

The Unheard Voices of Santalis: Communicating About Health From the Margins of India

This article takes a culture-centered approach to exploring Santali meanings of health in rural Bengal. My conversations with Santalis and field journal accounts of interactions with Santali men and women bring to the surface critical issues and meaningful theories of health. The discursive constructions demonstrate that Santali health beliefs are polymorphic, accommodating multiple treatment approaches to disease and illness. Critical to Santali discourse is the acknowledgment of barriers created by the socio-politico-cultural structure encompassing Santalis. On one hand, Santalis talk about education as a salvation; on the other hand, they believe that the structure fundamentally needs to be challenged and transformed. Discourses of resistance and revolution emerge in the interviews, suggesting the necessity of locating agency in Santalis and their communities.

That marginalized populations ought to be the focus of health communication scholarship has been established by the increasing disparities between the health rich and the health poor (Marshall & McKeon, 1996; Viswanath & Finnegan, 1996). A growing body of evidence continues to support the theoretical conceptualization of knowledge gap theory, pointing out that health communication interventions contribute to enlarging the gaps between the rich and the poor instead of mitigating them, suggesting the need for a reconfiguration in health communication that focuses on serving marginalized people (Viswanath & Finnegan). In addition to the increasing disenfranchisement of the poor in the different realms of health, a review of the dominant health communication theories brings to the surface the systematic absence of marginalized voices in the discursive space (Dutta-Bergman, in press).

Pointing to the inadequacy of the dominant approach to health that minimizes the role of culture, Airhihenbuwa (1995) argued that the development of a culture-centered approach is critically important, em-

phasizing the role of health communication scholars in recovering the voices from marginalized spaces that have been systematically absent from the epistemic structures that are dominated by transmission-based models. In this project, I applied the culture-centered approach to document the co-construction of meanings in a marginalized community and in doing so, suggest the importance of theorizing alternatives to the dominant approach to health communication. This project documents my conversations with Santalis of Midnapur, West Bengal, with the goal of understanding how the life experiences of the members of a marginalized space shape their understandings of health. Considered to be the original inhabitants of India, Santalis stand at the cusp of tradition and modernization, struggling for resources in a severely impoverished environment (Mahapatra, 1986). The exploration of health meanings among Santalis (a) provides a template for understanding health communication among marginalized people whose voices rarely are heard and (b) offers an example of postcolonial health communication theorizing that is informed by the subalternity of marginalized people (Guha, 1988).

Typically, marginalized people are presented as subjects of health interventions in the dominant approach to health communication. Three theories/models of health communication—theory of reasoned action (TRA), health belief model (HBM), and extended parallel process model (EPPM)—have been extensively applied either separately or in combination to inform message design for campaign interventions (see Murray-Johnson & Witte, 2003). Founded on a transmission view of communication, these theories/models are used to identify beliefs, perceptions, and barriers that are then applied in the construction of strategic health messages on topics such as seat belt use, safe sex, smoking, healthy eating, exercising, drug and alcohol consumption, immunization, and mammography (Murray-Johnson & Witte, 2003). The development of praxis and the articulation of knowledge based on these dominant theories/models take for granted the voices of marginalized people in monolithically constructing them as the target audience of persuasive campaigns based on “universal truths” that are defined by dominant values, morals, and ideologies located in individual choice. Furthermore, these transmission-based theories/models that seek to modify individual behavior via persuasion perpetuate violence on subaltern spaces by imposing messages from outside that focus on changing cultural beliefs and practices. The culture-centered approach provides a point of departure from the dominant approach by articulating the very absences in the dominant approach and by emphasizing context in the construction of health meanings. In the following sections, I will provide a backdrop for Santali theorizing of health by discussing TRA, HBM, and EPPM and comparing them with the culture-centered approach.

Dominant Theories/Models in Health Communication

As suggested in the previous section, TRA, HBM, and EPPM are message-oriented theories/models that are widely used to inform campaigns targeting individual-level health behavior change via persuasion (Murray-Johnson & Witte, 2003). TRA explains that human behavior is most closely dependent on behavioral intention, which in turn is shaped by an individual's attitude toward the specific behavior and his or her subjective norms (Fishbein, 1990). Salient beliefs about the outcomes of the behavior shape the attitudinal component whereas the subjective norm component is shaped by the individual's motivation to comply with salient others in his or her social network, accompanied by the normative beliefs regarding the target behavior ascribed to these salient others. Once the probabilistic and evaluative beliefs have been identified, they are placed within a message design framework with the goal of achieving behavior change. Yet another model that defines the construction of messages is the HBM.

Based on the concepts of severity, susceptibility, benefits, barriers, cues to action, and self-efficacy, HBM is used to formulate communicative strategies for behavior change (Janz & Becker, 1984). Perceived severity taps into the individual's assessment of the negative outcomes associated with the preventive behavior and perceived susceptibility focuses on the individual's evaluation of the extent to which he/she is likely to succumb to the negative outcomes. Benefits refer to the individual's beliefs regarding the effectiveness of the proposed behavior in reducing the vulnerability to the negative outcomes, and barriers are those elements that decrease the individual's ability to engage in the preventive behavior. Self-efficacy measures the amount of confidence individuals have in their ability to perform the health behavior, whereas cues to action are the communicative stimuli that trigger the appropriate health behavior.

Continuing the line of individual-level conceptualization of message strategies, EPPM argues that the evaluation of perceived threat and perceived efficacy in a threatening health message determines the behavioral choices of the target audience after exposure to the message (Witte, 1992). Upon exposure to a fear appeal, an individual can either control the danger by adhering to the recommendations of the message or control the fear through defensive avoidance. If the perceived threat elicited by a message is low, the individual is not motivated to further process the message. However, if and when perceived threat is moderate to high, the individual evaluates the efficacy of the recommended action. In situations in which both the perceived threat and perceived efficacy of the recommended action are high, the message recipient is prompted to follow the recommended action. However, upon processing a message

triggered by high perceived threat, and not being convinced about their ability to deter the threat, individuals use a defensive mechanism to cope with their fear.

