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Health Among Men in Rural Bengal: Exploring Meanings Through a Culture-Centered Approach

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Researchers in health communication usually adopt a linear approach to the study of health. Under this linear model, the emphasis is on the transmission of beliefs, information, and knowledge from key points at the core (the traditional senders) to the peripheral receivers of messages. A growing body of scholarship foregrounds the importance of understanding health communication from a culture-centered perspective that privileges the dialogue with community members. Drawing on a culture-centered approach, the authors examine the meanings of health among men in rural Bengal. Their dialogue with these men suggests that communication in the realm of health exists in the context of responsibility as care providers, work life, structural barriers, and solutions through participatory processes. The findings elucidate the connection between structure and the communication practices of marginalization. The authors' discursive engagement with the participants points toward spaces of entry for theorizing health communication and developing culture-centered praxis.

Keywords: *culture; campaign; dialogue; rural; India; participation; meanings; context; marginalized; marginalization; structure*

Researchers in health communication have traditionally adopted a linear model to the study of health without taking into account the voices of subaltern participants in scholarly discourse (Airhihenbuwa, 1995; Dutta-Bergman, 2004a, 2004b; Mokros & Deetz, 1996; Ray, 1996; Sharf & Kahler, 1996). Under this linear model, the emphasis is on the transmission of beliefs, information, and knowledge via one-way health messages from the core sectors of the globe to the subaltern spaces in the periphery. A growing body of health communication scholarship criticizes the top-down approach, foregrounding the importance of understanding the articulations of health by engaging subaltern voices in the marginalized sectors of the world (Airhihenbuwa, 1995; Dutta-Bergman, 2005; Ford & Yep, 2003).

Recently, researchers in health communication have called for the development of a culture-centered approach that foregrounds the agency of cultural participants in coconstructing health meanings and engages in dialogue with cultural participants in developing an understanding of the key problems faced by the members of the community (Airhihenbuwa, 1995; Dutta-Bergman, 2004a, 2004b, 2005; Ford & Yep, 2003). Essential to the culture-centered approach is the emphasis on dialogue based on the act of listening to the voices of cultural members. In applying the culture-centered approach in this article, we examine active meaning making among men of rural Bengal, exploring the agency of participants in their interactions with a resource-deprived environment.

Rural Bengal provides a particularly rich context for the discussion of meanings because of its material existence at the peripheries of the modernization projects in India. Whereas some of the villages in these rural areas are accessible by road, others are inaccessible via modern modes of transportation. Therefore, much of the rural experience is located at the geographic margins of modern India, suggesting the link between the physical location of marginalized spaces and the lack of access of these spaces to the amenities of modern-day health care. Our discursive engagement with men in rural Bengal is driven by the role of men as the primary providers of health for their families in much of rural Bengal. In most instances, as primary providers for their families, men bear the responsibility for securing healthful resources for their families, ensuring access to preventive services,

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and acquiring treatment options for family members. Therefore, the health of rural residents in Bengal often depends on the earnings of men. In engaging with the health beliefs and values of men, we seek in this article to contribute to the existing literature on how men articulate health and its meaning (Charmaz, 1995; Waldron, 1995). It is also relevant to engage in discursive constructions with members of rural communities, because in most instances, these communities have been conceived of as passive receivers of messages, as target audiences of large-scale campaigns stripped of agency (Airhihenbuwa, 1995; Dutta-Bergman, 2004a, 2004b; Ford & Yep, 2003).

Dominant Approaches To Health Communication

The dominant approaches to health communication construct members of marginalized spaces in terms of lack of agency (Airhihenbuwa, 1995; Dutta-Bergman, 2005; Escobar, 1995). Although scholars and practitioners who typically theorize about and apply the one-way models of health campaigns might articulate that the current models in vogue are inherently two-way because they involve members of target communities in formative research, it is critical to question this form of involvement as respondents in formative research for predetermined problems shaped by external funding agencies as two-way communication. In formative research for health campaigns, the involvement of cultural participants is minimal and is enlisted so that the researcher can understand more fully the best ways to diffuse a predetermined campaign message into the community. The data from formative research serves the purpose of effectively developing the message that would subsequently generate adequate behavior change as desired by the campaign planners and the funding agencies. Absent from the process of campaign design and implementation is the involvement of members of marginalized communities in defining the health problems and articulating the solutions (Dutta-Bergman, 2005; Escobar, 1995). In this project, we locate the culture-centered approach as an alternative to these transmission-based models of communication in the arena of international health.

