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Indigenous Health Organizing at the Margins: Creating Access to Health by Building Health Infrastructure

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ABSTRACT
Socio-economic challenges, communicative barriers, and the lack of health infrastructure constitute and reinforce obstacles to health for all, especially for those who live in the underserved spaces of the Global South. This research addresses such contextual adversities by investigating how indigenous people in a remote Himalayan village collectively took ownership of a health-organizing initiative. The result of this initiative was the creation of a four bed mini-hospital designed to increase community members’ access to basic curative and preventative health care. Grounded in praxis-based critical health communication approaches, this research challenges top-down and externally-dictated interventions by placing subalterns at the forefront of a bottom-up and community-led health initiative. The centrality of discursive engagements and local-centric participatory actions of marginalized indigenous participants in this research calls for culture- and communication-centric research initiatives for increasing access to health at the margins.

Aligned with global missions such as Sustainable Development Goals, many countries in the Global South have committed to address health disparities by providing universal access to equitable, affordable, and quality health care (Buse & Hawkes, 2015). In underserved regions of developing countries, where health infrastructures are typically inadequate, these commitments remain largely unmet. Rural India is one such region. India ranks 154th among 195 countries on the healthcare index, and experiences more than one-fifth of the global burden of disease (Townsend, Greenland, & Curtis, 2017). Lack of structural access, including inadequate infrastructure, is a major barrier to both preventive and curative health for the rural Indian population, which numbers approximately 900 million out of a national population of 1.2 billion (Balarajan, Selvaraj, & Subramanian, 2011). For example, Singh and Badaya (2014) note that 85% of medical visits in India are made by rural residents, the majority of whom travel more than one hundred kilometers to seek care. Additionally, there are only about 0.7 doctors, 1.7 nurses and 1.3 hospital beds per 1000 people in India (including both urban and rural spaces) (Savitha, Kumar, & Kiran, 2016). As rural people are differentially dependent on public health infrastructures, they are disproportionately affected by the lack and poor quality of public health services. Moreover, the overall health disparity among the lower social-economic indigenous populations’ is even more grievous (Patel et al., 2015). In addition, caste-based and other forms of discrimination, prejudice, and strategic ignorance and oppression by the mainstream population exacerbate indigenous peoples’ lack of access to health. Further, hindered by communicative barriers and habitual silence, indigenous people experience health disparities both materially and discursively. The situation is even worse in geographically remote and isolated indigenous spaces such as remote Himalayan villages, where this research was conducted.

Structural marginalization and disengagement by the state and its health collaborators both constitute, and contribute to, the lack of health care access in rural India. For example, public- sector health care expenditures in India constitute 1.4% of GDP, while the global average is 6% (World Bank, 2014). Working from colonialist and deficit-oriented perspectives, top-down health interventions from the Indian government and its international partners, particularly public-private partnerships (PPPs), typically ignore community members’ aspirations and priorities (Farmer, 2008). Such interventions often fail to fulfill contextual needs and, consequently, decrease access to basic health care at the margins of society (Millen & Holtz, 2000). Dutta (2016) argued that most dominant interventions were confined to improving individuals’ behavior, ignoring broader structural issues such as sociopolitical and environmental constraints. Consequently, the interventions typically fail to address health inequities, particularly in underserved spaces. In contrast, critical health communication (CHC) scholarship, by interrogating hegemonic power and control, emphasizes cultural participants’ active contribution and agency “in defining the scope of health problems that are relevant to them and determining corresponding and equally relevant solutions” (Airhihenbuwa & Dutta, 2012, p. 35). CSC scholars note that a critical consciousness about structural (including infrastructural) absences and negligence is a precursor to...
meaningful health initiatives, particularly in economically poor and marginalized spaces (Chinn, 2011). Answering Friere’s (1970) call to envision ordinary people as makers of history, engaged and emancipatory health communication scholarship questions west-centric, taken-for-granted assumptions. Such work also legitimizes indigenous and de-colonial approaches in exploring and developing paths to catalyze and co-create bottom-up, culturally meaningful health initiatives. By challenging aid-intensive, externally-dictated, and often pre-defined health interventions, these critical approaches argue in favor of communication-centric community-led actions and organizing for producing meaningful change in local spaces. Grounded in CHC principles, this research espouses critical listening, dialogue, and participatory action to explore a community’s capacity for leading and implementing actual health interventions (i.e., beyond defining and seeking health solutions). To address local health solutions from within local communities, this research focuses intimately on indigenous agency, consciousness, autonomy and ownership. It de-centers externally led top-down interventions rooted in unquestioned presumptions about health sub-alternity. To this end, the current study examined how socio-economically marginalized indigenous people in an eastern Indian Himalayan village collectively organized a health infrastructure-building initiative on their own to create alternate health access for community members.