The dominant theories/models suffer from significant shortcomings when critiqued from a subaltern perspective. Informed by the individualistic approach to health, they locate behavior in the individual and in his or her perceptions. Instead of being a part of the individual, a healthy behavior may actually be located in the roles, interpersonal linkages, and community norms in a more collectivistic culture. The dominant theories/models do not acknowledge the pivotal role played by structure in defining, shaping, and constraining health practices of the individual and the community. Furthermore, by isolating cultural beliefs as barriers and by constructing cultural practices as undesirable, the dominant theories/models disregard cultural context and impose alien practices that are often out of line with cultural understanding. The violence perpetrated by such one-way interventions on subaltern spaces is aptly captured in the following description provided by two American doctors working in the northern Indian state of Bihar (Chakrabarty, 2000):

In the middle of gentle Indian night, an intruder burst through the bamboo door of the simple adobe hut. He was a government vaccinator, under orders to break resistance against smallpox vaccination. Lakshmi Singh awoke screaming and scrambled to hide herself. Her husband leaped out of bed, grabbed an axe, and chased the intruder into the courtyard. Outside a squad of doctors and policemen quickly overpowered Mohan Singh. The instant he was pinned to the ground, a second vaccinator jabbed smallpox vaccine into his arm. Mohan Singh, a wiry 40-year old leader of the Ho tribe, squirmed away from the needle, causing the vaccination site to bleed. (p. 44)

With their focus on individual-level behavior change, the dominant approaches fail to account for the context that encompasses human existence and, therefore, silence the voices of marginalized people by not including them in problem definition. The health problem is preconceived by funding agencies and campaign scholars instead of being developed in dialogue with members of the community. The singular commitment to a particular behavior constrains the ability of the scholar to see the whole picture of health, to really understand the narrative, and to understand the “real” risks faced by the people of the culture. Instead of focusing on communicative meanings, the theories/models impose a dominant worldview on receiving populations and erase the voices of cultural participants; the participation of the receiving population in formative and evaluation research serves the dominant framing of health problems rather than articulating a community-based problem that emerges from within. The culture-centered approach offers an alterna-

tive framework for health communication scholarship by foregrounding context and agency in the study of health meanings.

Culture and Health Communication

In contrast to the dominant approach that minimizes context by pushing dominant values located in individual choice, the culture-centered approach foregrounds cultural context by articulating the voices of subaltern participants via dialogue. In contrast to the imposition of a particular health problem definition on a community, the culture-centered approach engages in co-construction of health meanings with cultural participants; the emphasis is on recovering the agency that is typically backgrounded in the persuasion-based campaign research by listening to subaltern voices.

Culture here is conceptualized as both transformative and constitutive, providing an axis for theorizing the discursive processes through which meanings are socially constructed by members. This process is considered to be a dialectical one. Stressing the “relational, processual, and contradictory nature of knowledge production” (Martin & Nakayama, 1999, p. 14), the dialectical approach captures meaning construction as a dynamic cultural process with the possibility for coexistence of multiple, and often contradictory, meanings. The objective is to develop an understanding of the complexity of meanings constructed around health rather than drawing neatly packaged stable constructs that might inform one-way campaigns of health communication. Drawing on Foss and Griffin’s (1995) conceptualization of an invitational rhetoric as an alternative to the dominant persuasion rhetoric, the culture-centered approach to health communication foregrounds the voices of marginalized people, in dialogue with the academic researcher or theorist, with the goals of developing mutual understanding and respect, as opposed to imposing the dominant worldview embodied in TRA, HBM, or EPPM by pushing a specific intervention in the community. This emphasis on contextually informed meanings co-constructed in dialogue with cultural members is highlighted by Sharf and Kahler (1996), who discussed the idea of meaning centeredness, writing that “health communication is the attempt to create meanings with others” (p. 101). The focus is on meanings developed through dialogue rather than on the achievement of behavioral objectives (such as 10% reduction in smoking), as defined by the campaign planners and funding agencies. Although the dominant discourse in health communication continues to embody the one-way, transmission-based approach, we are increasingly hearing the voices of marginalized peoples in the works of Ford and Yep (2003), Geist and Gates (1996), Marshall and McKeon (1996), Ray (1996), and other scholars.

By recovering the agency of subaltern participants, the culture-centered approach reveals alternative articulations of health problems that are typically absent in dominant theories and models because these theories/models begin with an a priori problem conceptualization. In this sense, the culture-centered approach is located within the subaltern studies project, with its emphasis on the position of subordination (Beverly, 1999), a position that is “in effect, a subtraction, rather than a positive identity that is internal to the people as subaltern” (p. 88). The goal is to theorize the absences by engaging in dialogue with voices that have typically been erased from the discursive space. Enunciating the role of the researcher within the subaltern studies project, Beverly wrote:

Subaltern studies entails not only a new way of looking at or speaking for the subaltern, but also the possibility of building relationships of solidarity between ourselves and the people and social practices we posit as objects of our study. . . . The desire for solidarity must begin, however, with a relation of what Gutierrez calls “concrete friendship with the “poor”: it cannot be simply a matter of talking though or “conversation,” or for that matter of romanticizing or idealizing the subaltern (pp. 38–39).

This friendship with the marginalized offers the substratum of the culture-centered approach developed in this article. As a result, the meanings co-constructed by the culture-centered approach are located within the relationship between the researcher and the cultural participants, building on dialogical communication methods such as focus groups, community meetings, team-building exercises, in-depth interviews, and ethnographies that focus on social construction of meanings constituted by the culture (Dutta-Bergman, in press). Given the emphasis of the culture-centered approach on dialogue, the analysis is driven by a co-constructive grounded-theory approach. Describing this approach, Charmaz (2000) argued that “the viewer creates the data and ensuing analysis through interaction with the viewed” (p. 523). It suggests that researchers spend adequate time learning about the cultures and immersing themselves within these cultures and their politics in order to better develop applications and assessment tools on one hand and build lifelong friendships based on understanding via dialogue on the other.

Recent years have seen an exponential growth in the application of participatory communication in the more traditional frameworks of health communication (Storey & Jacobson, 2004). In these applications, the participation of community members is enlisted during formative research in order to find the best ways to diffuse the preconceived solution into the community. The culture-centered approach is distinctly different from such participatory approaches in suggesting that problems need to be articulated and solutions need to be developed by community

members, and the role of the communication scholar lies in facilitating dialogue and working with community members in solving the problems that are most important to them. Instead of beginning by asking how to best convince community members to get their children immunized, the culture-centered approach begins by asking how the community defines health and what factors prevent community members from achieving health as they conceptualize it. Unlike the participatory approaches that seek to find better ways of diffusing the externally defined intervention into the community, the culture-centered approach posits that campaigns driven by the dominant theories/models are likely to fail in subaltern communities by not taking into account the lived experiences of community members in the formulation of problems.

Pragmatically, unlike the focus of the dominant approach on altering individual beliefs, attitudes, and behaviors, the culture-centered approach focuses on articulating, challenging, and altering those elements of dominant epistemologies and community contexts that silence subaltern voices. It serves an emancipatory purpose by challenging the dominant epistemic structures through the introduction of marginalized voices into the discursive space (Mokros & Deetz, 1996). When the culture-centered approach becomes a conduit for legitimate theory building from marginalized spaces, social change is achieved through the presence of the marginalized voices and through the participation of these voices in changing policy, securing resources, and achieving redistributive justice; those systems of domination that privilege certain forms of meanings over others are exposed and challenged.