Culture-Centered Approach

The culture-centered approach suggests a shift in the role of the researcher from that of an interventionist, who plans and executes campaigns, to that of a listener and a participant, who engages in dialogue with the members of the community. For Freire (1970), engaging in dialogue meant the fusion of identities among the participants based on the absence of subject–object distinctions, where the sense of the self and the world is developed through the interactions among the participants. The researcher moves from his or her objective position outside the field to being a participant that is engaged in the process of dialogue; reflexivity becomes a critical tool. Noting the moral commitment required for the dialogical process to occur, Freire articulated that "being dialogic is not invading, not manipulating, not imposing orders. Being dialogic is pledging oneself to constant transformation of reality" (p. 46). The culture-centered approach is rooted in the notion that members of communities actively participate in interpreting the social structures that encompass them, in making sense of these social structures, and in interacting with them on a daily basis.

Drawing on the agency of cultural participants in actively engaging with the world and in making sense of the communication processes that surround them, the culture-centered approach highlights the role of context. The context is foregrounded in the conversations between the researchers and cultural participants; the voices of the participants guide the meanings that are constructed in the discursive space. Ultimately, applications are developed through this process of dialogue. Cultural participants actively engage in identifying the issues that are critical to the community; these configurations of the critical problems drive praxis instead of the problem's being defined by external entities. Opportunities for learning, in this case, are opened up not only for the participating members of the culture but also for the researcher-scholar that engages in dialogue with the culture.

In this essay, we seek to apply the culture-centered approach to understand the meanings of health among rural Bengalis. The history of rural Bengal, much like that of other rural parts of India, has been marked by its existence along the margins of national Indian policies and the active involvement of the subaltern classes in political participatory processes and democratic movements (Chatterjee, 1998). Our emphasis on men is tied to our interest in looking at the discursive constructions of health among those members of the community who primarily play the role of the providers of health and basic resources.

Our research question was How do men in rural Bengal construct the meanings of health?

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Method

Context: Rural Bengal

West Bengal is a state in India's northeast. A seat of power during the British colonial rule, this agricultural state accounts for nearly 8% of India's population of more than 1 billion people, according to the 2001 census (Registrar General and Census Commissioner of India, n.d.). Close to 72% of this population lives in rural areas and is not exposed to the forces of modernization and consumerism that are sweeping across the urban centers of India. The rural population in this state, like in other states across the country, has historically been marginalized and has remained poor. A measure of this is seen in the fact that although the state, according to the Census of India data for 2001, recorded a high gross domestic product (GDP) during 1993 to 2000, only a fifth of the rural households in the state had electricity for lighting. According to the same data, in 2001, only 13% of rural households in West Bengal owned TVs, and only 25% of them had any source of drinking water within their homestead. This level of marginalization in terms of structural resources has led to continued poor health among the rural people of Bengal. It is not surprising, then, to note that the daily struggle to make ends meet leaves little in terms of money and time to imbibe healthy practices. Yet another characteristic of rural Bengal worth articulating is the active political involvement of community members in grassroots politics (Chatterjee, 1998). The democratic political process in Bengal draws much of its participant base from rural participants. This active rural participation lends the field setting to the documentation of participation in the health context.

Data

This project is part of a larger ongoing project on redistributive justice in rural health in five communities of West Bengal initiated in August 1996. The most recent round of data gathering was conducted in December 2005, and the overall project involves dialogues about experiences of health, identification of resources, and community mobilizing for securing resources. In the larger project, repeated interviews have been conducted with approximately 75 members of the community over the 9-year period to give a longitudinal sense to the data, to contribute to its depth and richness, and to document the ways in which the community has been mobilized for securing health resources (Lincoln & Guba, 1985).

The data reported in this particular study were gathered over two 1-month periods in December to January 2001 and 2004. Data gathering included taped in-depth interviews and participant observation involving visits to hospitals, clinics, dispensaries, and homes of participants. The visits to the health settings were particularly valuable in providing a sense of the material condition surrounding the health of the participants. One of the authors maintained journal entries of the visits in Bengali, the primary language of the region. This resulted in approximately 58 pages of field notes. The project was approved by the institutional review board of the university with which the authors are affiliated. To ensure informed consent, the consent forms were translated into Bengali. We maintained the confidentiality of the participants by destroying the tapes after transcription and by changing the names of the participants on the transcripts. In addition, the transcripts were stored on secure computers. The local municipality of the township of Kharagpur approved the study.

The five villages where interviews took place were located between 4 and 45 kilometers from the main town of Kharagpur, which served as the main artery to the villages. Although some of the villages were accessible by pucca (concrete) roads, others were not. In the instances where the villages were not connected directly with a road, we had to walk on the embankments in the paddy fields to reach them. Both of the researchers grew up in rural or semirural communities in West Bengal, and this gave us a context for participating in dialogue. In addition, one of us was actively involved with the trade union movement in this region of Bengal and thus had an understanding of the context through personal experience of approximately 10 years.

