

Poverty, Structural Barriers, and Health: A Santali Narrative of Health Communication

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Recent years have witnessed a surge in scholarship that problematizes the linear, Eurocentric approach to international health communication and suggests the pressing need for a culture-centered approach. This author takes a culture-centered approach to exploring the Santali meanings of health in rural Bengal. The open-ended interviews conducted with the Santals bring to surface key issues and meaningful theories of health. Central to the Santali experience of health is food; for the Santal, it is his or her hunger that is the greatest cause of disease and illness. Poverty and the presence of structural barriers that cripple Santali existence emerge as the critical themes of Santali health meanings. The study also illuminates the complex process of meaning making engaged in by participants of marginalized sectors. The author draws policy-based implications from the findings of this research.

Keywords: *subaltern studies; marginalization; health; culture; international; post-colonialism*

The centrality of culture to the study of health communication has received particular attention in recent years (Airhihenbuwa, 1995). In spite of the emphasis on culture in the discussion of health meanings and health services delivery, research and theorizing in health communication continue to originate from the core sectors that have traditionally defined the discursive realm of health communication (Dutta-Bergman, 2003). Extant theories such as the theory of reasoned action and the health belief model continue to capture our attention when documenting issues of health in other cultures (Airhihenbuwa, 1995; Dutta-Bergman, 2003). Although, the rhetoric of locating culture at the center of theorizing is a welcome move, scholarship and application in the realm of health communication continue to echo the voices of those with power and access (Dutta-Bergman, 2003). Absent from the literature in health communication are those voices from other cultures that have traditionally been marginalized and silenced (Marshall & McKeon, 1990).

Culture is especially important in international health communication research, because it constructs and interprets meanings from within instead of imposing them from outside (Airhihenbuwa, 1995). Based on the culture-centered perspective, I offer in this project a narrative of the Santali people of Midnapur, West Bengal. The Santali narrative is especially important because of the location of the Santal at the boundaries of tradition and modernization in India, accompanied by his or her marginalization at the hands of the national elite (Duyker, 1987). Through the Santali narratives, I seek to elucidate how marginalized people construct health. In the following sections, I will review the literature on the culture-

centered approach to health communication and the Santals of West Bengal. Subsequently, I will present the research questions that will guide the stories shared in the rest of the article.

THE CULTURE-CENTERED APPROACH TO HEALTH COMMUNICATION

Criticizing existing approaches to studying health communication, Airhihenbuwa (1995) has argued that health communication theorizing ought to be driven by culture. Culture-centered health communication envisions culture as transformative, constantly metamorphosing, and constitutive in the realm of health meanings (Dutta-Bergman, 2003). With an emphasis on speaking from the margins, on building epistemologies from the margins, and on creating alternative discursive spaces for the conceptualization of health, the culture-centered approach reverses the traditional one-way flow of communication from the core to the periphery.

Central to the culture-centered approach is the foregrounding of agency of the cultural participant. Participants actively construct meaningful explanations that make sense to them. In his book *Encountering Development*, Escobar (1995) outlined the culture-centered approach, emphasizing the importance of acknowledging marginalized people's capability to determine their own life course, model their own behaviors, and develop epistemologies based on self-understanding. The culture-centered approach promises to open up legitimate discursive spaces for marginalized cultural groups, bringing to the fore the narratives that are articulated within these cultural spaces (Freire, 1970). Meanings are socially constructed via dialogue among cultural participants, and essential to these meanings is the broader context that surrounds them. The emphasis of the culture-centered approach, therefore, is on examining the discursive processes through which the culture engages in the social construction of communicative meanings. In this article, I have taken the culture-centered approach to health communication, proposing to construct a narrative of Santali health that originates from within the discursive spaces of Santali life. The stories that emerge in the following pages are the stories that were shared by the Santals about their day-to-day lives and the issues of health encompassing their lives.

THE SANTALS

Spread across the Chotanagpur Plateau of Bihar, West Bengal, and northern Orissa, the Santali tribe is located at the margins of mainstream India, struggling with the tensile forces of assimilation and resistance (Mahapatra, 1986). The Santals constitute a significant portion of tribal India and were a wandering tribe before the invasion by the Aryans (Duyker, 1987). They originally occupied the central alluvial valley of the Ganges, subsequently migrating southwestward to the Hazaribagh hills after the Aryan invasion (Duyker, 1987).

