isolated from CRHP’s multi-sectoral development activities. Perhaps the biggest limitation due to these larger changes in society is to understand how much
information about preventive health and new social practices is primarily due to CRHP’s training and health promotion activities, and how much causes from other sources.

The researcher could not actively involve the community in the research process because many participants were busy due to the harvesting season. The only exception was some members who performed rapid rural appraisals using village and seasonal maps and half a dozen men and women who took photographs to depict social change in their lives and community. However, the ethnographic methods fit the purpose of this study, which was to understand how people participate in improving their well-being and what CRHP does to facilitate this participation. As a result, the focus was on learning from the participants about what they do as opposed to allowing participants to become active in the research process.

Despite these limitations, the present research demonstrates how theories about communication for participatory development can be informed by analyzing the practice of communication in a project steeped in community participation. The study also shows that integrated and ongoing communication efforts can contribute to the empowerment process. And it shows how communication is the means to facilitating participation in development projects that are bold enough to challenge the existing social practices and make a difference in the lives of the poor.

Scenes from Jamkhed: II

Let’s revisit Jamkhed through the story of Ganpat Waibhat. At first sight, Ganpat, a resident of Jamkhed in his 50s wearing a long white shirt, \textit{dhoti} (a special type of pants) and a small white cap, can pass for an ordinary village man. But what is extraordinary
about Ganpat is that he values who he is as a human being and tells you he is who he is because of Jamkhed and Drs. Arole. When Ganpat was about 15, he was a poor boy who had dropped out of school and was working as a laborer on construction sites. His father had died when he was very young, so he had to work and provide for his family at a young age. Around that time, in the early 1970s, Ganpat found himself working on the construction site for the CRHP hospital and training center. Upon completion of the hospital, Ganpat asked the doctors, Raj and Mabelle Arole, for a job as a guard or janitor in the hospital. The Aroles had liked Ganpat’s dedication to his work so they offered him a job, but also told him that he had to learn new skills so he could be more helpful in the hospital.

Given Ganpat’s experience as a mason and his natural inclination to make things with his hands, he was asked to go to Jaipur in northern India to learn how to make the Jaipur foot, a prosthesis used by amputees. Ganpat was thrilled; he would be spending a few weeks with one of India’s best-known orthopedic doctors, Dr. Sethi, who had invented a simple yet durable wooden leg suitable for Indian sitting habits and affordable to the poor. Upon completion of the training, Ganpat and two other lay people in Jamkhed were responsible for making the wooden prosthesis. Soon afterwards, Ganpat found himself in a workshop in southern India learning how to make puppets and use strings to make movable puppets. Ganpat began making puppets and, with the help of the doctors, wrote skits that used traditional entertainment media and would become the cornerstone of health promotion in Jamkhed.
What is unique about Ganpat and other men and women like him from Jamkhed are the opportunities given to them by CRHP. The Aroles invest in ordinary people and provide them with the knowledge and freedom to develop to their full potential. These characteristics of CRHP are central to the principles of communication for participation development. CRHP has been doing this on a sustainable basis for over three decades, which has resulted in improved health, social and economic indicators. Moreover, many villages have reached a point where local people have taken control of the project activities and asked CRHP to work with other poor communities in the region. CRHP continues to work with people who need them the most, and it shares its vision of development by training people who can replicate and adapt the success of Jamkhed in other regions of the world.
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APPENDIX A: QUESTION GUIDE FOR INDIVIDUAL AND GROUP INTERVIEWS

Purpose of the data collection is to learn about: communication, empowerment and participation that has lead to positive social change in the villages in Jamkhed due to CRHP activities from the mahila mandal, Farmers’ Club and Self-help Group Members.

(Preferably choose at least two-thirds to three-fourths of the women to be 18-35 years of age, married, and pregnant or with 1 or more living children. Their membership with MM can vary but they should be active for at least 1 year).

Begin by saying: I am requesting you to share with me your experience as a MM/FC member, specifically with respect to a) how you learned about it, b) what motivates you to be a member and c) how you participate in the different activities and tasks?