**Literature review**

CHC scholarship fundamentally questions and problematizes assumptions of west-centric and culturally uninformed health communication theories and praxis. Focusing on structural and contextual realities at local and global levels, this critical lens prioritizes and legitimizes social justice, solidarity, and social transformation to foster health equality at societal margins (Ford, Crabtree, & Hubbell, 2009; Lupton, 1994). Zoller (2005) argued that critical discursive engagement and agentic participation, especially at the margins, are quintessential in challenging existing material and symbolic power dynamics and disrupting the status quo. Such research practices are useful for enhancing access to, and the quality of, health care delivery.

Acknowledging the praxiological trajectory, health communication scholars noted that practical applications and examples in community building, mobilizing, and organizing are lacking in the extant literature (Minkler, Wallerstein, & Wilson, 2008). There are a few Community Based Participatory Research (CBPR) and Participatory Action Research (PAR) studies conducted in marginalized contexts that have argued in favor of (i) reducing power-distance by communicatively inverting the relationship between researchers and participants; (ii) envisioning researchers as engaged co-learners; and (iii) legitimizing an active role for, and inclusion of underserved communities, thus empowering them by challenging dominant perspectives (Mammen, Sano, Braun, & Maring, 2018; Peterson, 2010). Having said that, examples of CHC research from rural/indigenous India are rarer still. Dutta’s (2011) culture-centered approach (CCA) represents an exemplar for CHC as it focuses on structure, culture and agency (and their interplays) to foreground lived realities and voices at the margins. In indigenous contexts, aforementioned CHC-guided approaches and interventions emphasized building (and maintaining) relationships and consulting with local/tribal populations to make research praxis inclusive, organic, and bottom-up. Existing CHC approaches both involve and work toward empowering communities, where citizens define agendas, identify problems, analyze relevance, and propose solutions/interventions.

However, such a problem-posing approach that does not envision a subaltern community’s capacity beyond defining health and suggesting solutions likely generates limited impact in contexts to address health disparities and create meaningful health access. Scholars have noted that while critical health researchers legitimized the ideas of complete community participation and autonomy, in reality “control over all aspects of the research is rarely completely in community hands” (Tobias, Richmond, & Luginaah, 2013, p. 132). The present study addresses this concern by prioritizing meaningful community mobilization and control, a research environment where cultural participants independently organize health initiatives. Such an approach is often termed as self-organization (i.e., extending beyond participation; e.g., von Unger, 2012), where communities collectively lead health interventions without fully depending on external institutions. In other words, they may contact external institutions for resources and/or suggestions, but retain control over resources and their usage.

Stemming from practical theory (Barge, 2001; Barge & Craig, 2009), grounded practical theory (GPT) (Craig & Tracy, 2014) explores how scholarship can be translated into practice through enhancing communities’ communicative capacities for action. By building communication theory and methodological approaches and by developing empirically grounded solutions, these theories tackle applied communication problems and seek to make practical differences in community members’ lives. Rooted in systematic investigation of communication practices and problems and grounded in action-based research and reflective thinking, GPTs are transformative tools. They co-evolve with cultural participants’ lived experience and agency. Craig and Tracy (2014) argued that future GPT research must be more critical and applied in nature towards expanding its vocabulary of action and scope of repertoire. They further argued that oftentimes, critical approaches are criticized for being less effective to address local health problems (e.g., not robustly fostering independent and/or practical community actions in underserved spaces).