Some of the earliest written accounts of the Santali life are found in Hamilton's (1828) *Eastern Indian Gazette*, in which he wrote, "Some parts of these jungles were occupied by poor miserable proscribed races of men called Santals" (p. 229). These

jungles were the dominion of tribal chieftains and had never been subjugated by the Moghul invaders of India (Hamilton, 1828). Practicing slash-and-burn horticulture, the Santals lived in close relationship with nature, clearing new lands and allowing the old plots to grow into secondary forests until the British invaded Midnapur. The Santali form of life was fundamentally threatened by the British land revenue policies (Duyker, 1987), which favored *zamindars*, the local landholders who served as rural agents for the foreign rulers (Palit, 1975). The absence of documentary details of resources accompanied by the lack of access of the Santal to legal procedures ensured the transformation of the Santal to tenants-at-will (Duyker, 1987; Palit, 1975). Duyker further argued that the British system of jurisdiction also introduced rigid statutes of property and contract, leading to the birth of moneylenders, who exploited the Santal with 100% to 150% interest rates, such that the Santals had nothing left for themselves once the crops were ready to be harvested (Hamilton, 1828).

The Chuar rebellion of 1799 to 1800 and the Bhumij revolt of 1832 to 1833 were outcomes of the Santali resentment of the oppressive system (Duyker, 1987). The dislocation of the traditional Santali economy, accompanied by the continual exploitation of the Santal, led to the migration of Santals from Midnapur and other districts to the Dumka subdivision of Bihar, which later came to be known as Damin-i-koh. (Duyker, 1987). The increasing number of Santals in Damin-i-koh entered into land revenue settlements with the British government and for "the first time in their history had some form of land tenure" (Duyker, 1987, p. 32). However, the settlers of Damin-i-koh had to make payments to the British government in cash and, therefore, had to go to the markets immediately after harvests to sell most of their crop.

The participation of the Santal in the market economy reproduced the exploitations that were earlier seen in Midnapur and other neighboring districts, resulting in the Santali insurrection (referred to as *Hul*) of 1855. Between 6,000 and 7,000 Santals organized with the goal of overthrowing the British rulers (Datta, 2001). The insurrection, although initially successful, was defeated and continues to dominate the historical consciousness of the present-day Santal, retained through songs and invocations (Datta, 2001; Duyker, 1987). The leaders of the insurrection, Sidhu and Kanhu, are an integral part of present day Santali folklore (Duyker, 1987).

In the years following the independence of India from the British, the socio-political system continued to reproduce the exploitation of the Santal. More and more Santali peasants became landless laborers in spite of the Bengal Tenancy Act, proposed to give aboriginal tenants more protection. Whereas the number of Santal owner-cultivators decreased exponentially between 1961 and 1971, the number of agricultural laborers increased exponentially. This growing level of landlessness gave rise to the Naxalite movement of 1967, an attempt to regain the lost land. The Naxalite movement was repressed by the organized state apparatus (Duyker, 1987).

The Santalis are marginalized from the broader sociocultural system of India in spite of being the earliest inhabitants of the country (Mahapatra, 1986). Although the Santali population is distributed in regions that contain the richest deposits of iron, coal, and other crucial minerals, the narrative of the Santali life is marked by lack of access to the many basic resources available to the rest of the Indian population. How, then, does the Santal understand health and illness in the context of the sociocultural practices and the marginalizing modernization projects of India? Based on the Santali story, this article seeks to inform the process of meaning con-

struction in marginalized spaces. Informed by the culture-centered and subaltern approaches to studying health, two key questions are asked:

RQ1: How does the Santal construct health and illness? and

RQ2: What approach does the Santal take to treating disease and illness?

METHOD

Data Gathering

This article is part of a larger multi-site research project exploring Santali health beliefs in India. In this research, I have sought to serve an advocacy role by the inclusion of Santali voices in health policy and health services delivery in India. Interviews were conducted in the Midnapur district, the first site of British colonization in India. Initially, I identified local labor unions and nongovernmental organizations (NGOs) as the channels for recruiting opinion leaders in the Santali community; these opinion leaders were active members who participated in Santali issues in the region. Subsequently, additional respondents were recruited through the snowballing technique. Thirty two cultural participants engaged in the narrative construction; there were 18 (56.25%) men and 14 (43.75%) women in the study. The mean age of the sample was 37 years. Each participant was paid Rs50¹ for participating in the study. I obtained informed consent by translating the consent forms to Bengali, and reading them out and explaining them to the participants in instances where the participants could not read them. The reference provided by the opinion leaders, NGOs, and labor unions allayed the anxiety that might have been caused by the prospects of signing a written document and being audiotaped.

