Centralizing Context and Culture in the Co-construction of Health: Localizing and Vocalizing Health Meanings in Rural India

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Centralizing Context and Culture in the Co-construction of Health: Localizing and Vocalizing Health Meanings in Rural India

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A growing number of communication scholars have articulated the need for understanding context as a key component of health meanings. In this project, the authors seek to explore the role of context in the domain of health meanings in tribal India. The tribal population in India comprises people who have been consistently isolated and exploited, and stripped of their rights and resources. Interest in their health is propelled by this marginalization and their existence in the twilight of tradition and modernization. This article, through the use of participant narratives and a grounded theory of analysis, aims to lay out how meanings of health are contextually constructed by tribals in India. The results demonstrate the constant pain and hardship that envelop their lives, their pining for structural capabilities, and a dialectical tension between tradition and modernization in the coexistence of multiple treatment options.

In recent years, an increasing number of scholars have articulated the importance of locating and understanding context in the development, measurement, application, and evaluation of health communication theories (Dutta-Bergman (2006); Ford & Yep, 2003; Marshall & McKeon, 1996). Following the work of other health communication scholars who have sought to introduce context in the study of health, Dutta-Bergman (2004) examined the meanings of health among tribal participants in rural India, pointing out that these understandings of health are embedded within the context surrounding health behaviors. This project seeks to build on Dutta-Bergman’s (2004) work on health meanings in the realm of marginalized tribal populations by specifically exploring tribal constructions of the contexts that surround health in rural India (Dutta-Bergman, 2004; Ford & Yep, 2003; Marshall & McKeon, 1996). In doing so, it seeks to centralize context as a defining construct for understanding health communication processes.

The specific interest in tribal health is propelled by the increasing marginalization of tribal populations within the Indian landscape and their existence in the cusp of tradition and modernization (Guha, 1988; Guha & Spivak, 1988). We are interested in understanding the dialectics of tradition and modernity in the domain of health meanings in tribal India, situated in the geographical spaces that share the markers of tradition and modernity. We realize the wide scope of and the existence of a great deal of diversity within the tribal communities of India. At the onset of our article, we would like to point out that what we report here is a small part (collected within a specific geographical region) of a multisite project that was started in 1998. There are multiple pockets of different tribes spread all over India and this study is definitely not an attempt to generalize to the lives of all of these different tribes. Instead, this preliminary analysis is an effort to include voices of tribals in the “consultable record of what man has said” (Geertz, 1994, p. 231). In spite of the duration and extensive data gathering involved in the project, we can only reconstruct our coconstructions of meanings with the tribal participants within the limited geographical space.

CULTURE, CONTEXT, AND COMMUNICATION

The culture-centered approach to health communication builds on the agency of cultural participants in drawing
health meanings and in articulating the key problems faced by the community (Dutta-Bergman, 2004; Ford & Yep, 2003). In doing so, it foregrounds the role of context in defining the health experiences and health meanings of participants (Airhihenbuwa, Makinwa, & Obregon, 2000; Dutta-Bergman, 2004). Ford and Yep (2003) specifically discuss the sociocultural, economic, and political contexts surrounding the health of marginalized populations. For Melkote, Muppidi, and Goswami (2000), the economic and social contexts of AIDS are critical to the development of meaningful HIV/AIDS prevention efforts. Knowledge of HIV/AIDS and the perceptions of risk are embedded within contextual factors such as poverty, literacy, education, class, race, and gender (Mukherjee & Chatterjee, 1993).

The social and economic contexts not only influence knowledge, attitudes, and beliefs of prevention efforts but also the access of participants to health care services. For instance, Dutta-Bergman (2004) pointed out that tribal participants living in poverty often experience lack of access to prevention and treatment options. In this instance, the economic context defines the health experience of the tribal participants. Airhihenbuwa et al. (2000) observed that affordability in the context of HIV/AIDS is a key indicator of socioeconomic status, and is critical in the realm of access to combination drug therapy. Highlighting the economic context surrounding health experiences, Marshall and McKeon (1996) observed that women living in poverty are less likely to seek health care because they are forced to focus on more immediate needs, such as food and shelter, and are faced with barriers such as lack of transportation, unavailability of appointments, and absence of child care services. In these instances, context defines the health experiences of the community members by defining the limits of what is accessible and inaccessible. Therefore, essential to the culture-centered approach is the emphasis on dialogue as a conduit for presenting the context surrounding health outcomes. It underscores the importance of participation of community members in the context-based articulation of health problems as a first step toward achieving change that is meaningful to community members.