While these two frameworks (CHC and GPT) share commonalities – e.g., both theories value qualitative and ethnographic approaches, and are committed to culturally meaningful social change – they also complement each other. CHC values legitimization of indigenous voices and agencies, studying structural and contextual complexities, and raising collective consciousness at the margins. GPT, meanwhile, emphasizes transformative actions (Engeström, Miettinen, & Punamäki, 1999; Foot, 2001), as a means of developing bottom-up and local-centric solutions that meet cultural participants’ needs and aspirations. The current study embraces both GPT and CHC to foster grassroots health organizing to bring about
transformations, particularly by espousing a de-westernized and de-colonial lens. Such an approach would potentially catalyze the processes of inclusive and active participation, independent decision-making, community ownership and leadership (Kemmis & McTaggart, 2000). It also emphasizes agency, social change and critical-consciousness raising. Grounded in principles of CHC and GPT, this study attempts to build a contextually meaningful approach by focusing on four key aspects: indigenous subalternity, local-centricity, critical listening and dialogue, and participatory action.

Indigenous subalternity

GPT and CHC scholarship foregrounds and co-constructs alternative knowledge claims and practices that emanate from the grassroots (i.e., local and indigenous perspectives) that are historically de-legitimized and/or erased from discursive decision-making spaces (Dutta, 2011). In addition, many mainstream interventions reflect a poor understanding of indigenous ways of knowing, consciousness, and health imagining. Indigenous and subaltern studies embrace a critical, counter-hegemonic, and dialogic approach towards creating spaces for empowerment and autonomy at the margins. In indigenous contexts, LaVeaux and Christopher (2009) noted that instead of narrowly approaching health in terms of community deficits and weaknesses, we should recognize indigenous communities as a wealth of resources and as active agents who can play meaningful roles in bridging cultural and structural gaps in research.

Local-centric

Even if conceptualized as a process that opens discursive spaces for less privileged members of society (Rowe, Adams, & Beasley, 2004), participation in many interventions fails to recognize and respect local social norms and practices. In such cases, locals may react with skepticism and reluctance, and may actively resist participating in, and conforming to, externally imposed and expert-formulated propositions. This is particularly true when outcomes fail to yield meaningful direct local benefits (LaVeaux & Christopher, 2009). To address inequity, Friere (1970) argued that inclusive engagements potentially empower the community to overcome cultural silences, inferiority, and communicative barriers to legitimize their ideas, realities, and visions. Local-centric processes harness available cultural, natural, and human resources, as well as participants’ aspirations, knowledge and practices (Basu, 2010; Galdeano-Gómez, Aznar-Sánchez, & Pérez-Mesa, 2011). Bassey (2001) noted that local-centric theories are actionable, less abstract, and empirically grounded in situated knowledge and direct experiences. However, their impacts are not limited to local spaces; they inform and influence health issues and approaches in national and international spaces as well.

Dialogue and listening

Grounded in dialogic co-learning and critical consciousness of structural inequalities, CHC approaches seek to foreground voices and agency of the others and privilege alternative and/or transformative perspectives. Community-centered dialogue, deliberation, and collective decision-making are keys to developing solidarity with cultural participants and enhancing communicative capacities, and health/well-being in local spaces (Figueroa, Kincaid, Rani, & Lewis, 2002). As participants, community members have the right to know, comment, and take stands in well-informed decision-making processes through rigorous examinations of proposals and feasibilities of ideas and options (Walker, 2007). The two main components of engaged discursive involvement are critical listening and recognizing differences/different perspectives through dialogue. Such involvement opens avenues for voicing otherness and a willingness to be changed through communication (Kemmis, 2006). These practices can aid in developing new ideas, where cultural participants are frontrunners who dialogically define health, articulate solutions, and suggest plan(s) of action (Ganesh & Zoller, 2012).

Action and participation

Context-centered and community-led organizing is pivotal to addressing and overcoming health shortages in underserved spaces. Critical perspectives argue that community participation as a central organizing force helps communities gain control of negotiating health disparities (Chaturvedi, 2007). CHC-based approaches urge researchers to do research with (not on behalf of) the community by actively learning about contextual issues and root causes of marginalization. GPTs argue that community members’ adequate, early, and active participation and ownership in all stages of local-centric bottom-up initiatives – conceptualization, planning, implementa- tion, and evaluation – are often instrumental for meaningful empowerment at the margins of society (Willink, Gutierrez-Perez, Shukri, & Stein, 2014). Community engagements as co-researchers and owners foster transformative and alternate knowledge-production (David, Sabiescu, & Cantoni, 2013) as well as facilitate a project’s success and sustainability (Waisbord, 2005). Thus, action-oriented community participation and mobilization are instrumental to create alternate health imaginings and access in marginalized contexts.