We contacted an initial pool of participants through the local trade unions that worked in the villages surrounding the town of Kharagpur. The trade unions were particularly relevant to providing access to the men in rural Bengal because they worked with the participants on work-related issues and on securing access to a variety of resources, including health-related ones. Given the emphasis of this project on exploring the discourses in response to the marginalization of rural residents and the participatory processes related to health, the entry through trade unions provided access to narratives of social change that were evoked through the projects carried out by the trade unions. Subsequently, participants were contacted and recruited through the snowballing technique. The interviews started with the

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exploration of the meanings of health, followed by questions on meanings of illness, detection of symptoms, sources of health information, treatments sought out, and prevention services used, and concluded with probing questions that built on these basic questions. Interviews were conducted at the homes of participants, at their worksites at the end of the workday, and at the local market where the participants gathered after work.

Eighteen men ranging in age from 24 to 58 participated in this subproject over the 2-year period. The individual interview sessions ranged between approximately 20 minutes and an hour and were conducted in Bengali, the language of the participants. The interviews were translated by one coder who was conversant with both Bengali and English and were checked by the second coder for accuracy (Lincoln & Guba, 1985). They were supplemented by journals maintained by the first author, who conducted the interviews. The journals contained reflections regarding the interviews, the exploration of meanings, and the authors' reflexive engagement with the materials and provided a contextual framework for checking the meanings developed through the analysis. The total amount of journal space amounted to approximately 21 single-spaced pages.

Data Analysis

The interviews were conducted in Bengali simultaneously with transcription, translation, and data analysis. Having grown up speaking both languages (Bengali and English), the second author, who did not participate in the interviews, conducted the transcription and translation. The first author checked the transcription and translation to ensure accuracy (Easton, Fry McComish, & Greenberg, 2000). We resolved disagreements on translations by discussing them further and modifying them based on consensus. The involvement of two coders (the two authors) in the transcription and the translation process ensured greater reliability and validity of the data (Lincoln & Guba, 1985).

The coconstructivist grounded theory method of analysis was particularly well suited to culture-centered approach of this project (Charmaz, 2000; Strauss & Corbin, 1990). We were interested in exploring the intersections of our conversations with the participants with our experiences in the field. Data analysis was started in 1996 simultaneously with the first interviews and continued through the life cycle of the interviews (Charmaz, 2000; Strauss & Corbin, 1990). We used the constant comparison technique, comparing and contrasting the themes and concepts that emerged from the interviews (Strauss & Corbin, 1990). We started the analysis with open coding, followed by axial coding and selective coding to develop a theoretical understanding of health communication in rural Bengal.

Open coding was used to identify discrete concepts that could be easily labeled and sorted. We pulled real examples from the text to identify and build themes. We examined the data sentence by sentence, which aided in the development of concepts. Subsequently, we grouped the discrete concepts that were related to the same phenomenon under conceptual categories. At this stage, the conceptual categories were checked by the second author, who had helped with the translation of the interviews. Open coding was followed by axial coding, which involved the formulation of relationships within and among the categories; finally, theoretical integration was achieved by selective coding (Strauss & Corbin, 1990). We continuously conversed with the key respondents through the different steps of open, axial, and selective coding to evaluate the validity of the themes (Lincoln & Guba, 1985). After we developed our categories, we conversed with these key respondents to ensure the validity of the results. Four key themes emerged from the interviews: health and a responsible life, healthy choices and work, health and structural barriers, and solutions through participation.

Findings

Health and a Responsible Life

When asked to talk about health, the participants discussed the importance of taking care of health to be able to provide support for family members. Taking care of health was primarily constructed as a responsibility toward others in the social network. For Mihir,[1] health dictated whether his children would have food to eat. He said, "I need to be in good health so I can keep working and taking care of them." One needed to be healthy to earn money and provide for the health of the dependents. Participants articulated the importance of providing access to good health care for their children, and this was their primary health concern. In this context, health was seen as a responsibility toward those that were dependent on the participants. Bapi talked about his children and expressed his frustration at not being able to provide access to good health care for them:

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> I have not been able to provide them very good health care. I would not say they are in the best of health. How could they be? I have not been able to provide them with the best of medical help. I do not have the ability to provide them with that. Who knows what illnesses they have? With my income all I can reach is the homeopathic doctor.