Santali Voices

The Santali tribe is spread across the Chotanagpur Plateau of Bihar, West Bengal, and northern Orissa in India and is marked by its continuous struggles for and against assimilation with the mainstream Indian culture (Mahapatra, 1986). Santali folklores construct the tribe as wandering hunters and cultivators who occupied the forests of India before the invasion by the Aryans (Duyker, 1987). Santalis originally occupied that central alluvial valley of the Ganges; the Aryan onslaught led to their migration southwestward to the Hazaribagh hills (Duyker). When the British rulers gained some degree of control over these jungles and assessed them for land revenue, the Santali form of life based on slash-and-burn agriculture was fundamentally threatened (Duyker, 1987; Hamilton, 1828). The transformation in the economic life of Santalis was marked by anger and resentment, resulting in the Chuar rebellion of 1799–1800, and the Bhumij revolt of 1832–1833 (Duyker, 1987). In

1855, between 6,000 and 7,000 Santalis organized themselves with the goal of casting off the foreign oppression (Datta, 2001). The insurrection, although initially successful, was defeated by the organized assault of the British rulers (Datta, 2001; Duyker, 1987). The story of Santalis in postindependence India continues to reproduce their exploitation (Mahapatra, 1986). In spite of the Bengal Tenancy Act proposed to give aboriginal tenants more protection, more and more Santali peasants became landless laborers. Duyker pointed out that between 1961 and 1971, the number of Santali owners-cultivators decreased exponentially, accompanied by an exponential growth in agricultural laborers. This growing level of landlessness was central to Santali resentment and to the subsequent participation of Santalis in the Naxalite movement of 1967 in an attempt to regain the lost land (Duyker, 1987).

Unexplored in academic writing in the context of health meanings, Santali voices are particularly important for the project of health communication because of the location of Santalis at the margins of the postindependence modernity projects of India. Understanding the process through which health and illness meanings are constructed and negotiated is critical to the development of scholarship on multicultural health communication. How do Santalis respond in a system that threatens their very traditions? How do they respond to the mainstream system when on one hand, the system threatens their traditional identity, and on the other hand, learning the ropes of the system is essential to securing access to basic resources? Issues of acculturation and resistance, and the associated health outcomes are better understood by investigating subcultures within cultures that reflect the opposing forces of multicultural societies. It is particularly important to examine marginalized spaces in multicultural societies in which the traditional beliefs and values of a marginalized culture are in direct opposition with the beliefs and values of the broader system within which the culture exists. Health communication, as a field, will be enriched by understanding the communicative struggles of a marginalized group and the survival strategies used by the group.

My Journey in a Santali Community

Because this article documents a co-constructive narrative based on my friendship with Santalis and draws upon my past experiences with Santali communities, it is important to establish my identity and involvement in the project as an active participant. I am a privileged 30-year-old heterosexual Hindu male who was born into a joint family of homemakers, academics, union organizers, and the many Santali servants who worked off and on in our house and in the fields owned by my family. I remem-

ber the rides on the back of the truck with Godaikaka (my union organizer uncle) and with Santali workers in the local biscuit factories and steel mills to rallies organized by the Communist Party of India-Marxist (CPI-M). When I was 13, I became actively involved with Rittwick, a cultural unit of the CPI-M-run Bharatiya Gononatto Songho, an organization led by my father's sister, *pishimoni* (a reference for aunt). As a performer and a political activist, I walked a part of my journey alongside many leaders of the Santali communities. I initiated the journey back into Santali spaces in graduate school because I found absent from the dominant readings in health communication the politics of the postcolonial world that interpenetrated health meanings. I wanted a starting point for initiating a dialogue with my past, with the hope of understanding the complexities and paradoxes that constitute me. Ultimately, I wanted to revisit the friendships I had made a decade back through my activism.

As you read this article, you will see that my journey inside Santali spaces is imbued with paradoxes that I discovered and rediscovered upon reflection. Many times during my conversations with Santali men and women whose voices we hear in these pages, I was sensitized to my position of privilege. I wondered about my identity as an outsider and as a member of the larger Hindu community that participates in the oppression of Santalis. However, on reflecting upon my position of privilege, I chose to continue my participation in this project, knowing fully well that it was impossible to represent the subaltern voice. This decision was prompted by the understanding that simply being paralyzed by my inability to represent the subaltern would further perpetuate the absences, and the stories of marginalization would remain untold. Pointing to the dilemma faced by the privileged scholar working in the realm of subaltern studies, Beverly (1999, p. 40) wrote:

Those of us who are involved in the project of subaltern studies are often asked how we, who are, in the main, middle- or upper-middle-class academics at major research universities in the United States, can claim to represent the subaltern. But we do not claim to represent (“cognitively map,” “let speak,” “speak for,” “excavate”) the subaltern. Subaltern studies registers rather how the knowledge we construct and impart as academics is structured by the absence, difficulty, or impossibility of representation of the subaltern.

Throughout my conversations with Santalis, I have been sensitized to the absences in the dominant discursive space, and through this project, I seek to offer alternative discursive spaces for documenting these absences with the hope of changing current theorizing and praxis in health communication that silence subaltern voices via one-way campaigns.

We conducted our conversations in Bengali, and not Santali, the language of the Santali people. Santalis living in the Midnapore area speak Bengali because the language is the mainstream language in the region. This is a critical element of the discursive space (a) because language shapes the discourses that emerge from the interviews and sets limits to the discursive field of the Santali interviews, and (b) because it creates and maintains positions of power. However, this also is a reality of the Hindu-Santali space: Santalis have to learn one of the predominant Indian languages in order to participate in the mainstream economy.

I began my journey into the Santali life-world by remembering my past and taking journal notes based on memories of growing up; I referred back to journal entries from my days of working with Rittwick. I also read fiction and nonfiction that documented Santali life. In addition, I traveled back to India three times between 1997 and 2001, spending between 1 and 3 months, and participated in conversations with 32 members (18 men and 14 women) of the Santali community. I translated the conversations and invited a second coder to check them. Most of my conversations were initiated via local labor unions and nongovernmental organizations (NGOs) that were active in Santali issues in the Midnapore area. The choice of labor unions as an initiation point was informed by my activist orientation to the fieldwork. This choice also constructed the conversational field as a political setting, sensitizing the discursive field to the realities of resistance that I had experienced as an activist who worked with members of the Santali community. During the different phases of work on the project, I went back to key Santali participants to make sense of my understandings of the conversations.