The interviews opened with discussions about Santali life, with the audiotaped interview being guided by the information that the respondents volunteered and the directions toward which they steered the interviews. The interview tapes were destroyed after transcription. The initial interview protocol was informed by my experience with the Santali community (approximately 26 years) and the article's focus on developing a Santali theory of health. I added questions to the protocol as the interviews proceeded to fill the information gaps. Held at the interviewee's home or at the local market where the Santals got together at the end of the workday before heading home, each interview ranged from 25 minutes to almost 2 hours, and the average interview length was approximately 45 minutes. I also took field notes in Bengali (48 pages) after returning from the interviews and kept self-reflective journals to assist me in drawing conceptual links (Strauss & Corbin, 1990).

Data Analysis

The interviews were conducted simultaneously with transcription, translation, and data analysis. Having grown up speaking both languages (Bengali and English), I did the translations. My participation in the transcription and translation ensured accuracy (Easton, McComish, & Greenberg, 2000). The translation from Bengali to English of the interviews was further checked by a second coder (whose mother tongue was Bengali), who taught English at a local postsecondary school. Disagree-

ments were resolved by further discussion of the translation and by modifying it based on the consensus between the two coders. The involvement of two coders in the transcription and the translation process ensured greater reliability and validity of the data (Lincoln & Guba, 1985).

Given the culture-centered approach of the study, the grounded theory method was particularly well suited for use in analyzing the data in this study (Strauss & Corbin, 1990). Data analysis was initiated in 1998 in conjunction with the first interviews and proceeded side by side with data gathering (Strauss & Corbin, 1990). I generated a culture-centered theory of health by using the constant comparison technique, comparing and contrasting the themes and concepts that emerged from the interviews (Strauss & Corbin, 1990). I used open coding, axial coding, and selective coding systematically to develop the Santali theories of health. I started the data analysis with open coding to identify discrete concepts that could be easily labeled and sorted; real examples from the text were pulled together to identify and build themes. I examined the data sentence by sentence, which aided in the development of concepts. Subsequently, I 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 coder, who had helped with the translation. 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). I kept in continuous touch with key respondents through the steps of open, axial, and selective coding to evaluate the validity of the themes and presented the final project to these key participants before getting it ready for publication (Lincoln & Guba, 1985). Five key themes emerged in the interviews: food and poverty, modern medicine, homeopathic medicine, the *Ojha*, and Santali oppression and resistance.

RESULTS AND INTERPRETATIONS

Where Is Food?

When interrogated about his or her concept of health, the Santal located health primarily in the realm of his or her access to food. The struggle for good health is embedded primarily within the struggle for food. Marked by the very essence of poverty, hunger is an integral part of Santali life and remains a primary impediment to the achievement of good health. The Santal's interrogation of a healthy life revolves around his or her ability to find food that would feed the entire family. As long as food is available, the family lives a happy and healthy life. Health comes as a guarantee when the Santali child is able to eat his or her daily share of *panta* (rice soaked in water and usually eaten with a green chili or an onion). Nimai¹² points out the agony of hunger that plagues his family:

Last year, it was the monsoon season. It rained every day. The rains kept coming. It was as if the rains would never end. I had to stay home. Could not go out to find work. Ten days I was out of work. I went and begged for job but did not find one. My children would wait at the door for me to return, their eyes were hungry. They wanted food.

Nimai1's poverty is central to his life and is directly related to health through the conduit of food. Working as a part-time laborer, Nimai1 had difficulty finding a job in the rainy season. Because he did not have any savings, and because his existence was intrinsically intertwined with the daily wage that he earned as a laborer, Nimai1 would not be able to provide his children with what he considered the basic source of life, a handful of rice soaked in water. The pain and the suffering of his children haunted Nimai1. He said,

How can I stand their pain? How can I see them go hungry? I am the father. I gave them birth. They look at me, they think I will take care of them. But I can't. I can't even offer them food. I think about this. I think. But then, what do I do?

Nimai1's voice resonated with a sense of hopelessness. He despaired at the fact that he was not able to bring rice for his children. For Nimai1, his failure as a parent was embedded in his inability to secure resources for his children. Imbued with agony, Nimai1's pain showed through his eyes when he shared the stories of hunger. He paused for a few minutes before going on to talk about the pain in which his children would writhe when they went to bed without food. Noteworthy is the importance attributed to food primarily in the realm of the hunger of the child. To the Santal, the health of his or her child is most important, and the basic problem with the child's health is Nimai1's inability to bring home food. Kali4 discusses her poverty on a similar note, pointing out how being nourished is the first step toward better health:

I say this, have a full stomach and live a happy life. We don't need much you know. Just enough *panta* for the day and this body is happy. It is fed and it is happy. But even that is hard to come by.