Bapi constructs his understanding of health in the realm of his responsibility toward his children. He laments his inability to provide them with medical help. The responsibility toward children and others in the family is enacted in the realms of providing them with basic health necessities, such as fruits and vegetables, and providing medical help in the case of illnesses. He articulates the constraints posed on access to health care by his limited income. The inability to provide greater access is seen as failure to carry out one's responsibility as a provider. Responsibility, in other words, is seen as the ability or inability to provide resources to one's family and take care of them. It is within this realm of securing access and carrying out their responsibility that the participants discussed their understandings of health.

The resource-based understanding of health also played out in the domain of participation in controlling the size of the family. Participants mentioned actively trying to control the size of the family so that they could allocate resources adequately to the children. It was important to have one or two children so that better resources could be provided to them. Jibonda[2] discusses his responsibility in ensuring that his children have adequate resources, and therefore, he suggests that he has to practice family planning.

> I have a daughter. And we are expecting another child soon. Taking care of the family is also a big headache nowadays. As long as this job is there it should be okay. It is also not advisable to have too many children because you have limited resources to look after them. And if you are not able to take care of them well, they are likely to blame you later. So we have decided, whether we have a girl or a boy, we will have an operation after that [Jibonda was planning to get vasectomy].

Jibonda wanted to control the size of his family so that he could provide adequate resources for his children. Note that he emphasizes the importance of providing access to resources to the children, irrespective of the gender of the child. Other participants similarly highlighted the importance of providing access to health resources and discussed their central role in the family as caregivers to carry out this responsibility. The ability to perform one's responsibility was connected with work; the income received from work provided the economic access to health resources.

Healthy Choices and Work

The participants we spoke with highlighted the importance of taking care of health on a daily basis through the engagement in health-oriented practices. Participants reported a variety of lifestyle-related practices, such as eating vegetables, eating food on time, exercising, and watching the type of food they eat as attempts to stay healthy so that they could continue working. Here is a description of exercising as a way of staying healthy: "The boys in the house have heard from their friends that exercise helps to stay fit and healthy. So they are into exercises, and sports. That's how they think they can remain healthy." Another participant describes being careful with what he eats: "I have had to be more careful . . . like trying to avoid potatoes, having less of fried food, mostly having boiled food." It is important to do all the things in one's control to be healthy, the participants reported, because falling ill is directly related to the inability to earn a living and provide for one's family. In a system that does not guarantee the next day's job, the participants have to make sure that they are doing their best to be healthy so that they can perform their work roles.

The responsibility toward one's family, depicted in the previous section, is often played out through the interlinkages between health and work. Highlighting this point, Modonda says, "I know that if I fall ill, I will not be able to earn for my family." For him, the greatest concern is to be able to go to work and earn money to support his family. Similarly, Prabir says, "I am not too well either. But I know I have to keep working because three more people depend on me. I seem to be living a life of great risk with my health. It's my responsibility towards my family that keeps me going." Although Prabir is not well and thinks that he is at great risk, it is his responsibility toward his family that keeps him going. He articulates that he must continue working because his family members depend on him.

Health for the participants is critical and essential to the work life; they report having to stay healthy to be able to earn a living and support the family. Being unhealthy is linked with the inability to earn a living. The desire and necessity to stay healthy, however, are intertwined with and limited by work-related structural barriers that impede the realization of healthful practices. The dialectical tension that emerges from the

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discourse of health is a tension between work and health. The participants have to stay healthy to find and retain a job and to be able to continue working. On the other hand, the demands of the job prevent the participants from engaging in the healthful practices they desire to practice. Whereas it is important to remain healthy to retain a job, it is also critical to forget about one's own pain and illness to keep working and earning the much-needed money for the family. According to Swapan, a 31-year-old participant,

> I also try to be careful about the food I eat. I try and avoid fried or rich food. And at times I am not able to take food on time. When that happens, I usually end up with gastric pain, dizziness and blood pressure. I can understand when that happens. And then I try to have the correct food and have food on time.

For Swapan, it is important to be careful to prevent illness; he needs to eat food on time to prevent his gastric pains. Although he points out his desire to eat food on time, he is unable to do so because of the demands of his work life. Time emerges as a critical structural barrier that is intertwined with the basic need of earning a living through work. Swapan also points out his efforts at monitoring his health. He keeps a watch on his health and changes his behaviors according to the symptoms he faces. Health becomes embedded in the daily struggles of life, in his attempts to ensure that he is healthy enough to go to work.