Given the emphasis of this project on culture-centered theorizing, the constructivist grounded theory approach guided me in making sense of the conversations I had with the Santali participants in this project. I used the constant-comparison technique, comparing and contrasting the themes that emerged from our conversations in constructing a culture-centered theory of health. My past experiences with Santali communities and the intertwined spaces in which I had shared my life with these communities dictated that I draw upon these past experiences in making sense of the conversations. As a result, I present myself in this essay as a participant who dialogued with the other voices present here; my observations and past experiences were integral to the project of reconstruction.

Although I was drawn to this work by my political intentions of presenting the forgotten presence of Santalis that has been obliterated from current epistemic structures, I felt the urge to monolithize, homogenize, and categorize Santalis, an urge I had to consciously and continuously resist. In spite of the continual resistance and struggle, though, I realize

that I monolithize the experiences of Santalis I conversed with in aggregating them under the umbrella category of Santalis, in discussing “Santali” narratives. But this exercise of aggregation has to be done, I feel, in order to hear the voices of a marginalized people who experience a lot in common in the oppression they face and whose experiences perhaps are a product of the treatment meted out to them as an aggregate (because of where Santalis are located with respect to the broader Indian system). Also, aggregation is essential in order to impact any policy-level decision making, which is a critical goal of this work.

Dialectics, Communication, and Health Meanings

The themes of Santali health that emerged from the discursive spaces of the interviews in this project support the theorization of a dialectical approach to health communication. My conversations with Santalis, along with my field notes, revealed the dynamic cultural processes in Santali spaces, bringing forth the paradoxes that inhabit marginalized spaces in the twilight zone of tradition and modernization and the constitutive role of communication with respect to these paradoxes. The Santali theory of health builds upon four key dialectics that operate interdependently and often simultaneously: tradition–modernization, structural limits–individual agency, despair–hope, and assimilation–resistance. These dialectics emerged from the data through the process of constructivist grounded-theory analysis.

The dialectical perspective demonstrates that marginalized cultures that exist at the peripheries of global modernization projects seek to maintain and reclaim age-old traditions; they also struggle with structural barriers to find access to the very modernization projects that threaten their traditions. On one hand, the voices of marginalized people reminisce about the loss of tradition in the hands of modernization and urbanization; on the other hand, the very same voices articulate their oppression through limited access to the benefits of modernization that are available to the bourgeoisie. Whereas the discourse is rife with tales of macrolevel structural barriers (such as access to food, clothing, and shelter) that cripple Santali life, it is also filled with stories of individual success and meaning making in coping with the structural limits. Hopelessness of Santalis in the context of the oppressive environment that constrains their life is juxtaposed against dreams for a future that would reclaim Santali glory. Finally, in articulating the tools for social change in Santali life, the discourse reveals the tendency toward assimilation with the mainstream Hindu society by becoming more educated and learning the tools for success. It also reveals Santali participation in re-

sistance and the dream of a revolution that would empower Santalis with the necessary resources. These dialectical tensions demonstrate the complexity and transitivity of cultural meanings as opposed to the stable belief-based constructs suggested by the cognitively centered dominant theories/models. I find these dialectical tensions and paradoxes to be played out around four key themes: a full life amidst nature, seeking multiple meanings within structural constraints, structural barriers to health, and folded fists and voices set free.

A Full Life Amidst Nature

When I asked them about what they understood by health, many of the Santali participants discussed the role of nature. Nature holds the key to the healthfulness of Santali life, and being healthy is considered a natural state. Rotton¹ said, “You go on with your life and you are healthy,” perhaps suggesting that being healthy is being able to continue one’s day-to-day activities without being disrupted. Disease and illness, in turn, represent an unnatural state and are caused by *bongas* (spirits) that enter the human body when the natural processes are disrupted. When I asked additional questions about the disruption of the natural processes, I was told that the modernization and urbanization projects that have started spreading to the countryside were destroying everything, being correlated with the rise in disease and illness. I had noted in my journal (Kharagpur, December 1998):

I am amazed at how many new houses have been built and how far the city has spread. I don’t even know now where the city ends and the village starts. The highway has ripped through this town, sending more trucks than ever before and making the air so hard to breathe in.

In talking about his health, Nimaida reminisced about the days of premodern Santali life that celebrated the harmonious relationship between nature and human health, “Then, everything was healthy because they [referring to the ancestors] respected nature. They offered their prayers to nature. They lived a full life. Roaming the mountains and the forests, they were happy. They were healthy because they respected nature.” Drawing a boundary between then and now, Nimaida’s nostalgic articulation of the mountains and forests lost in the hands of the modernization projects brings to our attention the juxtaposition of health and happiness in the realm of nature. Therefore, causality in Nimaida’s discursive formation is located in the sacredness of nature; the violation of this sacredness brings disease and illness. He constructs healthfulness in the ability of the human being to appreciate and understand nature, as opposed to the theme of individual-level control that resonates in the dominant literature (eating five servings of fruits and vegetables, using condoms while having sex, etc.).

To Santalis, the diseased person is possessed by the bongas that enter human bodies when they are displeased. Exploring the causes of such displeasure, Sonaton suggests that “they [referring to the bongas] live in the trees. They can live for many years on a tree and no one will even know. But you cut the tree, and tomorrow the spirit will enter you because it is angry.” In Sonaton’s story, we see the narrative of disruptive forces of modernization (such as cutting trees) that spark the wrath of the spirits. Similar stories were shared by other participants who believed that the increase in disease and illness is fundamentally caused by the rapidly increasing forces of industrialization and development that have destroyed the forests, the natural habitats of the bongas. Dharma talked about the time that the *babus* [referring to middle-class Bengalis] came one day and cut down all the trees, planted new seeds (eucalyptus trees were being planted instead as a part of the agro-forestry plan), and there was a sudden rise in disease and death. He called Shobuj who was smoking a *bidi* nearby to share the story of the dead fish in the ponds; the fish started dying because the babus had sprayed the ponds. Pollution and deforestation have ruptured the balance in nature, driving the spirits to pollute human bodies. Because nature and its happiness are the central elements in defining Santali understanding of health, there is no hope for the health of Santalis as long as the modernization projects of the developing nation continue to cut more trees, destroy more forests, and limit the natural spaces available to Santalis. Modern-day Santalis are disenfranchised, driven out of their natural environment surrounded by the trees, hills, and rivers, and are rendered homeless by the projects of modernization and urbanization.

In their articulations of pollution, the despaired Santalis point out that the spirit moves from one object to another, from an object to a human, or from one human to another. Therefore, disease and illness can be cured only by removing the spirit from the human body. Healing can occur by acts of exorcism conducted by the spiritual healer, also known as the *ojha*. After drawing the disease from all other parts of the body to one location, the *ojha* sucks it out. The *ojha* is gifted with certain supernatural powers that are beyond the realm of common people. The chants and invocations (known as mantras) used by the *ojha* are learned through rigorous training under a reputable teacher (the guru). The disciple (*chela*) also learns about roots and herbs that may be used as medicine. The medicine is either consumed orally or worn as a talisman made of metal.