Guided by indigenous and participatory action research, this study focused on markers of marginalization in underserved indigenous spaces. These markers included situated cultural and communicative barriers (e.g., language, literacy and attitudes such as skepticism and shyness); mainstream contempt and ignorance; and the community’s lack of access to information and resources. In marginalized indigenous contexts, scholars are increasingly calling for embracing a resilience perspective (instead of a defect-based lens), which privileges indigenous autonomy and ownership as well as decenters taken-for-granted presumptions, exogenous expertise and uncritical praxis (Dawson, Toombs, & Mushquash, 2017). Embracing the principles of CHC and GPT, this study advances scholarship by presenting a practical case study of community-owned participatory organizing that led to creating meaningful transformations at the margins.

This research argues that if under-resourced and underserved people lack control and access to basic health services and infrastructure, mere knowledge of health issues and best practices will not ensure health for all. Health subalternity can be better addressed through inventing situated structural and
communication absences that underprivileged populations negotiate at the margins. Accordingly, the present study embraces continual processes of listening, dialogue, and action to examine how one rural indigenous community in remote eastern India collectively decided, mobilized and implemented a health initiative to enhance communal health and well-being. To understand indigenous health organizing, it is important to learn about the nuances and the processes of community-driven deliberations and decision making that can lead to co-creative actions for addressing local health problems in culturally meaningful ways. Guided by CHC theories and GPT, and focusing on elements of critical/cultural communication, participants’ agency/consciousness about structural absences, and practices of co-developing practical health solutions, this study explores two research questions:

(i) What communicative processes (including dialogue and listening) and actions influenced the framing and emergence of the intervention?
(ii) How did the indigenous participants communicatively implement and lead the local-centric project with limited material resources both during the construction of the health facility and afterwards?

**Context**

In rural West Bengal, an Indian state where this research was performed, material and communicative gaps constituted and reinforced health shortages (Dutta & Dutta, 2013). This research was conducted in the Chunabhati village, home to about 450 people in approximately 80 families. Chunabhati is one of 13 remote indigenous Himalayan villages in the Buxa Duar region, located near the India-Bhutan border. A total of about 3500 indigenous people live in these villages. To reach Chunabhati, located at an altitude of approximately 3000 feet, I had to walk for two hours after a 19-hour bus and train journey from Kolkata. I learned that villagers face constant challenges from soil erosion and landslides, a poor local economy, and inadequate infrastructure – including absence of roads, transportation, and electricity. Research participants were primarily Dukpas, an indigenous tribe who speak a local Jongha language within their community; and speak in Nepali and Hindi dialects when communicating with non-indigenous people and outsiders.

In describing health access in Buxa Duar, Himalaya-Darpan, a local Nepali newspaper, wrote:

(Nearly seven decades after independence) ... the government of India failed to provide basic health infrastructure and could not build a primary health center in the extremely remote areas of Buxa Duar region. To get basic medical treatments and facilities, the villagers have to trek for seven to eight kilometers and then they have to travel for 46 kilometers by road to reach the nearest hospital in Alipurduar. Many of the patients died while in transit (Kharail, 2012).

Walking is the only option for traveling from one mountain village to another. Thus, villagers face transportation barriers to accessing health facilities. During transit, many patients fall from hand-held stretchers in the steep and narrow mountain terrain and often die as a result.

My long-term interactions with indigenous people in Buxa Duar revealed that the subaltern populations experience extreme poverty at both the household and community levels (the average family income is Rs. 3,000 or $45 per month). Medical treatment is often prohibitively expensive, costing several months’ worth of income. To pay medical bills, villagers often sell domestic animals or approach moneylenders. Villagers frequently hope for a spontaneous medical recovery or a miracle while they helplessly wait to die. Villagers told me that government hospitals are full of middlemen with illegal connections with doctors, diagnostic centers, and medicine shops. They also reported that oftentimes health providers, identifying the villagers as rural/indigenous people, abuse them materially and communicatively. The providers often demand bribes, financially exploit and/or discriminate against villagers by taking advantage of their illiteracy (or semi-literacy), lack of proficiency in mainstream languages and habitual shyness.