Similarly, Sonaton articulates the constraints placed on his health by the demands of work: "Well, I want to remain healthy and try my best to be so. But I am not able to devote too much of time or money." Once again, the inability to pay attention to one's health arises from the demands of the workplace and the limited time the participants have during the day to engage in healthful practices such as eating on time. Jhontu also points out his inability to eat food on time because of his desire to secure an education so that he could make a living:

> I studied, passed my higher secondary and then did a technical course. I had a gastric ailment because of not having food on time. I used to leave my home early in the morning. I used to take tuitions and then have some food, pack some and leave. I used to take the 9 am train and reach my institute at 10.30. There I used to take classes and return at around 4 in the evening. Not taking food on time during this period led to gastric problems and I grew weak.

Jhontu's gastric ailment was related to his inability to have food on time, which, in turn, was constrained by the pressures created on his schedule during the period when he had to travel a long distance to attend a technical course in a different town. Other participants articulated similar concerns about not having the time to take care of their health. They also reported poor working conditions, which they thought were causing their poor health. Jonardon worked in a steel mill and complained about the fumes. He also reported organizing his coworkers in the mill to complain to the owner. Babu reported that his poor health was caused by "the stench and the poisonous fumes that we have to inhale in the factory here." Ram pointed out,

> The fumes are suffocating. We have petitioned the owner of the factory asking him to make arrangements such that the fumes are sucked out through a ventilator. But he has not paid heed to our appeals so far. A lot of us have been having gastro-intestinal tract problems because of having to inhale these fumes. One of our colleagues—Nishikanta—now has gastric ulcer because of this. And now he has been prescribed medicines over an extended period of time. He was off duty for five months and has rejoined recently. Many of us are suffering in the same manner. I get ill off and on.

Although Ram reports having petitioned the owner of the factory, asking him to make alternative arrangements for the fumes to be sucked out through the ventilator, the owner has not been willing to do so. Ram reports having gone on strikes to get the owner to change the ventilation, but that has not worked. He points out that he and other workers are limited in their ability to negotiate with the owner because they depend on the owner to make a living. Jonardon also pointed out the importance of having a job to support his family; he further articulates that the demands of his role as a provider keep him from thinking about his own health:

> But I am helpless. To keep my family going I have to forget about my health and keep earning. Maintaining a good health requires money and I cannot waste my time complaining that I do not have enough money. I have to keep working with little regard for my health.

Jonardon has to background the problems he has been having with his own health so that he can keep working to provide for his family members. Evident in Jonardon's narrative is the basic absence of structural resources and the dialectical tension between work and health. As pointed out earlier, one has to be healthy to work. At the same time, a man has to forget about his health problems so that he can keep

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working and provide for his family. This leads us to the next section, which emphasizes the role of structure in the construction of health meanings.

Health and Structural Barriers

As depicted in the last two sections, health in rural Bengal is deeply ingrained within the structural environment. The narratives that are shared by the participants highlight the experience of marginalization within the constrained structural environment. The ability or inability to access health care is played out within the limits set by the structure on the life experiences of the participants. Participants articulated the role of structure in the context of being able to purchase healthy foods and engage in healthy lifestyles, and being able to seek out appropriate treatment in the face of illness. The following excerpt brings out the limited choices of participants:

> We can afford only basic food—rice, lentils and a few vegetables. Buying fruits is out of our reach, it's like a dream. I do know that fruits help to keep you healthy. I can see people around who have fruits and are healthy. So I know that it is true.

For Rotton, buying fruits is a dream. His day-to-day struggles focus on the need to acquire the basic resources of health needed by his children. He states that with his meager income, his family can afford only the basic necessities, such as rice, lentils, and a few vegetables. Rotton knows that eating fruits is healthy but simply cannot afford them, as they are sold in the local market at an exorbitant price.

Shyam points out that his limited income allows him to provide his wife and children with only the basic needs. After meeting these basic demands, he is not able to do much more: "And the little I earn is spent on providing my wife and children with basic needs. Little is left for eating good food and remaining healthy."

Once again, for Shyam, the day-to-day struggles are centered on being able to provide his children with the basic needs.

Hand in hand with the lack of access to basic resources for maintaining good health is the absence of resources for securing access to treatment. Probal has this to say about the local government hospital, which is supposed to provide the poor with access to medical treatment:

> There are good doctors in government hospitals, but they are accessible to only those that have money. The rich go to these hospitals, are able to pay the required money and get the best treatments. We poor people are left behind. I am not able to get the best treatment that I could get at such hospitals. Poor people like us are asked to leave when we ask questions. Doctors and medical staff are rude with us and they tend to forget that they are here to serve the people, not solely to earn money. However, people who have money are treated far better.