The inclusion of context allows health communicators to engage with marginalized communities in ways that view their cultural norms as existential enablers and work with them to facilitate the desired health behavior change and build community capacity through member participation. For instance, the dependence on oral modes of communication in African cultures can be perceived as an enabler and used to promote health messages with greater impact and reach, rather than being discarded or blamed for fostering resistance to behavior change (Airhihenbuwa et al., 2000). Culturally meaningful health communication entails creating a dialogic, participatory framework that allows the deprived to affirm their worldview, use their cultural knowledge and beliefs, and build on their strengths and needs (Dutta-Bergman, 2004; Ford & Yep, 2003). The participatory, dialogic approach empowers marginalized communities to talk about their existential realities, trial and error experiences, perceptions, needs, and capabilities. This “liberatory” (Ford & Yep, 2003, p. 249) process of engaging ensures that the cultural contexts surrounding the lives of the marginalized are incorporated into theory building and application development (Dutta-Bergman, 2004). In this project, we explore the role of context in the meanings of health among tribal participants living in rural India. The theorization of the contexts surrounding the health experiences of the tribal participants opens up the discursive space to the documentation of dialectical tensions that arise from the location of the participants in the borderlands of tradition and modernity (Papa, Auwal, & Singhal, 1995).

MARGINALIZATION AND TRIBALS IN INDIA

Be it the Berbers in Morocco, stripped of their land by oil multinationals, or the Santals in India, who have been historically denied access to the land they once owned, indigenous peoples have, through time and throughout the world, been forced to live a marginalized life. Marginalization can be defined as the mix of social, structural, cultural, economic, and political processes by means of which a group is ignored, trivialized, considered invisible and unheard, and/or perceived as the deficient “other” (Ford & Yep, 2003). With respect to a “mythical norm” (p. 243), these less privileged communities are deprived of access to structural resources. Marginalization has a direct bearing on health and health decisions because these “others” are shackled in terms of access to resources and in their ability to improve health and living.

Ford and Yep (2003) posit that the social, cultural, and economic experiences of marginalized members affect their daily lives and their relationship with the broader health care system. More specifically, in their research on abused Asian and Latina women, Ford and Yep identified several socio-cultural, structural, and economic factors that influence the health and well-being of the abused women. Similarly, Airhihenbuwa and Kumanyika (1996) observed that being Black and marginalized influences African Americans’ choice of healthy food. The case with tribals in India is similar to the extent that tribals experience marginalization in terms of their access to health-related resources, and this replicates the economic deprivation of other tribal populations. Dutta-Bergman (2004) pointed out that such marginalization is played out both structurally and through communication processes.

A review of the literature on tribal India demonstrates a great deal of debate around the definition of the concept of tribes in India (Hasnain, 1983). Considered the aboriginal inhabitants of India, the tribal communities are marked by their attachment to natural resources, geographic isolation from others, and strong kinship rules...
(Majumdar & Madan, 1967). Summarizing the disparate definitions of tribe, Naik (1960) points out that a tribe has least functional interdependence, has a common dialect, exists in comparative geographic isolation, and relies on a production–consumption economy. In spite of the large number of definitions of tribe (Hasnain, 1983), anthropologists and sociologists typically agree about the isolation of Indian tribes and their exploitation at the hands of the broader Hindu culture (Hasnain, 1983). The tribal landscape of modern India is imbued with the problems of poverty, indebtedness to moneylenders, land alienation, lack of access to education and health care, and lack of major resources of communication, such as roads and electricity (Majumdar & Madan, 1967). How then do these structural factors play out in the realm of health meanings? How does the context of deprivation interplay with how health is realized among the tribal participants? How does the tribal participant understand health and illness in the context of the sociocultural practices and the marginalizing modernization projects of India? The construction of the context surrounding health meanings among the tribals provides us with a starting point in locating the relationship between context and health meanings. Informed by the culture-centered approach to studying health communication, we ask the question

RQ: What is the role of context in the understandings of health among tribals in India?

METHOD

Data Gathering

Tata Steel Rural Development Society. Data for this article were gathered through interviews in the eastern Indian state of Jharkhand as a part of a larger project on tribal health in India that began in 1998 and is still in progress. The goals of the umbrella project are to (a) develop a theoretical understanding of health communication in marginalized spaces, (b) develop a systematic base of methods for data gathering in subaltern spaces, and (c) participate in a social change effort with the aim of securing access to resources. The interviews reported in this study were conducted in two separate health clinics run by the Tata Steel Rural Development Society (TSRDS), a voluntary organization of Jamshedpur-based Tata Steel, India’s largest integrated private sector steel company, which was established in 1907. TSRDS was established in 1979 to share Tata Steel’s resources with rural areas within which the company operates its business. TSRDS is headquartered in Jamshedpur, Jharkhand, and its units operate in 12 districts and 650 villages in the Jharkhand and Orissa states. TSRDS works in the realm of “corporate social responsibility,” including empowerment, income generation, and promoting health and hygiene. Tackling air- and water-borne diseases, providing eye and neo-natal care, and providing immunizations and treatments for chronic diseases like tuberculosis (TB), leprosy, and malaria are among activities that TSRDS undertakes in health care. (TSRDS pamphlet, “TB Clinics of TSRDS,” 2003)

As stated earlier, interviews with tribals, from which data for the project were culled, were conducted in two TSRDS clinics near Jamshedpur—a TB clinic in Kandra village in the Gamaria block of the Sareikella district, 17 km from Jamshedpur, and a mother-and-child health care clinic in Karandi, which is 10 km from Jamshedpur. On the days we conducted the interviews, almost all visitors to the TSRDS clinic at Kandra were TB patients. At the mother-and-child clinic, along with new and expecting mothers, we saw an equal number of TB patients. Both clinics offer TB medicines and checkups at a nominal rate of 5 rupees per patient (approximately 10 cents in U.S. currency).