In addition to visiting the *ojha* for treating illnesses, the participants talked extensively about seeking out two other forms of treatment: allopathic medicine (also referred to as modern medicine in this part of India) and homeopathic medicine. Although present-day Santalis believe

in the healing powers of both allopathic and homeopathic medicines, they also believe that such medicinal remedies do not have the answers to the causes of disease and sickness. Instead of looking at allopathic medicine or homeopathic medicine for answers, Santalis explore answers regarding the causes of disease in phenomena that disrupt nature and natural processes, minimizing the ability of modern medicine to get at the root of the real problem. According to Dukhu, “I use allopathic medicine. But disease is caused by unnatural elements that cannot be explained by such medicine. The forces often run deeper and cannot be touched or healed by allopathy.” To completely cure the illness, modern medical treatment is supplemented by religious rituals that appease the spirits and the Gods.

Santali theorization of health differs starkly from the dominant health theories in approaching health as an ecological outcome and in locating health within the realm of nature and natural processes; the health of the individual is a product of the natural environment in which he or she lives and is intrinsically intertwined with harmonious coexistence with nature. Disease and illness are not caused by individual behavioral choices, such as exercising and eating healthy, as dictated by message-oriented individual behavior-based strategies informed by EPPM, HBM, or TRA. Instead, health is fundamentally intertwined with the ability of the human being to live in harmony with nature, suggesting a shift in the broader ecological outlook in order to reclaim better health. This emphasis on the location of the disease or illness in the broader environment is typically conceptualized as an external locus of control in the social scientific literature and is treated as a trait of the premodern, something that ought to be transformed via messages of self-efficacy (see, for instance, Murray-Johnson & Witte, 2003). However, my conversations with Santalis suggest a very different picture, the acute sense of understanding of natural processes and the profound realization of the interplay between nature and human health make us interrogate the validity of monolithizing concepts such as locus of control in understanding marginalized spaces. Santali articulations remind me of the work of ecofeminist Vandana Shiva (1988), who cogently located the local in relationship with more universal patterns, demonstrating the displacement of local knowledge with expert knowledge that destroyed the sustainability of natural resources and the destruction of nature that deeply influenced the health of local lives.

Seeking Multiple Meanings Within Structural Constraints

Multiple contradictory meanings play a fundamental role in the Santali conceptualization of health. Most pertinently, they have mixed motivations, understandings, experiences, and feelings about the different treat-

ment options available to them. Although modernization practices carried out in the form of deforestation and urbanization pose a threat to Santali men and women, and despite the belief that modern medicine does not eradicate the true cause of the disease, the lived experiences of the participants have demonstrated the effectiveness of allopathic medicine. Santalis narrate that they treat disease and illness with homeopathic, allopathic, and ayurvedic medicines, accompanied by visits to the ojha or to the local Hindu temples. The following narrative of Chanpa provides the picture of a highly resource-constrained life that integrates different meanings within the realm of the available resources:

Dr. Bera [allopathic], Bidu [homeopathic], Nath babu [Ayurvedic practitioner]. I don't know. I will go to any one of them. . . . They all give good medicines at different times. Sometimes one works, sometime the other works. I don't know who is better. Sometimes, I try combinations.

For Chanpa, the choice of a medical treatment is not defined by the belief that one treatment option is inherently better than the other. Instead, it is informed by a trial-and-error process. Through this process of trying out different treatments, Chanpa learned that the treatments vary in their effectiveness from time to time, from disease to disease. Chanpa also informed me that she sometimes takes combinations of the medicines simultaneously. When probed further about the possible conflict that might be created by the lack of reliance on one medical system, Chanpa went back to the narrative of the “real” cause of the disease being located in the disruption of natural processes. In fact, according to Chanpa, “they [the different treatment options] help each other out.” What emerges from Chanpa's narrative is a complex web of treatments (often contradictory) that integrates alternative discursive frames informed by her narrative of a life constrained by financial resources, seeking out treatment depending upon the seriousness of the disease, the amount of money demanded by the treatment, and the amount of time the visit would take. On a similar note, Shyamda said:

I have to get all the different tests because I have this pain in my stomach that doesn't go away. I also have blood in my stool. My wife says, go get the tests done. But I don't have the money now. I tell her, I will wait a few more months, save up some money, and then I will get the tests done. Until then, I will take homeopathic medicine and it will keep me healthy.

In Shyamda's self-description of his condition, the awareness of the need to get the medical tests done is enmeshed within a greater awareness that he does not have the money to get them done. Instead of being

crippled by this structural barrier, Shyamda talked about saving up money to get the tests done. In the meanwhile, he is taking homeopathic medicine that is very much within his financial reach (he can most often get the medicine for Rs. 2 or 3²). Shyamda's story reminded me of Modonda, who worked part-time at our house, lifting buckets of water from our well and filling up the water tanks in the house. Modonda had suffered a quick death after reporting chest pains for a few days. Modonda had learned to ignore his pains in order to keep working and to make enough money to continue living and had been to the homeopathic doctor just the night before his death. The homeopathic doctor had recommended that he get checked at the state hospital, but Modonda did not want to lose a day's work, thinking that the pain will eventually go away. Jibonda, when asked to talk about the medical treatments he sought for himself and his family, informed me that his wife had passed away a few years back. He told me:

When my wife was sick with cancer, and the doctor at the state hospital said: go to the hospital in Calcutta. I took her to the hospital in Calcutta and waited there for three days; the doctor said you take her to some other big city, I don't remember the name. I said, how can I pay *babu*? I brought her back here to Kharagpur . . . went to Biduda [local homeopathic doctor] and he gave medicine for 2 rupees every week. She took that all those months, gave her relief. . . . I also gave *manat* [offerings] at the *Shashan Kali* [Hindu goddess] temple and prayed there every week.

As the narrative of Jibonda demonstrates, beyond the ojha, the Santali participants also went to local Hindu temples to offer their prayers to the Hindu goddess *Kali*. A *manat* is a special offering to the goddess Kali. Usually, a relative of the patient promises to offer something precious to the goddess if the patient is healed. For Jibonda, offering a manat to Kali was really important because his wife was suffering from cancer and she was on her deathbed. In his prayers to Kali, Jibonda found solace; he tried different treatment options and spent approximately Rs 2000 on the different treatments for his wife, taking loans from local moneylenders and babus (Jibonda pointed out that he usually makes approximately Rs 8,000 a year if he works almost every day of the year). Jibonda was told that it would cost him another Rs 12,000 to bring his wife to the other big city. Now, after having tried all other options, Jibonda took refuge in his offerings to Kali. Jibonda's story about his wife's illness demonstrates that the spiritual pathway to healing becomes particularly important when the suffering is not abated by seeking out allopathic or homeopathic medicine. The reliance on age-old practices and on religious rituals increased when the nature of the disease was severe or when the disease persisted over a long period of

time. This further reiterates the Santali belief system that disruption of the natural order by supernatural forces leads to disease and the cause of the illness needs to be addressed in more severe cases instead of simply superficially treating the illness with modern medicine. Also, Jibonda's narrative demonstrates the limitations imposed on Santali participants by the lack of financial resources.