According to Kali4, all she needs to be happy is her fair share of the *panta* that keeps her nourished, and yet for Kali4, securing this basic nourishment is a difficult task. She discusses her life as a wage laborer working on construction projects and, therefore, depending on the stroke of fate to find work. The day-to-day struggle for food is dependent on the Santal's ability to find a job. An important theme that emerges from the interviews is the importance of rice in Santali life; the security of access to good health depends on access to rice. Also essential to the Santali discourse of health is the central location of poverty and lack of access to basic resources that define much of the Santali experience.

The Santal realizes that health is a commodity, something that should be purchased at a price that he or she cannot afford. Although health was an integral part of Santali life before the invasions, modern practices in India have put health out of the reach of the Santali peasant and part-time laborer. Whereas a healthful life that existed in harmony with nature was an integral element of the Santali discourse, the deforestation projects have created unhealthy spaces accompanied by the commercialization projects of the market economy, which have commoditized essential resources and moved them beyond the reach of the Santal. Nimai4 states,

A child is naturally healthy. Just as it is natural for my son to be healthy, it is also natural for him to eat good food that keeps his good health. Rice, vegetables, spinach, banana, these are things that a child should naturally eat. These are things that come from nature. But you have to buy them here.

Although the Santal is surrounded by tropical fruit-bearing trees, he or she is denied access to these fruits. Santali children have to go stealing in the orchards and gardens of the *babus* [referring to middle-class Bengalis] to get their share of the fruits. For the Santal, living in harmony with nature involves access to natural resources. However, the projects of modernization and development have shaped a market economy that is detrimental to the health of the Santal. The fruits and vegetables that are plentiful in this particular part of India find their way to local markets of the *babus*, where they have to be purchased at a price that is typically beyond the reach of the Santal. Otherwise, they are exported for high profits. The Santal values the healthy activities that will let him or her lead a better life but articulates his or her inability to purchase an iota of health. The healthy ways of living that have to be purchased in modern India remain elusive to its Santali residents. For instance, Nimai5, a 50-year-old male participant, talks about fruits and vegetables:

Fruits like bananas and apples are important for them [referring to his children]. I know I should feed them an apple or a banana. I walk by the fruit stall every day, you know, when I go to work. Money. But where do I get the money? . . . I have to get work every day so they are not hungry. Especially, during slow time, there isn't any work.

Although the Santal is cognizant that it is crucial to feed fruits and vegetables to his child, he is simply unable to purchase them. Once again, although the Santali part-time laborer-peasant works very hard to earn the day's rice, he or she does not have the money to afford the luxuries of fruits and vegetables. Also reiterated in Nimai5's voice is the lack of jobs, which, in turn, keeps him from earning sufficient money to buy panta. He considers himself lucky if he is able to afford the rice for his children so they do not cry in the agony of hunger. Whereas food emerged at the core of Santali health, modern medicine, homeopathic medicine, and the *Ojha* emerged as the key elements in the treatment of disease.

Modern Medicine

In the realm of "modern" medicine, we see the manifestation of an intricate web of meaning making that is hinged on the social context encompassing the Santal. Modern medicine is used here to refer to Western medicine, or allopathic medicine. Modern medicine is typically offered through three types of providers: dispensaries, hospitals, and nursing homes. The dispensaries, hospitals, and nursing homes in the cities and townships that serve as the arteries of access for rural Bengal attest to the existence of modern medicine in the lives of the rural participant. Modern medicine has made inroads into the Santali discursive space, and the Santals are cognizant of the existence of modern medicine for the treatment of disease. Medicine, to the present-day Santal, is synonymous with progress. It is a solution to one of the many problems faced by the Santal. Nimai1, a 38-year-old Santali man, articulates his respect for modern medicine:

I know it makes miracles happen. When my little daughter was sick with fever, she was trembling, would not eat anything for many days . . . I took her to the hospital and she had to be there for only two days. She was cured . . . Whenever something serious happens, I want to take my daughter to the hospital. I also go to the doctor for stomach upsets or fevers.

It is important to note the power attributed to modern medicine. Based on his or her life experiences, the Santal has learned that the allopathic doctor can cure disease. However, according to the participants of this study, access to modern medical treatment is one of the most important problems facing the poverty-stricken Santal. It is accessed when the disease is considered serious.

Both private dispensaries and nursing homes are expensive and require personal expenditure, in contrast to the state-sponsored hospitals, which are supposed to be subsidized for the lower income patient. The state-sponsored hospitals, however, mostly are unable to serve the Santali patient because of the limited medical supplies, lack of doctors, and corrupt practices. In many cases, the respondents discussed their lack of faith in the medical system because of its ineffectiveness in serving the resource-starved patient. Nimai11 states that state hospitals are a hoax:

Who will go to the state hospital? Do you want to go there and stand in line for the whole day? Who cares if the patient is dying? You go talk to the doctor. The doctor says settle down. Can't you see? There are all these people that are waiting. I stopped going to the state hospital. If something big happens, I will sell everything and go to the private doctor.