**Method**

**Data collection**

After receiving IRB approval and a research scholarship of approximately $1,200, this study was conducted in two phases: (i) local needs and aspirations were identified, as along with intervention options; and (ii) the subsequent community-led decision-making process, project planning and project implementation were studied. I visited the Buxa Duar area six times between May 2011 and August 2015. Each visit lasted between two and four weeks. Phase 1 included participant observations and three focus group interviews that involved 29 participants. During focus groups, participants discussed contextual socio-economic realities to identify material and communicative needs. Villagers also collectively deliberated ways of addressing underdevelopment and health disparity. During phase 2, six focus groups were conducted, involving 52 cultural participants. They discussed how they made collective decisions about the health organizing as well as resource planning and implementation. Thus, a total of nine focus group interviews were conducted with 81 participants (44 males and 37 females). These individuals were primarily young and middle-aged adults.

Given a prolonged history of oppression and exploitation, my presence initially created suspicions in the community. Villagers were cautious and skeptical about talking to me. They preferred group conversations in public spaces, where others could join and participate at their convenience. To address these realities, focus group discussions (FGD) were chosen for this research. FGD aided this research in several ways. First, along with eliciting situated information and narratives, FGDs helped in foregrounding local perspectives, practices and customs. Second, villagers could exchange perspectives as well as compare views, which helped build a deeper communal understanding. Finally, during FGD sessions, participants posed questions, reflected on and monitored as well as evaluated the health intervention. Thereby villagers dialogically led and took ownership of the project.
This research presented several challenges. Given my social privilege (i.e., middle-class, educated, patriarchal urban elite), I was largely considered an outsider, and remained so to the community members. Past oppression and exploitation of subaltern communities historically stemmed from the privileges I embodied. Community members were also unfamiliar with academic research. Thus, some villagers were curious about my intentions, particularly when no material and/or political return was expected. To build trust and ensure transparency, I regularly mingled with the villagers, addressing their questions, concerns, and doubts. During both formal and informal interactions, I constantly questioned myself and remained vigilant about my presence (am I intruding on their material/discursive spaces?) and my words/gestures (are they culturally appropriate? Do they contribute to/reinforce power differentials?), and attempted to modify my interactions to build mutual trust.

During my first visit, I traveled to multiple villages in and near the Buxa region. Finding Buxa Duar remote and underserved, I decided to conduct research in 13 indigenous villages. During phase 1, I stayed mostly in a centrally located non-indigenous village that included a tourist lodge and a few shops. I met local social workers who informed me about Dukpa villages, including their locations, and shared the names of a few villagers they knew. With their help, I went to the indigenous villages multiple times. These visits and interactions alleviated initial community skepticism, built rapport, and created a sense of trust.

During the final phase 1 focus group, a senior community member, along with his friends and family members, questioned me. They had met several visiting academicians and documentary filmmakers. The senior community member said, “Do not eat our brains. So many people like you come and converse, do research, and give us hopes. Like them, you will also forget about us immediately after exiting our village. Can you do something substantive for these villagers, so that our life can be improved?” After this exchange, I took a public oath that I would never visit the villages again without bringing resources to facilitate meaningful change.

Attending to community voices, I used my research funds to implement an intervention of the villagers’ choice. After (re)sharing my commitments and telling the villagers about the available funds, I asked them to collectively decide whether they would participate in solving a local problem. When they agreed, I asked them to choose a cause collectively. To ensure open and non-coercive decision making at the beginning of phase 2, I left the village after sharing the proposal and stayed in a nearby non-indigenous village. The indigenous villagers communicated to me their decision to partake in this problem-solving intervention. They then helped me move to their village as a paying guest for phase 2. It is important to note that we collectively and organically decided upon a community health problem to address without a prior (or pre-determined) agenda. Discussions identified building a health facility as the most important local need. After villagers volunteered to perform the entire research project, construction materials and hospital accessories were primarily purchased with my research funds.

Nine focus-group interviews (involving 81 participants) were conducted at gathering and socialization spaces. Participants were recruited using a snowball technique with the help of active or senior community members. Interactions with community members facilitated the initial development of interview protocols that were constantly revised based upon cultural meanings and appropriateness. Phase 1 protocol questions included: What key local issues do you negotiate in your everyday life? What solutions do you suggest to address these issues? Phase 2 questions included: What are the efforts/resources needed for the intervention? How can such a solution be implemented? What are the processes/challenges associated with it? Interviews began with a discussion of contextual health and underdevelopment issues and possible avenues for local organizing. Villagers’ statements provided opportunities for additional probing and of brainstorming as they co-designed the initiative. All the focus group interviews lasted between 75 and 130 minutes, were digitally audio recorded. In addition to recordings, the entire research process was documented via photographs and note taking.