As articulated in the earlier section, traditional Santali treatments such as a visit to the ojha are also widely used in the community; however, their use depends upon the nature of the disease and the extent of acculturation into the Hindu system (reflected by education). Whereas in some occasions Santalis went first to the ojha for treatment, in other occasions, they chose modern medicine. Participants reported a great deal of variety in the extent to which they relied on the ojha. This variety depended upon the type of disease and the educational background of the participant. Younger, more educated participants talked less about the ojha; references to the services of the ojha were more common in the stories of older, less educated participants (education is measured by the attendance of a Bengali school located within the broader Hindu culture). This is a critical finding, demonstrating the impact of acculturation on the traditions and beliefs of the Santali culture. The onslaught of modernization projects, including projects of education targeting Santalis, threatens the essence of the Santali culture. Such projects couched as projects of emancipation seek to impose an educational system that threatens the Santali way of knowing. Many of the older participants voiced this threat of cultural extinction and said they feared that the children will no longer learn the Santali songs, the Santali dances, and the Santali stories. "Pretty soon, they will become the babus," said Nimaida. So, on the one hand, education is constructed as the tool for the emancipation of Santalis (we will hear this in the following sections), it is also an oppressive force that threatens the Santali cultural identity.

To summarize, the path taken by the individual is interpenetrated with the socio-cultural-economic context, changing trajectories in response to the nature of the marginalized space. In contradiction to the dominant theories/models, Santali voices centrally locate the role of culture, constructing treatment choice in a richly dynamic field imbued with active meaning-making. Often, the stories that are produced through the process of discourse construction are not linear, systematic, and monolithic stories of consistent cost-benefit analyses that would fit the modernist belief-based dictates of the dominant models. Whereas in the dominant theories/models, truth is universal and beliefs exist in stable and measurable categories, in the Santali philosophy, beliefs and actions are a product of the pathway taken by the sojourner with the possibilities of simultaneity of multiple realities and meaning spaces informed by the

context. The emphasis is on the situation, and the meaning attributed to a construct arises from the guiding principle of the situation and the corresponding situational needs, highlighting the transitive and co-constructive nature of health meanings and health choices rather than static conceptualizations of constructs as dictated by the dominant theories/models.

Structural Barriers to Health

Health is a precious resource that is typically out of the reach of poverty stricken Santalis. Struggling to find work, Santalis drew my attention to their daily struggles and the barriers to a healthy life. The despondence of Santalis at their displacement from the natural spaces via the modernization projects is further exacerbated by their exclusion from the benefits of these projects. Santalis narrate stories of oppression that marginalize them and deprive them of necessary resources in their own land. So far we have heard the voices of Santali participants who discuss the financial impediments to securing medical treatment. Resonating with the theme of structural barriers, Lokkhi talked about the choices she has to make between getting medicine for treatment and being able to buy food:

It is very expensive [referring to allopathic medicine]. A visit to Dr. Bera is Rs. 20 just for the visit, Rs. 10 for the medicine. If I get that medicine, I won't have rice at home. I won't have the money to buy anything. You know, I work hard. Day to night. But I can't go to the doctor.

Lokkhi works as a part-time peasant during the farming season. The rest of the year, she goes around from house to house looking for daily jobs, mostly working as a maid (Lokkhi reported that she made approximately Rs. 15–25 on an average day). Most Santali participants make their living as part-time laborers. Nimaida's wife begged for work during the rainy season when work was hard to come by. For Lokkhi, spending the Rs. 30 on allopathic treatment is simply impossible because she makes around Rs. 20 a day and is hardly able to make ends meet with the limited money she earns. Three primary access points to modern medicine are available in West Bengal: private dispensaries, privately run nursing homes, and state-sponsored hospitals. Whereas both private dispensaries and nursing homes are expensive and require personal expenditure, state-sponsored hospitals are supposed to be subsidized for the poor patient. Santalis pointed out, however, that although state-sponsored hospitals were supposed to provide access to modern medical treatment, they were typically unavailable because they require long waits (meaning the loss of a workday), limited medical supplies that must be purchased from private dispensaries, and long distances to reach them. I jotted down the following entry after my trip to the state hospital:

The disparities between the two worlds is mind boggling. I remember taking *baba* (father) to Woodlands in Kolkata for a test, I remember how everything was spic and span, the secretaries dressed in navy skirts and bright red tops greeted us with warm smiles, the hum of the air conditioning cooled us, the CNN anchor on the television screen and the magazines spread on the coffee table in the waiting area entertained us as we waited for about twenty minutes before being called in. The state hospital I visited today reminded me of the despair and hopelessness in the other world. The first thing I noticed was that it was dirty, chewed beetle leaf stains decorated the walls, lines of men and women spilled out into the hallway, squatting on the floors and waiting for their names to be called. It was 11:30 in the morning and the doctor was nowhere to be seen. (journal entry, December 2001)

Waiting in long lines is a common feature of state-sponsored hospitals. For Reba, state-sponsored hospitals are practically nonexistent because they involve such long waits:

I don't even think of going to the state hospital. I went many times, waited in lines, lost a whole day. . . . What's the use if I have to pay Rs. 40 on the medicine after waiting in line to see the doctor and losing Rs. 15 because I missed the day's work?

What Reba points out is that although the visit to the doctor is free, such state hospitals typically overflow with people and do not have adequate resources to pay sufficient attention to all the patients. For Reba, making a trip to the state hospital means losing Rs 15 for the day's work. This additionally implies that she wouldn't be able to feed her family for that night or the next night because many of the Santalis like Reba depend upon their day-to-day livelihood for daily food.

Bagram also articulated the same concern, stating, "If I go to the hospital and spend the whole day there, the *babus* will not give me work tomorrow. They will have hired somebody else to do the job." So, not only do Santalis lose the Rs.15–20 for the day's work, but they also lose the guarantee of a job the next day and the days to follow.

In addition, Reba pointed out that hospitals lack an adequate supply of medicine to be disbursed to patients. Patients often have to pay exorbitant sums of money out of their own pockets to procure the medicine from private practices (dispensaries) that are typically located on the other side of the road from the hospital. The hospital doctors hold private hours at these dispensaries where the lines are shorter and middle-class patients (*babus*) pay visitation fees to the doctor.