Pulmonary TB is a highly prevalent disease in rural India, stemming mainly from factors like poor housing, lack of health awareness, malnutrition, long course of treatment (usually 7–9 months), lack of ability to buy medicines, and wrong treatment and guidance by ojhas (traditional healers; C. R. Sardar, personal communication, July 11, 2004). Although the Indian government has been running the TB Control Programme since 1956 (revised in 1967), results have not been too encouraging and TB continues to be a killer disease, particularly among poorer sections of the country’s population. The Centers for Disease Control noted in 2002 that every year nearly 2 million people in India develop TB, accounting for one fourth of the world’s new TB cases. It also noted that TB “causes more deaths in India (421,000) than malaria, hepatitis, meningitis, nutritional deficiencies, sexually transmitted diseases, leprosy and tropical diseases” taken together. (Progress Toward Tuberculosis Control, 2002)

TSRDS’ TB control programme has been running from 1987, encompasses six clinics, and the number of patients treated under the program has increased from 300 in 1996–1997 to 370 in 2002–2003. At the TSRDS clinics, suspected TB patients undergo a sputum test and are registered as TB patients once they test positive. They then go through a 9-month course of medicines provided at the TSRDS clinics. Their progress is mapped through visitations to the clinics and following the 9-month period, they go through repeat tests to check for incidence of TB. They are released from treatment if they are cured, or given a further 2-month dose of medicine if they are not. However, as Dr. Sardar noted (personal communication, July 11, 2004), and as we found in our interviews, several TB patients, particularly those living in rural areas, visit ojhas for treatment (following initial symptoms of consistent coughing, weakness, etc.). The ojhas typically perform ritual sacrifices and exorcisms to cure ailments.

Establishing contact, context, and setting. We established contact with Tata Steel’s public relations
division in Jamshedpur, and subsequently with TSRDS. Field visits to the TSRDS clinics were conducted with two doctors who oversee the two clinics, and TSRDS paramedical staff. At the two sites 10 tribal participants engaged with us in the coconstruction of meanings of health and illness.

The TB clinic in Kandra is temporarily set up every 2 weeks in a room in the local panchayat (government) office. The clinic is run by a TSRDS doctor and a paramedical staff member, and TSRDS medical personnel travel to the clinic with their medical supplies in company-provided vehicles from Jamshedpur. The doctor assigned to the clinic has a room to conduct the examinations, after which the patients line up on the porch to collect their medicines from the paramedical staff of TSRDS. We approached the patients who came for treatment to the clinic and asked each of them who had lined up for medicine if they wanted to speak with us on a study we were conducting on the health of tribals. Most of the interviews were conducted in a corner of the porch, where we recorded the responses of the participants.

The mother-and-child clinic at Karandi was set in a school building run by the local tribal youth club. This clinic saw a greater number of patients than the TB clinic at Kandra. Although most patients were women coming for natal care, there were several male TB patients, too. Again, we spoke to these patients—both male and female—while they lined up for medicines or were leaving the clinic. Most of the women we asked did not want to talk, and a few escorted women were not “well enough to talk.” Besides talking to the person who ran the tribal youth club (who was not a TB patient), we spoke to several TB patients—all male.

In all we conducted full-length interviews with 10 people, the interviews lasting 45 min to 1 hour. We conversed with 9 men and 1 woman living near the two centers we visited. One of our respondents said he was 14 years old, the other respondents were aged between 27 and 45. Two of them had come to the respective clinics to take medicines for patients in their household. The others were patients themselves, and 6 of the 7 had visited the respective clinics before. One of them—Durga—was a cured TB patient, who had come for medicines to treat a gaping wound on his left foot because he was very comfortable with the doctor at the clinic who had cured him of tuberculosis. Whereas Durga was working as a daily wage laborer in a roadside stall serving tea and snacks, one interviewee was a private tutor, one was a truck driver, one a school administrator, the six others were farmers. All of them either lived in villages far away from the nearby urban centers or had settled in semiurban areas, but still had relatives and family members living in villages.

Data Analysis

Our interview questions centered around age, occupation, earnings, place and conditions of living of the respondents and their families, their access to structural resources, how they dealt with health and illnesses, their beliefs and practices related to health and illness, proximity to urban sites and medical centers, and their opinions about governmental agencies and activities. The interviews were conducted in Bengali and were combined simultaneously with transcription, translation into English, and data analysis. Translations were done by the researchers, who grew up speaking both languages (Bengali and English). Given the emphasis on context, the grounded theory method of analysis was particularly well suited to analyzing the data for this study (Strauss & Corbin, 1990). As outlined by the grounded theory approach, data analysis proceeded side by side with data gathering and the interviews were continued until conceptually dense theory was derived from the data (Strauss & Corbin, 1990). A culture-centered theory of health was generated by using the constant comparison technique (Strauss & Corbin, 1990). Open coding, axial coding, and selective coding were systematically used to test the fit of new pieces of data with the emerging theoretical framework.