To Nimai11, the free service provided by the state hospital is a government ploy. The state hospital exists only as an imaginary point of service that is typically unavailable to the Santal. For Nimai11, the doctors at the state hospital do not care about his or her health. In situations of urgency, the limited resources at the state hospital come to no avail. Nimai11 sees the option of selling his property to visit a private doctor as the only legitimate option of securing access to modern medicine when faced with a life-threatening condition. Worth noting in Nimai11's discursive construction is the sense of dispossession and marginalization with respect to access to modern health care in India.

A trip to the hospital and the long wait in the lines not only robs the Santal of the day's earnings (Rs15-20) but also excludes the opportunities for future work. An individual making a trip to the state hospital runs the risk of losing employment for perhaps a considerably long period, which, in turn, could lead to starvation for a few consecutive days. Because food and hunger are central to the Santali experience, most Santalis are not willing to go to the hospital.

Yet another recurrent theme in the interviews was the corruption in the medical delivery systems. The respondents talked about the resources' being drained away by the corrupt administrators and doctors that ran the hospitals. In most cases, in spite of being allocated for hospitals, the medicines were not available for the patients and needed to be purchased from the private dispensary, which was often operated by the same doctors who worked at the state hospitals. In some instances, the doctors working at the state hospitals were not available at the hospital during regular hours; instead, they were available at the private dispensaries. The costs put these private dispensaries beyond the reach of the Santal, and hence, getting good treatment remains a far-fetched dream for many of these participants.

Homeopathy: Medicine for the Poor

Homeopathic medicine is widespread in West Bengal, with a high reach in most areas of rural Bengal. Homeopathic medicine is cheaper and more accessible (in

many cases, homeopathic doctors charge Rs2 to 5 for a visit and the medicine), making it popular among the rural Santali residents. There are approximately four homeopathic centers in each of the villages where the interviews were conducted. Reflecting the easy access of the homeopathic option, the Santals point out that they rely on homeopathic medicine for treating day-to-day minor illnesses. Also, the residents often resort to homeopathy as the first step to treating an illness. Nimai³, a 23-year-old respondent, points out, "Homeopathic medicine does its work for me. The price is a lot lesser, it is something I can afford . . . The medicine is free and the doctor charges only four rupees." The accessibility of homeopathic medicine makes it especially popular among the Santals. The theme of accessibility resonates in the articulation of Kali1:

Yes, I like homeopathic medicine, you see. It must work because in most cases I feel better after taking the medicine. Here I go to the dispensary of Biduda [homeopathic doctor] in the evening, don't have to stand in long lines, and I get my medicine. He cares about me.

For Kali1, homeopathic medicine counters the inaccessibility of allopathic medicine. It is available to her at not too great a cost. The homeopathic doctor is able to treat the Santal without her having to wait in long lines and risk the chance of losing the day's work. The Santal also discusses the fact that in most cases, she is treated with respect by the homeopathic doctor, whereas at the local state hospital, she is simply another body. She points out that the homeopathic doctor cares about her health, unlike the corrupt doctor at the state hospital, who is pursuing money.

Although the Santal uses homeopathic medicine as a first step, he or she goes to the allopathic doctor (practicing modern medicine) if things start getting worse. Although getting the money for the allopathic medicine is often an issue, the participants believe that the allopathic medicine works faster than its homeopathic counterpart. However, the respondents are quick to point out that in other instances, they find homeopathic medicine to work better, although it might take a longer time to work. When the allopathic doctor is unable to detect the disease, the homeopathic doctor treats it effectively, although the treatment calls for patience. As Kali1 once again points out,

I use homeopathic medicine as long as I am not really sick. I keep trying and then when I can't take it any more, I go to Dr. Das [a local allopathic doctor]. I keep taking both; [I know] one will work.

The Ojha

Although the Santal uses both modern and homeopathic medicine to heal disease, some diseases can be healed only by the Ojha. The Ojha is a spiritual healer who resides within the village and specializes in healing particular types of diseases that are caused by the entry of a spirit (*bonga* in Santali) into the body of the diseased person. The Santal points out that the evil spirit moves from one object to another, from an object to a human, or from one human to another. The ultimate cure for any disease lies in appeasing the *bongas*. Disease and illness can be cured by removing the spirit from the human body. Healing, therefore, can occur by acts of exorcism conducted by the Ojha. Kali7 refers to the powers of the Ojha:

When a snake bites, you take your child to the Ojha. He has all the power. The Ojha will heal your son. If you wait though to go to the State hospital, your child will die on the way. The Ojha works but you must believe in him. No point going to state hospital.