Ram stated:

Sometimes, I go and wait at the hospital for hours, and then the doctor asks me to come to his clinic where I pay money or the doctor tells me to do big tests. The hospital won't give medicine and then I go to the dispensary to buy it. But where will I get the money?

When I probed Ram and asked him why the state hospital is in such shortage of medical supplies, he gave me a mocking look implying “as if you don’t know.” Then he went on to say:

I can’t read the paper. I only tell you what I see and hear. They get medicines, all the expensive ones. But then, they channel them out through the backdoors and sell them to the dispensary across the road at a cheaper price.

Ram’s sarcastic smile targeted at me was meant as a reminder that corruption is an integral part of the Indian medical system. The resources allocated to the state hospitals are constantly depleted in the hands of corrupt doctors and hospital officials, often channeled to the dispensaries where they have to be purchased.

Yet another deterrent that prevents Santali patients from seeking out modern medical treatment is the location of the state-sponsored hospital in the main city, approximately 30 kilometers away from some of the villages. The villagers typically do not have access to telephones or local pharmacies with routine medicines. This is a problem especially when the disease needs immediate treatment. Santalis talk about the long time it takes to take the patient to the hospital, documenting patient deaths on the way to the hospital. Santali patients also do not have access to vehicles such as cars or ambulances. During the months of interviewing, I saw occasional trolley rickshaws (pedaled four-wheeled carts) carrying patients to the Kharagpur state hospital from distant villages. Kalidi narrated the story of a neighbor child who was bitten by a poisonous snake and needed immediate care:

Shontu was crying a lot. He had froth in his mouth and it kept coming. His father put him in the back of the rickshaw and a few of the village men went with him. They kept going and a little way from the hospital, Shontu died.

The death of Shontu and other Santalis needing immediate attention and not getting it due to the lack of physical access is prevalent. The strong awareness of Santalis of the structural barriers in their environment was something I was familiar with during the years I worked with labor unions and different subunits of the CPI-M. I wondered why it was that in spite of being in power for all these years, the CPI-M was unable to do much to better the plight of the Santali. Lokhon voiced his feelings of marginalization:

Where do we have anything babu? Where do Santals get to say anything? Work hard for a job, get scolded by the babus, go to bed hungry. Even the little children go to bed hungry. They need food. They cry. But they go to bed hungry.

A paradox of Santali life is the coexistence of hard work and deprivation. In spite of all the hard work they put in as laborers or part-time peasants, Santalis are deprived. Poignant in Lokhon's voice is the articulation of the marginalizing forces of modern India. Structural forces such as the lack of a basic supply of food and good public hospitals and the dearth of medicines strongly impact Santali life and point out the limits of the dominant health communication theories that take structural factors for granted. Unlike the dominant theories committed to changing externally determined individual behavior dictated by the agenda of funding agencies, the culture-centered approach brings forth Santali voices in articulating problems facing Santali communities. Santali theorization of structurally defined health meanings is fundamentally different from the dominant theories/models that locate health in individual behavioral choice without taking into account structural limits that constrain human behavior. For Santalis, the structural context lies at the core of health experience, not the performance of any particular behavior, pointing out the fundamental need for change in structural access to resources in deprived communities. This severe deprivation of structural resources is a feature of marginalized spaces elsewhere in the world and needs to be altered before pushing individual preventive behaviors in resource-deprived spaces.

Folded Fists and Voices Set Free

The resource-deprived context of Santali life is marked by narratives of overcoming the barriers. Whereas some of the narratives emphasize assimilation, others emphasize resistance. During those years that I was actively involved in resistance through participation in street theaters and rallies, I observed how Santalis dealt with their disenfranchisement with conviction and hope. Yet, at other times during my journey with Santalis, I felt hopelessness. How then, I wondered, were things after almost a decade? In their attempts to make sense of the world around them, Santalis engaged in the discussion of the two conflicting feelings of despair and hope. Although the structural forces of mainstream India and a Hindu-led government are key players in silencing them, the Santalis search for avenues for expressing their frustration and anger. In spite of being cast into the role of being an invisible section of Indian society, Santalis seek alternative spaces of hope. For Bijon, this hope is embedded in the education of Santali children. He says, "There are many dreams. . . . The children go to school and find a job. Sonatan's son Jhontu found a job in the railway station. A government job. Has a quarter. His parents now stay with him." Jhontu is an example of a Santali son who went to school and got an education. In Jhontu's achievements, community members see the glimmer of hope, the hope for emancipation of the community from the structural limitations in their environment. The

dream that “maybe, one day, Santalis will live a happy life that gives them access to the fundamental amenities of life” (Nimaida) drives Santalis to get an education, seek a job in the city, and work toward the betterment of their communities. Speaking about their children, Rotton articulated:

I tell them all the time, they have to work hard. I will bring them all the books they need. . . . To become somebody, to enjoy your life, you have to work hard at school. Then they can find jobs in the city, not worry about what to feed their son the next morning.

On one hand, learning the idiom of the *babus* through education is central to Santali progress. On the other hand, Santali voices speak of resistance. Santalis organize and participate in local protests. They actively participate in the politics of local governance to ensure the supply of resources. They participate in protest marches and strikes (risking the loss of the daily wage that feeds their families) to express their voices. Aruna voiced her anger and let me know that she finds an outlet for this anger through participation in political rallies organized by the local unit of the Women’s Democratic group:

Basantidi [one of the local organizers of the party] says, you can’t just sit and watch it happen. I like her. I like what she has to say. In July, I went to the meeting and they asked me to come every two weeks. I talk about my problems, and they all work with me. We all help each other out. They also help me out with money when I need it. . . . I participate in processions and meetings.

Aruna’s narrative of her engagement in the Women’s Democratic group is empowering. She finds the party meetings as avenues for expressing her thoughts and ideas. She also finds a place at the meetings to share her problems. The efficacy of the collective in solving problems together and helping each other out is a critical element in dealing with the severely resource-constrained environment. Aruna’s participation in the processions and meetings is yet another source of strength and sustenance for her.