During both formal and informal public meetings facilitated by villagers, I performed detailed observations. I also did such documentations during some village-level meetings I was allowed to attend. I attempted to create a non-coercive environment to ensure free and open decision-making and implementation of the project. To ensure a community-centered and reflexive research process, I earnestly tried not to impose my views on the community or influence their collective decisions. For example, I often waited outside the village for them to complete discussions. Critical listening and dialogic engagement foregrounded both local voices and agency in deliberative and decision-making activities so the villagers could discursively own the process. Such ownership centered outside expertise and situated community perspectives at the center of the research.

I also attempted my best to perform local-centered reflexive research by understanding and addressing the issues of social exclusion and power distance. I stayed with the indigenous people in their homes, shared their food, and sometimes participated in household chores. These cultural communities, traditionally treated as untouchables in India, valued these engagements. Moreover, ongoing interactions with villagers, which often involved continued learning on my part, helped establish of my authenticity as co-learner. It also helped in community work and organizing. For example, during phase 2 I participated in villagers’ visits to local health units, organizations, healers, and doctors. During work time, I was primarily a researcher, but at other times, I acted as an ordinary villager. For example, I regularly visited sick community members and attended gatherings. I helped co-researchers (i.e., villagers) plan and draft letters to local organizations. When villagers desired, I engaged in construction work.

We experienced communication difficulties because community members were not fluent in mainstream languages (e.g., Hindi and Bengali) and I did not initially speak the local dialect. Repeated interactions with villagers helped me
to gradually learn their dialects. Moreover, remaining cognizant of the continually eroding dialogic spaces (due primarily to my unearned privileges) reminded me to remain vigilant, critically reflexive and question my taken-for-granted assumptions when engaging with the villagers.

During research interactions, we traversed in Hindi and Nepali dialects. Interactions with the villagers were translated and transcribed by me. Transcription was difficult, particularly in transcribing local proverbs and colloquialisms. In these instances, I relied on local informants and scholars to ensure authenticity of the translation. The accuracy of the transcriptions improved after consultation with another academic conversant in the Nepali, Hindi, and local dialects. Informed consent was obtained from each participant before initiating interviews. Following IRB guidelines, the interview recordings were destroyed following transcription. I used pseudonyms while analyzing the data to ensure that responses could not be traced to particular interviewees.

**Data analysis**

This research utilizes critical and participatory health communication as well as indigenous and de-colonial frameworks. This study addresses health disparities at the margins not by depicting hopeless images of indigenous communities, but by foregrounding local agency in mobilizing action to create access to health services. During data analysis, principles of CHC, GPT, and decolonial perspectives guided me to be cognizant about situated power dynamics, unexamined presumptions, and diversity of thoughts and actions. I paid careful attention to various structural and agentic aspects such as contextual realities and obstacles. I also observed participants’ structural consciousness, their communicative negotiations, and their organizing strategies regarding the initiative.

While analyzing data, I focused on (i) local communicative behaviors that reflected the indigenous community’s cultural values and health realities; (ii) consciousness and discourses about structural and health inequity; and (iii) community actions designed to overcome structural and communicative challenges. Grounded theory was employed to analyze the villagers’ discourses (Charmaz, 2000). Using the constant comparison technique, interview data were compared and contrasted to make theoretical inferences (Strauss & Corbin, 1990). Open, axial and selective coding processes were systematically used to understand the participant voices from the field. Open coding was used to identify and categorize discrete concepts. Transcriptions were examined sentence by sentence, allowing me to group similar phenomena under conceptual categories. In axial coding, relationships within and among categories were analyzed. Finally, determination of core categories and subsequent theoretical integration were achieved using selective coding.

Given the data-analytic processes performed to investigate the research questions, the following research themes emerged: framing the health initiative-collective communication, collective consciousness and project implementation, and post-project leadership. The identified themes were intimately intertwined with the previously mentioned four key areas of indigenous subalternity, local-centric, dialogue/listening, and action/participation. (I paid less attention to technical aspects of construction work, such as measurements, workmanship, and inventory management). I partially focused on narratives of everyday health adversities to avoid overemphasizing deficit perspectives of situated disparities. Once the codes were identified and developed, I brought them back to the community members to determine whether they made sense to them.