He points out that the government hospitals are not available for poverty-stricken people such as him. The best treatments are reserved for those with money, even in government hospitals, which are supposed to serve the deprived sectors of the population. He also articulates the marginalizing communication practices in the hospital. Probal and other rural men who participated in the interviews pointed out that they are asked to leave when they ask questions. We remembered our field visits and observing similar rude behaviors the staff engaged in when speaking with rural participants that were apparently poor. Here is an excerpt from a journal entry one of us made during a field trip to a hospital:

> I am continuously reminded of the mistreatment of the poor during the visits to the hospital. Today, a hospital staff was yelling at a patient because he kept asking questions and could not understand the prescription instructions. After trying to retort a few times, he gave up and sat down on the bench. I don't really think he understood the instructions and went to speak with him. He asked me if I could explain what the prescription meant.

This points directly toward the interpenetration of structure and communication practices. The marginalization via the structural forces is intertwined with the silencing of the subaltern participant through hostile one-way communication. His location at the peripheries of the socioeconomic system dictates his communicative position of being silenced. He further points out that the doctors and medical staff are rude to him because they want to treat only people who have money. Medically and communicatively, the subaltern participants of this study pointed out that they are mistreated because they do not have money, the fundamental structural resource that ensures the flow of health and medical resources. In navigating a resource-deprived environment in which the rural participants find themselves, what solutions do they propose? The discursive space is filled with suggestions for solving the basic problem facing the rural areas of Bengal.

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Solutions to Health

In their discussion of the problems, the participants located the importance of finding solutions to the key issues that they thought influenced their health and articulated the importance of active involvement of community members. For Sishir, "We can not simply wait for something to change. We have to take charge ourselves. Politics is one way we can change things." In other words, participants such as Sishir highlighted the importance of their involvement in political processes to change the structure that limited the access to health resources. As articulated earlier, participants talked about going on strikes to ensure safer and healthier workplace conditions, but they also indicated the limits imposed on them by the structure because of their day-to-day dependence on jobs for daily living.

One of the key areas that needed to be addressed was the provision of access to basic health resources. The participants suggested the importance of opening a health center that would have the basic supply of medicines. Sonaton said,

> With a little help from you we can do this. . . . We can set up a small health center here. And we will have to ensure that the health center has a stock of medicines. In most health centers around the country there is a dearth of medicines. The situation is really bad. All that they can give for free are the Digene and Gelusil tablets.

Sonaton's articulation of solutions suggests the active involvement in the creation of a local health center that would provide access to some of the basic medical necessities. He further points out that this responsibility is really one of community members, who ought to work toward ensuring that the medical resources are available to them. He also reminds us of our role as facilitators for securing access to structural resources.

On a similar note, Rabin remembered the time that he and his colleagues had to take one of their coworkers, who had injured himself at the mill, to a hospital. He pointed out that the hospital experience brought to the forefront the lack of access to basic medical supplies, making him want to work toward changing something: "That day I realized something will have to change." He stated that the hospital did not even have antacids, which he considered to be a basic medical supply.

> Remember, we had taken that person from Nishikantapur to the general hospital. He had injured his hand while working on a machine. . . . They gave him some painkiller tablets that did not work and he even had to buy the antacid tablets. A government hospital does not even have the antacid tablets.

Expanding on this articulation of lack of access, Rabin further pointed out that the political system needed to be engaged to ensure access for all and to keep a check on the quality of hospital services. He also discussed his active participation in the local political system where he discusses some of these needs with other community members and the leaders of the trade unions and political parties.

For the participants, in addition to creating points of access to basic resources of health, it was also critical to create points of access to education for the children in the rural areas. They pointed out the importance of education in securing a job, which, in turn, is critical to gaining access to health resources. Jhontu suggested that building a school would be a good starting point, one that is fundamental to improving the plight of the poor in rural Bengal (including health conditions). He pointed out the current state of the system, which limits access to education for the poor, and suggested that we build schools as a solution to the health problems:

> Or we can do this [build schools with access]. In every village in our country we have kids . . . say 500 of them in every village. And there is a primary school in every village. For all these 500 students there are not more than three teachers. It is difficult for these teachers to tackle 200 to 300 students. So the education these children receive is not always up to the mark. Our education system is not that great. For those people who have money, they are able to afford private tutors for their children. These students later join the IIT (a premier educational institution in India located in the town of Kharagpur), do well and leave the place or the country for better prospects. For those who are poor and who cannot afford, they have nothing to do but rot here.