During our discussion of political participation, Lakidi referred to the Naxalbari movement. Reflecting upon the movement, she also raised questions about a revolution that would perhaps move them from the margins to the center of society, give Santalis the access to the critical resources that are quintessential to their existence, and perhaps reclaim the glory days of Santali tradition. Resistance here is critical because the departure of the British from India has not decolonized the country and given Santalis their freedom. The Santali revolution seeking autonomy and self-determination reflects the possibility of a discursive space where

peasants find a voice through self-organizing. Inherent in Santali disenfranchisement is the paradox of assimilation versus resistance. Whereas, on one hand, the solution to the disenfranchisement is the acquisition of mainstream resources and the ability to learn the mainstream skills via education so Santalis can engage in the civil society projects, on the other hand forces of resistance beckon Santalis to revolt. Whereas Santalis recognize that the education of their children is the solution to their disenfranchisement, they also fear the loss of culture in the hands of an assimilative educational system that does not recognize and value Santali culture. Once again, the discourse that emerged in my dialogue with Santalis was different from the dominant theories/models because it demonstrates the active role of participants in marginalized spaces in interpreting the structural forces and in working toward shifting these structural impediments. Instead of stealing agency from Santali participants by imposing the dominant paradigm, the culture-centered approach demonstrates the agency of Santalis in constructing narratives of structural readjustment. In contrast to the emphasis on stability embodied in the dominant paradigm, the location of agency in subaltern participants demonstrates the transitivity of meanings, the existence of tensions, and the active participation of subaltern people in change efforts.

Discussion

Theoretical Lessons

The culture-centered approach to health communication emphasizes dialogue and mutual understanding, locating the agency for examining health practices in the culture being studied, not in the researcher and the institutional practices that inform his or her research practice. Cultural context is located at the center of the culture-centered approach, emphasizing the meanings that are co-constructed by the researcher and the cultural participants. The findings of the project provide support for the culture-centered approach, divulging an intricate sense of meaning making that is informed by the contexts that surround Santalis. Given the transitivity of the meaning structures informed by context, the culture-centered approach provides an adequate theoretical lens to conceptualize health communication, harnessing the paradoxes and the dialectics that constitute the richness of the cultural space and locating health within cultural, social, economic, and political contexts. Communication in the culture-centered approach, therefore, is constitutive rather than being transmission-based; it is understood within the contexts that shape it and that, in turn, are shaped by it. Communication here is a process rather than a static message; the culture-centered approach takes us away from the emphasis on messages that can be strategically developed for

the purposes of achieving behavioral objectives to the agency of the cultural participants in making sense of politically, economically, and culturally informed contexts.

During the course of my journey, I discovered the inadequacy of dominant theories of health communication that are routinely taught to graduate students and the theories with which scholars go out to capture and control the life experiences of subaltern peoples within stable frames such that message-based persuasive interventions can be designed. Applying the culture-centered approach provides the scholar with a starting point for understanding meanings created in marginalized spaces via dialogue, meanings that would perhaps not be brought to the surface by transmission-based models of campaign design, meanings that are politically charged and economically embellished and that raise further questions without presupposing resolution and the appropriateness of particular kinds of health campaigns. The constitutive approach to understanding health communication provides a space for marginalized voices, a space that is typically absent in the aggregate measures of beliefs or perceptions in the TRA, HBM, or EPPM. The Santali discourse embodies a polymorphic view, demonstrating the coexistence of multiple treatment options often manifested in a trial-and-error approach to treatment and suggesting that communication around health is a dynamic process, transforming the meaning spaces based on the contexts that constitute such spaces. Surveys testing cognitively oriented models are likely to fail in such situation-centered cultural scenarios because of the malleability and the situational volatility of the underlying beliefs of Santali life. Drawing on this research, I have concluded that the dominant approaches are ill equipped to explain and account for the cultural context of subaltern people. In particular, the Santali experience points to the importance of three sites that merit further theorizing by health communication scholars: nature, structure, and politics.

Very much in contradiction to the dominant explanations of health and illness that locate health outcomes within individual choice, Santali narratives point out that health is ultimately located in the relationship of the human being with nature and natural processes. Yet another important discourse that emerged in the interviews was the salient role of the social structure as a barrier to a healthy life, suggesting that communication be theorized as a process of constructing, negotiating, and transforming cultural meanings through interactions with the structural limits, with the goal of building capabilities that empower cultural participants to articulate their needs and secure resources for fulfilling these needs. The findings also bring to surface the necessity to politicize health communication and open up the study of health and culture in marginalized groups to the possibilities of resistance and revolution.

Applications

This article suggests a different process of conducting health communication than the traditional transmission-based health communication theories/models embodied in campaigns. Instead of defining a problem a priori, the culture-centered approach emphasizes understanding and engages in dialogue with community members to identify the critical health problems in a community. In so doing, it brings forth alternative problem definitions in the realm of health communication that foreground contextual features such as the environment and the structure. Applications informed by traditional health communication theories/models typically fail to engage in and put forth such culture-based and context-sensitive definitions of health problems because of their myopic commitment to a preconceived behavior. Based on the articulation that the culture-centered approach foregrounds problems defined by the community, it may be argued that funding agencies need to shift their objectives from individual behavior change to communicative empowerment and creation of spaces for dialogue with subaltern participants, channeling resources toward addressing contextual factors.

More specifically for the Santali communities with whom I engaged in dialogue, the key problems are located in the realm of nature and access to health resources. Therefore, health communication applications in these communities need to focus on minimizing pollution and deforestation and securing natural resources for Santalis based on activism at the local, state, national, and global levels targeted at impacting environment policy. The documentation of oppression and lack of access to basic resources suggests the need for activist projects of redistributive justice that harness effective strategies of community organizing, community mobilizing, lobbying, and media agenda-setting.

Finally, perhaps the most important pragmatic contribution of this project is its critical interrogation of the dominant theories/models in health communication that inundate current campaign applications achieved through my conversations with various Santalis. Health campaigns are one of the most funded and widely applied areas of health communication scholarship with critical practical implications for target populations. This article, therefore, serves a pragmatic goal by documenting critical absences in the dominant paradigm of campaign applications, the support for the status quo achieved through such applications, and the violence perpetrated by interventions on subaltern spaces. My dialogue with Santalis locates power, resistance, and politics as central to health communication, pointing out that the communication of health is a political process imbued with differences in power between core and marginalized sectors of the globe. The co-constructions in this article suggest that more and more voices of subaltern people need to be

heard in order to alter the structures that impede the health of marginalized people through changes in policy, by securing the basic resources of life, and by shifting the focus of practical applications. As scholars of health communication, we need to create new spaces for dialogue and application development. Through the creation of these spaces, we can engage with subaltern participants in achieving meaningful social change that ensures better access to good health for subaltern participants.

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Notes

¹ The names of the participants have been changed to protect their identities. The use of Hindu names reflects the broader acculturative pattern in the Santali community. Most Santali participants I grew up with and conversed with during the fieldwork had Hindu names. The suffixes “da” (for males) and “di” (for females) are used with some names to reflect the older status of the participant in relationship to the interviewer, a typical Bengali practice.

² Rs. denotes Rupees, the Indian currency. The dollar was worth Rs. 45.15 on March 22, 2004.

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