The data analysis started with open coding to identify discrete concepts that could be easily labeled and sorted; subsequently the discrete concepts that were related to the same phenomenon were grouped under conceptual categories. Open coding was followed by axial coding that involved the formulation of relationships within and among the categories; finally, theoretical integration was achieved by selective coding. At this stage the relationships among the distinct categories were established at a more abstract level and were validated by returning to the data and finding evidence to support or refute the relationships (Strauss & Corbin, 1990). The two interrelated themes that emerged through our narrative coconstructions are (a) living in the twilight zone, and (b) the dialectic of tradition and modernization. The first theme develops a spatial locus to the contextual meanings of health, and provides the fulcrum for understanding the dialectical tension between tradition and modernity in the area of health meanings.

LIVING IN THE TWILIGHT ZONE

One analytic theme that characterized the data that we gathered from interviews with our respondents was their existence in the twilight zone—the cusp between tradition and modernity. This theme embedded health within its geographical context, as a dynamic product of the space within which it is situated. In other words, meanings of health were spatially situated, with space playing a key role in the realization of health among the tribal participants. The participants highlighted their rural location as

1The full names have not been disclosed in order to protect the identities of the participants
a source of health meanings and as a central component of health. It is within this rural setting that we heard the narratives of poverty, lack of education, and lack of access to structural resources (including access to modern medicine). This lack of access, in turn, led to frustration with the prevailing sociopolitical system and subsequently dictated the way the participants dealt with health and illnesses, often leading them to take recourse to the traditional modes of healing that were more easily accessible. Although the participants discussed the central position of the rural settings to their lives, their narratives were also imbued with markers of modernity such as exposure to television, the urge to send their children to schools, migration to urban areas, changes in their beliefs about tackling illnesses, and increased propensity to use available modern medicines. It is within this context of hard-to-access rural settings imbued with certain elements of modernity that we observed a tension between tradition and modernity in the ways health meanings were constructed among the participants.

The Rural Connection

As articulated earlier, the contextual location of the spaces where we conducted our project was central to the health meanings of the participants. The centers where the interviews were conducted were located in semiurban areas. Traveling on TSRDS private vehicles, it took us approximately an hour to reach the clinics from Jamshedpur. However, several of the respondents live in villages far away from the nearest semiurban center, often having to spend significant resources (time and money) in getting to these centers. In discussing their health, participants highlighted this problem of geographical (in)accessibility as critical to their health experiences. Participants like Gangadhar, Lethar, and Bilom have little contact with the urban centers except the necessary visits to the TB/health clinics and urban commercial centers. Farmers by trade, the three say they (and other members of their community) come to the nearby small towns—Gamaria, Adityapur, Kadma, Kandra—to sell their produce, to buy necessities like clothes, or to go to the TB clinic for medical visits. They travel by bus, which sometimes takes as much as 30 min, or on bicycles, which sometimes takes approximately an hour.

Essential to the context is the lack of access to the signifiers of modernity. The tribal participants point out that in some of their villages there is no electricity (although Narayan says his village will soon have electricity). Government facilities such as schools and health centers are nonexistent. Therefore, the rural areas where the participants live are clearly demarcated from the urban settings of modern India by the lack of access to resources such as schools, health centers, electricity, and roads. The narratives of health and illness that emerged from the interviews are located within this context of separation from the amenities of modern India. The distance from the urban centers is not only physical but also material with respect to the way of life of the tribal participants and their access to resources. This physical and material distance inhibited access to and knowledge of modern medical amenities, often leading the participants to rely on traditional beliefs and practices in terms of health and healing (to be discussed later). The rural spaces where the participants lived were also tied in with poverty such that lack of access was not only geographical but also economic in nature.

Poverty and Access

Poverty lies at the core of tribal life in India. Therefore, the discourse of health is located in relationship to poverty, in relationship to the discourse of trying to find work. The contextual exploration of health meanings suggests the importance of locating health within the context of work lives of participants in the marginalized sectors of the globe. The participants systematically discussed their lack of health in the realm of lack of adequate resources. This lack of adequate resources, in turn, was related to the work life of the participants. Most respondents earn a pitance, mainly through agriculture. Gangadhar’s family earns 700 rupees a month (approximately $14). They survive on the rice and the vegetables they grow in the field. During the off-season (seasons when vegetables cannot be grown) some people in Gangadhar’s village work as daily laborers with contractors in nearby towns. However, these jobs are hard to come by. Here is a snapshot of a conversation with Gangadhar, exploring this context of work that surrounds health of the tribals:

What is your occupation? Work as in farming.
What else do you do? [a probe we learned through our earlier interviews] Some related activity. Growing a few vegetables here and there.
Are all families in your village engaged in farming? Yes, farming. Some also work as daily laborers with contractors in nearby towns.