1. Demographic information
   i. village name
   ii. name
   iii. age
   iv. caste/religion
   v. age at marriage
   vi. occupation
   vii. husband’s occupation
   viii. number of children (number of living children)
   ix. number of people in the household
   x. housing type
   xi. ownership of livestock
   xii. MM/FC member since

2. Community Organizing and Change
   i. How did you learn or come to know about the MM/FC in your village?
   ii. What motivated you to want to join the MM/FC?
   iii. As a MM/FC member, today what do you do that is different than before?
   iv. Would you say that your life has changed in some respect because you joined the MM/FC and thus learned new knowledge?
   v. How has your life changed? Can you give me some examples – have you gained more confidence, you get more voice in the house, you have begun feeding your children differently, your husband is happy that you have learnt new knowledge, etc. (I may use these probes if needed)

3. Community Participation (probe for involvement in the Triple A cycle)
   i. As a MM/FC member, in what kind of activities do you participate?
   ii. In what ways do you participate in changing the conditions in your village?
   iii. Who motivates you to continue to be a MM/FC member?
iv. How has the VHW helped in facilitation?
v. How has MHT facilitated you to continue to be MM/FC member?
vi. How have some of the other members of MM played a supporting role?
vii. What specific activities at CRHP (weekly training, regular visits by MHT, seminars at CRHP, etc) have helped in encouraging your MM/FC to carry out its work in your village?
viii. How has the community supported your MM/FC your activities?

4. Participation and Self-interest (Why and how do women and men participate)
i. Since becoming a MM member, how are you able to take control or make decisions in your life or for your family? Can you give me some examples?
OR Since becoming a FC member, what changes have happened in the way you work?
ii. How has joining the MM/FC benefited you and your family?
iii. What do you do differently today now that you have received information and training from CRHP?

5. Barriers to Participation
i. What barriers or constraints did you or do you face to be an active MM member?

6. Changes in the Community
i. What changes have you seen among your children or children in the community over the past few years (or since you joined MM/FC)?
ii. What changes have you seen among women and adolescent girls in the community over the past few years?
iii. What changes have you noticed or experienced in your village in the past few years?
iv. What do you think has facilitated these changes to occur among people and the village?

7. Communication and Education
i. How have you learned about the following topics?
   i. Health (of children, pregnant women, adolescent girls, elderly)
   ii. Social issues (harmful traditions)
   iii. Gender issues (treating girls and boys as equals, attending to girls’ and women’s special needs – nutrition, etc)
   iv. Environmental/hygiene (why and how to keep surroundings clean)
   v. Micro-credit (saving money to help women in need)
ii. How do you like to learn about these above topics? What makes it relevant to your life and who do you think helps you or can help you in learning it?
iii. What do you do with the information that you gather about the above topics?
iv. Most recently, what topics did the VHW discuss with you using the flash card?

v. What kinds of information have you learned from the flash cards that is with the VHW?

vi. When did you last attend the communication group’s performance? Do you remember any messages/information? How do you use that information?

vii. Do you think you get enough opportunity to share your knowledge with the VHW and other MM/FC members?
APPENDIX B: TIMETABLE FOR VILLAGE VISITS IN AUGUST 2004

<table>
<thead>
<tr>
<th>Date</th>
<th>Day</th>
<th>Village</th>
<th>VHW</th>
<th>Staff</th>
<th>Village</th>
<th>VHW</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug 26</td>
<td>Thursday</td>
<td>Karhewadi</td>
<td>VHW Staff</td>
<td>Draupadi Bangar &amp; Gayabai Sangle</td>
<td>Pimpalkhed</td>
<td>Munna B. Sayeed</td>
<td>MHT</td>
</tr>
<tr>
<td>Aug 27</td>
<td>Friday</td>
<td>Jawalka</td>
<td>Babai Sathe &amp; Sarubai</td>
<td>Jhadav</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aug 30</td>
<td>Monday</td>
<td>Pimpalkhed</td>
<td>Munna B. Sayeed</td>
<td>MHT</td>
<td>Pangulgawhan</td>
<td>Jhadav</td>
<td></td>
</tr>
<tr>
<td>Aug 31</td>
<td>Tuesday</td>
<td>Ghodegoan</td>
<td>Yamunabai</td>
<td>MHT</td>
<td>Sharadwadi</td>
<td>Rambabai Sanap</td>
<td>Jhadav</td>
</tr>
</tbody>
</table>

Repeat visits

| Sept 2 | Thursday  | Pimpalkhed | Karhewadi |
| Sept 3 | Friday    | Ghodegoan  | Jawalka  |
| Sept 6 | Monday    |            | Pangulgawhan |
| Sept 7 | Tuesday   |            | Sharadwadi |