Kali7 points out that an Ojha is effective when you believe in his powers. Once again, articulated in her choice of going to the Ojha is the structural impediment of the long distance that she has to travel to get her son treated at the state hospital. Structure continued to embed itself in the health and medical choices of the Santal. Kali1 reiterates:

You can trust the Ojha. He answers to the village. He keeps us healthy and keeps the spirits happy. The Ojha is not after your money. This is not like the doctor in the dispensary that he will give you a long list of medicine to buy. He understands your pain. The Ojha knows how. He will make the disease go away.

The Ojha can be trusted, because he is a member of the community, unlike the doctors at the hospital. The Ojha is accountable to community members and can speak the language of his fellow Santals; he is gifted with certain supernatural powers that are beyond the realm of common people. Instead of being drawn by greed, the Ojha is able to understand the pain of the diseased person and offer solace. The Ojha sucks out the disease after drawing it from all other parts of the body to one location. 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 medicinal roots and herbs. The medicine is either consumed orally or worn as a metal talisman. Whereas on some occasions the Santal goes first to the Ojha for treatment, on other occasions, he or she takes the recourse of modern medicine. The reliance on age-old practices and on religious rituals increases when the disease is severe or persists over a long time. This reflects the Santali belief system that disruption of the natural order by evil forces leads to disease, and the cause of the illness needs to be addressed in more severe cases instead of simply treating the illness superficially with modern medicine.

Oppression and Resistance

Lacking access to some of the basic elements of healthy life, such as food and medicine, the Santal feels silenced. This dispossession has resulted in the hopelessness of the Santal in the modernization projects of India. Hunger and poverty have silenced them. Capturing the silence of the Santal in modern India, noted Bengali writer-activist Devi wrote,

Why didn't they utter one word? . . . Why were they naked? And why such long hair? Children, he had always heard of children, but how come that one had white hair? . . . "We are not children. We are Agarias of the village of Kuva . . . There are only fourteen of us. Our bodies have shrunk without food. Our men impotent, our women barren . . ." The World Health Organization said it was a crime to deny the human body the right number of calories. (Devi, 1993, as quoted in Loomba, 2001, p. 11)

The undernourishment of the Santal is aptly captured in Devi's depiction presented above. The lack of food has reduced the Santal to a childlike appearance. The men and women have lost their reproductive capabilities, capturing the essence of Santali marginalization. The Santal as a tribe is threatened by extinction; their voice is hopelessly absent, and this absence is marked by the lack of food. The poverty of the Santal accompanied by the oppressive treatment by the elite Hindu population produce the sense of hopelessness and dispossession among the Santal depicted throughout this article. The Santal point out that they do not have a voice in the policy and governance of his native land. Instead, their fate depends on the babus. The following stanza from a Santali song paints the discourse of Santali marginalization in modern India:

We are natives of this country,
 Yet they are driving us out;
 They are driving us from our birthplace.
 Be learned brother, be knowing, be a man. (Santali song translated by Orans, 1965, p. 109)

Although the Santal is the native of India, he or she is being driven out of his or her native space by modern Indian policy. The modernization and short-term development projects announced by the government before elections soon dissipate, and the funds disappear. The ultimate goal of the government projects is to reap profits for the contractors and the government officials. The Santal continues to be displaced by many of these projects. To the Santal, the solution to this dispossession is to learn the language of the babus and to become educated. Education and learning perhaps will equip the Santal to fight back; he remembers the stories of Santali children that struggled to earn an education and offer a glimmer of hope for the Santali community:

Nimai, Rotton's son . . . He worked very hard. Night and day he sat with those books. He worked hard and everyone else played [referring to other children his age]. But he is happy and his mother and father are happy. They worked hard for him. He has a job and helps us out when we need things. (Nimai5)

Nimai5 also discusses another possibility for countering the oppression. He remembers the Hul, the stories of the brave Santali sons Sidhu and Kanhu, and goes on to say,

Can't we do it? They did it . . . You can't listen to the babus. Sidhu and Kanhu led all Santals, in the plains, in the forests, in the mountains to come out and fight. We can do it. But where is the leader? Something needs to happen.

In his memory of the story of Sidhu and Kanhu, Nimai5 sees hope. Perhaps, he suggests, armed rebellion is the solution to his oppression. Marginalized by the Hindu system for years, like Nimai5, other Santals talk about revolution as the only possible solution to the oppression and corruption that is widespread in the system. Only by countering the bourgeois Hindu system could the Santal find his or her health, they suggest. In essence, the Santal responds to marginalization by discussing the possibilities of (a) assimilating with the broader Hindu system and learning

to navigate it by becoming educated and (b) countering it with armed revolution. These two solutions present themselves as a dialectical tension in the Santali narrative of health.