Note the uncertainty surrounding jobs and the multiplicity of jobs that need to be juggled in order to make a living. Similar concerns are shared by other participants. For instance, Lethar works as a mason besides working in his fields. Bilom, besides farming, does some work under contractors whenever and wherever he gets them (thikadari, hettha hotha). His earning for his eight-member family comes to 1,500 rupees a month (approximately $30).

Well… It comes to 1500 rupees. Some contract work here and there… the family income is around 1500 rupees. Well… I am not doing much work. Sometimes from contract jobs (thikadari) I earn 40 rupees, 35 rupees (less than $1) per day.
How many members are there in your family?
There is my mother. My father has passed away. There is my grandfather, grandmother (didi-buri, dada-buro), I have one brother and three sisters.

In each of these narratives, we witness the struggle for daily resources and the shuffling of multiple jobs to make ends meet. The money earned from a single job does not cover the basic resources needed by the family. In addition, the work life of the participants does not promise a stable income. It is important to note the uncertainty in the voices of the participants as they talk about work. Whether one is able to find work depends on the season, introducing a great deal of uncertainty in the life of the tribal participant. Income varies from month to month, week to week, day to day. This uncertainty reiterates itself as a central theme of the narrative of poverty, constraining the flow of resources and thus impacting the ability to seek out health. This struggle for survival, as we see later, pushes health and education into the back burner. For Bilom, Lethar, and other people in their villages, poverty forces them to make do with whatever resources they have in terms of health. As a result, we see (later) how visitations to the ojha take precedence over trying to access modern medicine, which is costly and not readily accessible to the tribal participants.

For the participants, education holds the key to finding access to work and securing a stable source of income. It is this stable source of income that generates greater opportunities for accessing health care. The interlinkage between education and access to health resources is evident in the narratives coconstructed by the tribal participants. The lack of access to education breeds a vicious cycle because education is considered a critical ingredient in the ability of the modern-day subaltern participant to secure resources for the future. This point is captured by Bilom, who responds to our question about the education of his younger sisters, who do not study. On probing him further, he states, “Ya, there are some difficulties, moneywise. Well, you have to buy books and all.” Durga, who earns 10 rupees a day working in a tea stall, seems very angry at what he thinks is our abject inability to understand the circumstances (poverty, need to feed himself and his family members) that have led to his leaving school when he was in Standard (Grade) 5. When asked about his education, he replies, “If you do not work, who will feed you? If I study, no one will do that, is it not so?”

As articulated earlier, poverty also has its detrimental effects in terms of providing or impeding access to health resources. Mougli is a TB patient and comes from Purandi. She travels 40 km by bus to the Kandra TB clinic with her brother, almost her age. The bus ride is very costly for her, she articulates. It costs her 14 rupees per head one way. She says there are paramedics and ojhas in her village. She says there are no qualified (educated [porashona jana]) doctors like the one who treats her at the TB clinic in or around her village.

Paying for health needs and visitations to the doctor then becomes a problem, as Lethar notes: “We have difficulty paying at times to the small and big doctors [paramedics, qualified doctors].” Even access to the doctors that Lethar talks about becomes difficult for lack of quick and cheap means of transport, besides the money required to pay the doctor. Using the cheapest mode of transport, the bicycle, is not feasible when a patient is seriously ill. Nor are villages connected to bus routes. So when Bilom’s grandmother was seriously ill, he says he had to spend a large sum of money—180 rupees ($3)—to reserve a tempo to take her to the health clinic situated in the nearby urban center (approximately 10% of his monthly income).

Within this contextual backdrop of geographic and economic inaccess, the interviews bring to the surface a sense of frustration at the failure of the sociopolitical system to ensure access to resources among the tribal participants. Gangadhar rues that the government does nothing for people like him. Bilom seems pretty unhappy, too. There are no government facilities near his village. If a person is sick, she or he has to be taken quite a distance from the village. He makes his displeasure clear: “And we keep telling those government people who come to hold meetings in the village. We tell them about health center. … But there is no response from them. They went away. … But you know Duraijan is from our village. He tells us that if we do not vote for him we will not get anything out of or ration cards [laughs].”

Evident in Bilom’s narrative is the fact that the constant struggle for resources, the overriding need to meet basic necessities of life, is only exacerbated by the systematic neglect of subaltern needs within the broader political–socioeconomic landscape of India. An emergent theme in the discursive space is the strong awareness of the sociopolitical–economic context that surrounds the lives of these subaltern participants. The frustration of the participants is juxtaposed with the backdrop of narratives of hope, marked by the changing times in the sociopolitical sphere of tribal India.

Changing Times

The narratives elucidate an awareness of the changing social landscape in modern-day India by articulating the different ways of securing access (through education and seeking out jobs in the cities). Several narratives signaled a move toward modernity—in terms of increased literacy, exposure to mass media (televisions), migration to urban centers for jobs and greater earnings, and in the mores of negotiating health and illnesses. Bilom talks about television sets in his village (television is considered a symbol of modernity in rural India), Raipur, even though the ratio of televisions to the number of people in his village is as low as 3:500. Communal television watching is a popular pastime and this is what Bilom has to say:
There is one [television] at the tola ... where the gram panchayat [local government] meets. There is one with the mondols [doctors] ... three in all.