For Jhontu, whereas the education system privileged the middle classes and the rich, it did not provide access to the tools of basic education for the poor. The students from families with money are able to secure access to education and later leave for the United States, whereas those who are poor are left with nothing. The idea that the children of the privileged find

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access to quality education and subsequently leave the country was articulated by another participant, Binod:

> There are a lot of people here who have studied here and then gone off to America. The son of the local teacher and then my neighbor . . . I cannot recall his name. But his surname is Das. He too has gone to America, that's what I hear. But these people have not spared much of a thought for the country. That's quite evident.

Binod suggests the critical responsibility of the privileged in taking care of the underserved. He highlights the importance of giving back to the community and suggests that it is only by assistance from those who have achieved success that structural resources could be secured to create better avenues for resource acquisition. With this hope, Binod and the other participants look at us, suggesting that we do something to improve their plight. The articulation of solutions by the participants directs us toward their agency; they actively participate in suggesting ways of improving their health. They also make sure to articulate to us our roles and responsibilities as researchers, community members, and participants. They suggest that perhaps we could work with them in building a school or a community medical clinic to solve these basic problems in the community. The impetus for health solutions comes from within the community through dialogue with the community members.

Discussion

In this article, we have outlined the active participation of men in rural Bengal in the negotiation of health meanings, in practicing health-oriented behaviors, and in working toward addressing the structural barriers that set constraints on their health. Health is seen as a commitment toward others in the relational space; it is connected with one's responsibility toward members of the social network. When participants were asked to discuss their meanings of health, they immediately referred to the health of children and others in their social networks that were dependent on them (wives, parents, etc.). They also referred to their responsibility in ensuring that their family members have access to health resources. Because they perceived health in terms of their responsibility to provide adequate care for their immediate family members, health was also intertwined with the ability to find and retain work. It is only by working that participants were able to support the health of their families financially; therefore, they needed to ensure that they stayed in good health to be able to continue working. Such a functional perspective of health supports earlier research that articulates similar emphasis on health as an economic resource, as the ability to carry out daily duties without taking time off (Blaxter, 1983; Calnan, 1987; Hughner & Kleine, 2004; McKague & Verhoef, 2003).

The discussions reflected a sense of monitoring one's health within the limited health resources so that one could keep working and supporting one's family. This active sense of responsibility counters the existing literature in health communication that portrays the subaltern classes in terms of external locus of control and with a low sense of self-efficacy. The participants talked about the steps and procedures in which they actively participated so that they could maintain good health. Of course, such participation was limited by the economic factors that determined most of the life choices in rural Bengal. Yet another finding of this project was the role of the structural barriers in limiting what was available to the participants. The participants pointed out that most of their day-to-day struggles focused on being able to feed their children. The struggles focused on being able to access and secure basic food resources, such as rice and lentils. Although the participants suggested that they knew about the importance of fruits and vegetables, they were limited by their structural situation in terms of their ability to purchase these foods.

Similarly, the participants pointed out that in most cases, they were unable to secure proper care in the hospitals, which typically privileged the middle class. The experience of trying to seek treatment in a hospital was described as silencing; the participants pointed out that they had to remain silent so they would not be denied health services and were not really in a position to voice their discontent and dissatisfaction. They also highlighted the intertwined nature of marginalizing communication practices and the structural forces. The experience of the rural participants in the hospital was one of rude behavior and unsympathetic communication on behalf of the hospital staff.

In documenting the role of structure in constraining the resources available to them, the participants discussed possibilities of change. They participated in political processes to ensure access and work toward changing the unhealthy conditions that encompassed their lives. They also suggested key solutions (medical

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clinic, medical supplies, etc.), which, they thought, could be instrumental in improving their life condition. In addition to addressing the immediate health needs of the community, the participants suggested the importance of addressing more profound causes of structural imbalance, such as education of the children of the community. They articulated the need for schools that would provide access to quality education to the children of the rural communities, so that they could improve the plight of these communities. Theoretically and methodologically, the participants in this project remind us of our role as researchers. They express the urgency with which things need to change so that they might have access to food, a healthy life, and health-related resources.

Applications

Instead of defining a problem a priori, a researcher using the culture-centered approach emphasizes understanding and engages in dialogue with community members to identify the critical health problems and solutions in a community. Our culture-centered dialogues with community members suggest that funding agencies need to shift their objectives from individual behavior change to communicative empowerment and redistributive justice, channeling resources toward addressing contextual factors and problem articulations as voiced by community members.

More specifically, for the rural community members with whom we engaged in dialogue, the key problem is located in the realm of access to health resources. This problem with access, although specific to the local context of Bengal in this project, exists at a more global scale. For instance, within the United States, the uninsured and homeless constitute segments of the population who experience similar problems of minimal access. Therefore, health communication applications in underserved communities need to focus on activist projects of redistributive justice rather than campaigns targeting individual behavior (Wallack, Dorfman, Jernigan, & Themba, 1993).