DISCUSSION

This article was founded on the idea that the exploration of discursive spaces in other cultures needs to be informed by placing the culture at the heart of such exploration (Airhihenbuwa, 1995). Theories, in this approach, emerge from within the culture (Dutta-Bergman, 2003). The themes that develop from this project direct us toward the conceptualization of power in health communication theorizing (Dutta-Bergman, 2003; Wilkins, 2000). Health communication in marginalized spaces is intertwined with issues of power. The differences in access are played out in the realm of power, and power, therefore, becomes essential to the theorization of health. Relationship of indigenous groups with the dominant social classes informs the realization of health among indigenous people. The narrative of marginalized people is marked by this lack of access, which, in turn, is a manifestation of power differentials in society. Locating power at the core of theorizing allows us to understand health in relationship with the overarching structure.

However, the notion of power that evolves in this project suggests a multidimensional nature of the construct, locating the practices of resistance in a dialectical relationship with the marginalizing practices of the mainstream culture. The articulations of the Santali participants presented in this article point out the active role they play in constantly negotiating the discursive realm of power. They seek out multiple treatment options, often rationing out the limited resources. The participants also draw our attention to their active involvement in acts of political resistance as means of securing of securing access and voice (Habermas, 1987).

Multiple dialectical tensions become evident across the different themes of the study (Dutta-Bergman, 2003). The Santali participant feels hopeless with his or her life in modern India marked by lack of work, food, education, and health care; on the other hand, he or she speaks of overcoming the deprivation by securing access to resources. The process through which resources can be secured also is embedded in a dialectical tension. Being educated in the mainstream culture and securing a job hold the key to the emancipation of the Santal from his or her current condition of depravity. On the other hand, the oppressive system is challenged by talks of organized resistance. These dialectical tensions draw us away from the traditional conceptualizations of marginalized spaces as powerless spaces without agency (the traditional receivers). Instead, they point us toward the agency of the marginalized participant in negotiating the sociocultural practices that envelop his or her life. Meaning, therefore, is embedded within this agency of the cultural participant in negotiating issues of access. This article highlights the importance of the culture-centered approach as a theoretical lens, constructing culture as a complex and dynamic construct that is imbued with dialectical tensions.

Modern medicine simultaneously offers both hope and despair; the participants discuss the healing power of modern medical treatments juxtaposed in the backdrop of their lack of access to modern medicine because of financial constraints. Yet another concept that demonstrates the dynamic nature of meaning making located within the shifting context of culture relates to the choices of treat-

ment options. The Santali participants discuss the importance of tradition when reporting the visits to the Ojha. The same participants point out the importance of visiting the allopathic doctor. The homeopathic doctor is also visited, depending on the nature of the illness and the resources available to the participant. In other words, the securing of treatment options is a polymorphic process. Multiple treatment options accrue viability and are sought out, informed by a plethora of factors. This polymorphic existence of multiple treatments challenges the modernist conceptualization of health, illness, and treatment within a monolithic framework. The existence of multiple treatments and understandings of health and illnesses is a key characteristic of the globalized world, demonstrating the linkage between the global and the local in the construction of health meanings.

The meanings that emerge in this project suggest that health is located in the realm of poverty and hunger. The narratives we hear are those of a resource-deprived people that struggles each day for food. Santali articulations of health, therefore, are centered on the narratives of undernourishment, hunger, and pain. Health communication theorizing, informed by the Santali narrative, locates poverty and hunger at the center of health and illness. Also, fundamental to the findings of this study is the impeding role of the social structure as a barrier to accessing healthful life choices and securing treatment options.

The interviews narrated an oppressive environment, imbued with corruption and unfair treatment, in which health is denied to the Santal by the sociocultural practices of the bourgeois social system. The Santal's life is defined by her limitations in securing those basic resources that are essential to living. The resource-centered findings make a poignant and typically ignored statement about the way health is constructed in traditional health communication; they point out the naiveté of a message-based, individual-level approach that proposes communication solutions such as leaflets, television programming, and newspaper advertisements targeting individual behavioral changes as mechanisms for improving the health of at-risk populations without fundamentally addressing the structural resources that encompass and limit the lives of individuals and the goals they are able to attain (see Airhihenbuwa, 1995; Dutta-Bergman, 2003). Instead, they highlight the relevance of engaging in the co-constructions of health meanings as a first step to the study of health communication. Participatory communication approaches that emphasize the empowerment of marginalized communities via dialogue, the study findings suggest, are more important than one-way models of health promotion (Dutta-Bergman, 2003).