Do you watch television?
Yes, whenever time permits.

Use of the television signifies a move toward urbanization in these rural areas because the television is still very much an aspiration for the villagers, a wealth that the rich people (babus) in the cities possess. A measure of the seepage of the popular mass media is evident when Narayan states that even though there is no electricity in his village, residents have gone as far as buying batteries and getting their television sets hooked to the batteries. Although most respondents live in villages far away from the nearest towns, they seem to be in a frame of transition—not fully affected by the amenities of urbanization, yet not completely rooted in their rural mode of living—a notion exemplified in the visible changes in the attitudes and action regarding education.

As pointed out in the previous section, with poverty and access to education very restricted, most of the respondents have either not been educated at all or have quit school at an early age. However, most of them either have their children (mostly sons) studying or talk of people in their villages who are educated. Education offers hope for the tribal participant, a point of entry into a life with access to health care and the other fruits of modernity. Lethar is illiterate but has his son in his brother's house in town so he can go to school. Bilom is a matriculate and his brother too is enrolled in school. Narayan provides evidence of this: “A lot of people in my village are educated. The village has a high school and there is a middle school nearby.” Narayan’s narrative also exemplifies the increased sensitivity toward education among the semiurban tribes. The tribal youth club in Karandi—a rural pocket on the outskirts of Jamshedpur—that he oversees, runs a primary school. The language of education is English. This is what Narayan has to share:

Here we have from Lower Kindergarten to Standard [Grade] 6. It's all in English. It's an English language school. ... Children come, they learn and go. The parents have become aware and there is an interest among them to have their children educated. So they send them to school.

As an appendage to increased accommodation of education, comes the search for jobs in urban centers, jobs that help to earn more than traditional farming. This, in turn, has led to increased migration. Biswanath says sons in the village who are educated generally leave the village to live and work in urban settings like Adityapur and Tatanagar. Karam does not stay in his village anymore. He lives with his wife and children in a rented house in Kandra because he “does his duty” there. He has moved out of agriculture to working with contractors (in pipeline projects). His earnings have doubled, too, at the amount of approximately 2,500 rupees a month.

Narayan, too, has left his village. He is a graduate and works as a supervisor of the school run by the tribal youth club in Karandi.

I am the head clerk of the school, the treasurer of the tribal youth club and its sports secretary as well. I get my salary from the club. And what I said is my work. I get paid for that.

You are not engaged in agricultural activities?
No, I am not.

He, too, talks about people from his village traveling to the towns because some people have relatives—some have parents and some have brothers—who work in the towns.

What do people in your village who are educated do?
You have Rourkela, Tatanagar, Kolkata (urban centers) ... there are people who have got jobs in these places. They have left the village and live in their workplaces.

This migration to the urban spaces creates access to health care, both geographically and economically. The participants discussed their greater ability to receive medical treatment in the cities as compared to the rural areas. The juxtaposition of geographical and economic (in)access with the backdrop of the changing times provides the setting for exploring the negotiation of treatment choices in tribal India. The next section specifically examines how treatment is negotiated among tribal participants, drawing attention to the dialectic of tradition and modernity embodied within the geographic and economic contexts of the lives of the tribal participants.

NEGOTIATING TREATMENT AND THE DIALECTIC OF TRADITION AND MODERNIZATION

That the times are changing reverberates in the discursive space around seeking out different treatment options. Located in this twilight zone—between modernity, education, exposure to mass media, on the one hand, and deep-rooted traditional, cultural practices on the other—health and illness beliefs and methods of negotiating are in the process of a gradual shift. Intermingling, through increased interaction with the urban or semiurbanized population, the seepage of mass media in the village environs, increased urban migration seems to have structured a more modernist approach to the way the respondents look at health and illness. But that does not seem to complete the picture. The ambivalence in the lives of the respondents—their lack of access to structural resources, along with the effort to imbibe elements of urbanity—also keeps them clutching onto their deep-rooted cultural mores, seeking out traditional ways of healing when access to modern methods is difficult.
Narayan’s views on health and the way people in his village, Rora, deal with illness exemplify the importance of tradition. He not only says people in his village worship gods to get rid of illness, he also talks about traditional beliefs and how his people cling onto them, like visiting the ojha:

For them it is like something, some illness has suddenly come upon them. Like suddenly headache comes, or suddenly body ache comes, or may be stomachache comes suddenly. So what they try to figure out is why the illness has come suddenly... They think it should not have come suddenly and since it has, it means there is some problem somewhere. Problem means someone has... someone has... cast an evil eye on them. That’s what they think. And if they believe that it’s an evil eye that is causing the illness, they will first resort to jhar-phuk [exorcism].

The notion of holding onto cultural practices is articulated in the way Narayan constructs the worship of the traditional rice beer (handiya).