Strategies of community organizing, community mobilization, lobbying, and media agenda setting need to be developed further and applied to address community-based issues such as structural inequities and lack of access to health care in subaltern sectors of the globe. Along these lines, one of us has been involved over the past 4 years in conversations with local unions and participating in community theaters on issues of poverty, redistributive justice, and resource deprivation. Our coconstructions in this essay suggest that more and more voices of subaltern people need to be heard for the sake of articulating the systematic absences in the field, and 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.

Notes

1. The names of the participants have been changed to protect their identity.

2. *Da* is a suffix used with a name, and it means "elder brother." In this instance, Jibon is the name of the person, and *da* signifies that Jibon is considered an elder in the community hierarchy.

References

Airhihenbuwa, C. (1995). *Health and culture: Beyond the Western paradigm.* Thousand Oaks, CA: Sage.

Blaxter, M. (1983). The causes of disease: Women talking. *Social Science and Medicine*, *17*, 59-69.

Calnan, M. (1987). *Health and illness: The lay perspectives*. New York: Tavistock.

Charmaz, K. (1995). Identity dilemmas of chronically ill men. In D. Sabo & D. F. Gordon (Eds.), *Men's health and illness* (pp. 266-291). Thousand Oaks, CA: Sage.

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

Chatterjee, P. (1998). *Present history of West Bengal: Essays in political criticism*. Calcutta: Oxford University Press.

Dutta-Bergman, M. (2004a). Poverty, structural barriers and health: A Santali narrative of health communication. *Qualitative Health Research*, *14*, 1-16.

Dutta-Bergman, M. (2004b). The unheard voices of Santalis: Communicating about health from the margins of India. *Communication Theory*, *14*, 237-263.

Dutta-Bergman, M. (2005). Theory and practice in health communication campaigns: A critical interrogation. *Health Communication*, *18*, 103-112.

Easton, K. L., Fry McComish, J., & Greenberg, R. (2000). Avoiding common pitfalls in qualitative data collection and transcription. *Qualitative Health Research*, *10*, 703-707.

Escobar, A. (1995). *Encountering development: The making and unmaking of the third world*. Princeton, NJ: Princeton University Press.

Ford, L. A., & Yep, G. A. (2003). Working along the margins: Developing community-based strategies for communicating about health with marginalized groups. In T. Thompson, A. Dorsey, K. Miller, & R. Parrot (Eds.), *Handbook of health communication* (pp. 241-261). Mahwah, NJ: Lawrence Erlbaum.

Freire, P. (1970). *Pedagogy of the oppressed*. New York: Seabury.

Hughner, R. S., & Kleine, S. S. (2004). Views of health in the lay sector: A compilation and review of how individuals think

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about health. *Health: An Interdisciplinary Journal for the Study of Health, Illness, and Medicine*, *8*, 395-422.

Lincoln, Y. S., & Guba, E. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

McKague, M., & Verhoef, M. (2003). Understandings of health and its determinants among clients and providers at an urban community health center. *Qualitative Health Research*, *13*, 703-717.

Mokros, H. B., & Deetz, S. (1996). What counts as real? A constitutive view of communication and the disenfranchised in the context of health. In E. B. Ray (Ed.), *Communication and disenfranchisement: Social issues and implications* (pp. 29-44). Mahwah, NJ: Lawrence Erlbaum.

Ray, E. B. (1996). Introduction. In E. B. Ray (Ed.), *Communication and disenfranchisement: Social health issues and implications* (pp. xv-xxi). Mahwah, NJ: Lawrence Erlbaum.

Registrar General and Census Commissioner of India. (n.d.). *2001 census*. Retrieved July 11, 2006, from http://www.censusindia.net/

Sharf, B. F., & Kahler, J. (1996). Victims of the franchise: A culturally-sensitive model of teaching patient-doctor communication in the inner city. In E. B. Ray (Ed.), *Communication and disenfranchisement: Social health issues and implications* (pp. 95-115). Mahwah, NJ: Lawrence Erlbaum.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Waldron, I. (1995). Contributions of changing gender differences in behavior and social roles to changing gender differences in mortality. In D. Sabo & D. F. Gordon (Eds.), *Men's health and illness* (pp. 22-45). Thousand Oaks, CA: Sage.

Wallack, L., Dorfman, L., Jernigan, D., & Themba, M. (1993). *Media advocacy and public health: Power for prevention.* Newbury Park, CA: Sage.

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