The culture-centered meanings of Santali life point out that a clearer understanding of health in marginalized populations can be developed by highlighting the context of poverty. Poverty defines the limits of the communicative space, playing a critical role in how health meanings are negotiated in the struggles of marginalized people. In this article, I have put forth a structure-centered communication model that locates health meanings within the realm of structure. In this structure-centered model, communication can be conceptualized as a process of constructing, negotiating, and transforming cultural meanings through interactions with and transformations of the structural limits that constrain the lives of marginalized peoples. The critical point, however, is the interaction between structure and culture. Cultural meanings are continuously evoked as participants attempt to make sense of their marginalization. Therefore, efforts of structural access need to be informed

by the nature of the culture. The interplay of culture and structure can provide new ways of empowering marginalized communities (Freire, 1970; Ritchie, 2001).

Methodological Implications

The meanings structures evoked in the narratives presented in this article are evanescent, metamorphosing and taking alternative shapes depending on the nature of the context. Limited by the economic constraints, the Santal relies on traditional, homeopathic, and allopathic medicines, informed by the nature of the disease and who has the disease. Therefore, the beliefs underlying Santali health behavior are not stable constructs that can be captured by traditional instruments such as surveys; instead, the choices are richly informed by the context and are constituted by the very context. Although the Santal might respond in a certain way to the belief-based items when a particular situation is salient in his or her mind, he or she might respond completely differently when a different set of beliefs are highlighted by a different situation. Therefore, survey-based methodological attempts at testing belief-based models such as the health belief model and the theory of reasoned action are likely to fail in such situation-centered cultural scenarios because of the malleability and the situational interactivity of the underlying beliefs of Santali life. Instead, future studies of health communication in subaltern populations need to apply a social constructionist methodology and be informed by context-sensitive approaches that focus on exploring the inherent meaning structures within the culture.

Applications

That poverty is central to the health of people living in resource-deprived spaces was one of the most important findings of this research. What is essential, therefore, in health communication is a basic understanding of the structural processes, inequalities, and resource deprivations that are at the core of the lived experiences of marginalized people, not the development of communication skills for individual-level persuasion campaigns (Dutta-Bergman, 2003). Therefore, fundamental health resources need primarily to be made available to members of indigenous groups. Resource mobilization and structural readjustments are the critical stepping-stones for a healthy Santali society, not attempts at persuading them to immunize their children or eat five servings of fruits and vegetables.

Health promotion efforts in marginalized communities ought to focus on capability building (Sen, 1992). Capability building involves providing participants with the fundamental life resources such as food, clothing, and shelter that they need to continue living. The critical solutions for the Santali population are embedded in policy level changes and structural readjustments. Access points need to be created in resource-starved areas such that community members can fulfill their basic health needs. These capability building efforts need to be complemented by efforts of communicative empowerment such that community members can find legitimate public spaces to articulate their needs, and discuss the potential solutions to such needs (Habermas, 1984). This active participation of members of marginalized groups in identifying and solving health problems ensures the cultural legitimacy of the proposed solutions (Ritchie, 2001).

Limitations and Visions

This research is limited by my identity as an outsider and as a member of the larger Hindu community that participates in the oppression of the Santal. It poses important questions about the proper articulations of Santali beliefs and cultural practices. Essentially, the Santali narrative in the above pages runs the risk of exoticizing, of orientaling the life story of the Santal, of constructing “them” as inferior, silent, and in need for being spoken for (Said, 1990, as quoted in Airhihenbuwa, 1995). Also, the article is limited by its language-related constraints. The interviews were conducted in Bengali, and not Santali, the language of the Santal.

In spite of the limitations, this project offers a point of hope by seeking to change policy and participate in community level social change. I have been actively involved with the local NGOs and labor unions in identifying funding sources and am currently working to secure funding for projects of resource acquisition for the Santals. The ultimate goal of this project is to develop culturally informed points of access in the communities in which I am working. Another step in the direction of social change is the publication of the findings in popular media outlets. Media coverage of the project in West Bengal would perhaps draw the attention of key stakeholders to the plight of the Santali people. Clearly, the medical system needs to become more accessible to the Santal, and I hope to participate in this change initiative via my scholarship.

NOTES

1. Rs denotes rupees, the Indian currency. The U.S. dollar was worth Rs45.15 on March 22, 2004.
2. I have referred to participants as Nimai (for men) and Kali (for women) to protect their identities. The numerals are used to differentiate the participants from each other.

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