Everyone drinks handiya. We even worship handiya. We worship it during Diwali. Then our sarhool... We believe if we do not worship handiya at our homes during Holi, within 1 month or 2 weeks some unhappiness, some sickness, suffering comes to our home.

Now when this happens, we get the ojha. He looks around and realizes that we have not paid tributes to the god. He can make out that we have not done so.

These “strong beliefs,” as Narayan describes them, are held onto and proudly cherished even among “graduates” like him because “it is not about education. It is about customs, rituals, and traditions. We believe in it because it has come down through generations.”

Bilom reiterates the notions of going to the ojha and traditional sacrificial practices like khukri (sacrificing poultry). Karam and Konda share the same beliefs. Konda first went to the ojha when he fell ill, and when that did not work, he came to the TB clinic. He talks about worshipping gods at home and sacrifices to appease the gods: “We have gods in our home, we do some sacrifices. ... I do not know much about that. The elders in the family do it and worship, We follow what they say. ... When someone is ill ... we go to the doctor. If that does not work, ojha-pati and puja [worship of gods].” Note the usage of multiple forms of treatment articulated here. This multiple approach to illness and cure emerges in the way a number of respondents try to situate modern medicine and traditional mores in their negotiation of health and illness. For some it is the ojha first and then the doctor, whereas for others it is the other way around, or, at times, only and straight to the doctor. For instance, Gangadhar did not go to the ojha in his village when he was ill, although he tried jori-buti (herbal medicines) from the kobiraj (Ayurvedic doctor) in another village. However, he is quick to reiterate that when he finds the herbal medicines not working well, he will visit the doctor in town, “When his [kobiraj] medicines do not work, then we go to the doctor.” The multiplicity of beliefs regarding treatment is also articulated by Lethar, who adds that he does not believe in ojhas anymore, “there is no more of this ojha business now. Not much of it.” Bilom and his folk first go the village doctor [mondol], then to the ojha or worship gods: “First we take him (the sick person) to the doctor. ondol... We go to ojhas too. When we see that the mondol doctor’s medicines don’t work, we go to the ojha.”

There is an increasing realization among the participants that the treatment of the ojhas does not always work. And they would prefer to go to a doctor in the first instance, if a doctor was available nearby. Availability is the key here. Karam talks of Monohar doctor in his village and says people in his village first go to him for his pills and when he is not around, they come to the towns. Notable in his mention is the idea that when people are seriously ill, they have to be brought to the nearby town—to the nursing homes in the towns. “Sometimes people get serious. So we have to get the sick to nursing homes.” The multiple modes of tackling illness come to the fore in this narration: “When someone is ill... we go to the doctor. If that does not work, ojhas and god.” People in Narayan’s village first go to the lone “private” doctor near the village:

...First we call the doctor, who is available there, the privately learned doctor, home. He prescribes medicines and/or injections. ... And if the condition of the patient is serious, we get him to Rajnagar, which is nearly 3 km from the village.

Narayan’s words demarcate the serious illnesses from the trivial ones, and they lend to the thought that the multiple approaches to illness are also based on these types of illnesses. A serious illness warrants a visit to the doctor in the nearby town, but a trivial one can be gotten rid of by visiting an ojha or an Ayurvedic practitioner.

If there are illnesses like headaches, stomachaches or general unease in the body, we first go to the ojha. They are in the village itself. You know what they say when we go to them? They will say, this illness is due to some fault. Someone else must have done something to have caused you this illness, that is what they say. Then they will say they need a few things to rid the patient of the illness. They will say they need sacrifices. Some say they want sindoor (vermillion) and such other items that they want. Then with all these things they offer some sort of a sacrifice. And some people get well after this. For others who do not get well, we take them to the doctor. First we go to the ojhas.

An increasing awareness that ojhas are not always able to cure illnesses seems to catching on, too. Konda, who went to the ojha first, says the ojha told him
Evil spirits are troubling you. You need to offer a sacrifice. Then we offered a sacrifice. But then I realized that all this would not help. So I told my wife, “you spoke of the paramedical staff that goes to the clinic at the school, let’s go with her.”

He narrates how people go to bhagna doctor once the ojha fails to cure. And when the bhagna fails to cure too, the patients are moved to the hospitals in nearby towns. Sukhhal says, “If the ojha is able to cure us, fine. Otherwise he tells us to go to the doctor. We then come to the doctor.” This apparent shift away from the kobiraj and/or the ojha to modern medicine seems to have led to increased use of private nursing homes or health clinics in the urban locales. Biswanath talks of a government health center where once a week a doctor, a nurse, and a compounder are available. He also talks of his village folks coming down to Gamaria (2–3 km from the village) to clinics and nursing homes there. Bilom mentions coming to a nursing home, even though that entails renting an auto rickshaw and paying 200 rupees ($4). And although the trip costs a lot, Karam says people like him are left with few alternatives when an illness is serious.

**DISCUSSION**

What are the important lessons learned from our journey among some of the marginalized spaces in India that exist at the borderlands of tradition and modernization? Before articulating the key narratives that emerged during the conversations, we feel that it is important to go back to the roots of this project and explore our interest in the narratives of marginalized people. This project of coconstructing the narratives of tribal health originated from our interest in examining the nature of health communication in marginalized populations, particularly in the realm of context as a construct that shapes meanings of health. Context was placed at the core of our project. In other words, we were particularly interested in learning how health communication could be theorized from the marginalized context, and how context influenced the process of seeking out treatments for different illnesses. Therefore, our primary goal was to theorize the role of context as a source of meanings related to health. In addition, we embarked on this project because we felt the need to locate the agency of subaltern participants in constructing the narratives of pain and hardship that envelop their lives.

The narratives that emerged in the study demonstrated a heightened sense of awareness among the tribal participants about the lack of resources that enveloped their lives. Structure emerged as the key component in the articulation of health. Time and again, we heard narratives of deprivation from basic resources. Juxtaposing health and education as valuable resources, the participants pointed out that they did not have access to either of these basic resources. Structural deprivation was played out through the contexts of geographic location, economic deprivation, and instability of work. The rural location of the field setting was at the core of the experience of health and treatment of the participants. Being located away from the semiurban sites of modernization, the participants had to travel to nearby towns to find access to education and health care. They also discussed the need to migrate to the cities in the search of education and jobs, the markers of livelihood in modern civil societies. This is part of a larger trend in the Indian subaltern space; more and more peasants are migrating from the villages to the metropolitan centers in search of a better way of life, rapidly shifting the demographic landscape of the country. The geographic context of being separated from the mainstream resources was reinforced by the economic context of lack of access to basic medical care that was typically expensive for the participants. The lack of modern resources was present simultaneously with markers of modernity such as the presence of television, the hope that education would provide points of access to the fruits of modernity, and the migration to the cities in search of jobs, suggesting what we called a twilight zone between tradition and modernity. In other words, the context embodied the simultaneous existence of tradition and modernity in a seamless web that surrounded the life of our tribal participants.

In summary, the context brought out in our conversations with the tribal participants highlights the role it plays in constructing health behaviors of participants in marginalized spaces. In this case context was deeply intertwined with the attributions of causality and the process of seeking out treatment options. Context was both geographic and economic, and was dynamic in nature, often demonstrating the possibility of coexistence of multiple categories that are often conceptualized as mutually exclusive dichotomies. For instance, in our project, tradition and modernity were both embedded in the ways of life of the tribal participants. Also, it is this very context that shaped the complexity of meaning structures in the realm of seeking out treatment options. Future health communication scholars ought to further explore the role of context as a defining variable in the realm of health meanings.

The location of the tribal participants at the crossroads of tradition and modernization manifests in a dialectical tension between tradition and modernization in the way the tribal participants seek out different treatment options. The process of seeking out treatments demonstrates the coexistence of multiple positions. Similar results have been observed by Dutta-Bergman (2004) in his study of the Santals. The tribal participants demonstrated variance in the order in which they sought out the different treatments. Whereas some participants first went to the ojha or kobiraj before going to the doctor, others reported going to the doctor before visiting the ojha or the kobiraj.
The articulations also indicated the simultaneous usage of the different treatment options, suggesting a polymorphic system of health meanings. In almost all cases however, a distinction was made between minor and serious illnesses. When the illness was serious, the patient was taken to a nearby hospital. However, minor illnesses were more easily treated with traditional healing methods. The choice of treatment option was determined by the needs faced by the participants.

In the narrative of the tribal participants, the dialectical tension between tradition and modernity also emerged in the attribution of causality of the illness. For some respondents, the explanations are scientific, whereas for other respondents the explanations are located in the appeasing of the gods. In yet other cases different attributions of causality coexist. We also observed a generational difference in the affiliation with the traditions of the community, such that the older members of the family are entrusted with the responsibility of carrying on the traditions of the community. In summary, the narratives that emerged in the interviews demonstrate the agency of the tribal participant in making sense of his or her condition of poverty, located in the backdrop of the forces of tradition and modernization within the framework of globalization of India. The dialectical forces that emerge in this project raise the need for further research on the ways in which such forces play out in marginalized spaces at the cusp between tradition and modernization elsewhere in the world.

We set out to write this article as one that introduces voices of subaltern participants in the current discursive space of health communication. Our goal was to hear the voices, not to homogenize or monopolize the participants. Yet during our journey we realized that in drawing out the themes and presenting them, we were drawn toward generalizations and constructing the very monoliths we wanted to avoid. On one hand, we are drawn to the articulation of poverty as a central theme in the interviews (and hence run the risk of monopolizing the tribal experience). On the other hand, however, we also note the different voices that make sense of this poverty in different ways. The voices that talk about frustration and resistance demonstrate the hope and power of the subaltern people. We also note the multiplicity of voices in the articulation of the different treatments to disease and illness, the causality of disease and illness, and the coexistence of health meanings. Finally, we hope that our project moves us forward in contributing to policy change, playing a role in the struggle of the subaltern people in securing access to resources. To this extent, we realized that we had to draw thematic conclusions.

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