**Results**

**Framing the health initiative: Collective communication**

A collective decision about the health initiative emerged from cultural participants’ long-term dialogic and deliberative engagements. During phase I focus group discussions, villagers discussed several local issues including health matters. They also described their maltreatment by dominant stakeholders as agency-less receivers, and how their requests and demands were consistently declined or ignored. In the project’s second phase, the villagers, acting as a committed collective, critically evaluated various interventions and made a decision to construct health infrastructure utilizing their limited available resources. Their voices reflected a collective consciousness about health disparity through narratives of long-term inaccessible health care, along with suffering and a sense of rejection. These elements ultimately led them to undertake independent health organizing.

Villagers’ collective decision-making process was not instantaneous; rather, it was a long-term process, which demanded mutual trust and consistent dialogue and deliberation over several years. Pamu, an indigenous community member, described their interactions with me during phase I focus group discussions: “For the last three years, he (author) regularly came to meet the villagers and conducted meetings. In those meetings, we discussed various development issues we were facing.”

Community members were well aware that development initiatives, especially infrastructural, were resource- and capital-intensive. Therefore, economically poor villagers were often forced to depend on the dominant structure’s help, willingness, and material aid. For instance, to improve health care access, the villagers had long requested a nearby health facility in their mountainous region. Paku, a villager, shared:

A few years ago, a Member of Legislative Assembly visited this village. He asked us, “What do you need to develop this village?” We asked him to build a hospital here. He told, “I will definitely build a hospital in this village.” After that we met him thrice … we are still waiting for meaningful actions.

In a context of empty promises and endless waiting, villagers often felt frustrated and rejected. Past disappointments and experiences made this subaltern community a bedrock of nonconformity and skepticism (Scott, 1990). Feeling manipulated and losing trust in dominant structures, villagers did not want to be dependent and passive recipients of external aid and assistance. Instead, they realized that their empowerment was ultimately their responsibility. As Paku stated: “Year after year we believed them … and they exploited us. We do
not trust them anymore. Now we are trying to do our jobs independently.”

In some Buxa Duar villages, indigenous people formed collectives to develop their community. For instance, a few years earlier, Chunabhati villagers formed a local Village Development Committee (VDC) to facilitate collective projects. This organization was not affiliated with any political parties or established institutions. In focusing on local and agentic aspects, the VDC emerged as the “central force” to community organizing (Chaturvedi, 2007). Initially, a few members informally started performing local development work (e.g., cleaning the village and repairing dirt roads) and other villagers gradually joined them. During focus group discussions, VDC members and other villagers discussed local issues and aspirations. Lamu, a VDC member, stated:

It is our village. It is our responsibility to develop our village. If we do not do it … who else will develop our village? We work together to improve our lives. Many of us have new ideas. So, every one of us, irrespective of age, religion, work together and learn from each other to accomplish our goals. Love and respect for each other is the key to success in such collective effort.

Consistent disengagement and rejection from dominant and state stakeholders prompted the villagers to organize and take collective responsibility for developing local spaces. To address such marginalization amidst their underserved existence, villagers in this research project continued their journey toward ownership and solidarity by collectively exploring various avenues (Farmer, 1999). Such participation fundamentally differs from neoliberal organizing, as local communities decide to control and implement interventions without any external prompt.

During the first phase 2 meeting that I was allowed to attend – villagers had verbally invited me beforehand – one VDC member introduced my proposal to financially support a local-centric intervention of their choice. By summarizing key elements of phase 1 interactions, he initiated the process of collective discussion. In a critical communication project, it is crucial to ensure an open and non-coercive dialogic environment so all members can make decisions freely and collectively (Zoller & Kline, 2008). To ensure such an environment, I left the village after that meeting and stayed away during the collective decision-making period. I returned to the village once they made their final determination. In this way, I tried to ensure a free and conducive decision-making environment where the indigenous community could independently make their own decisions.

Unlike many indigenous eastern Indian communities, Dukpa villages do not have a traditional hierarchical system with a tribal head. Rather, villagers welcome inputs from all active and concerned adult members in their decision-making process. Lebo, a community member, shared:

We (the villages) conducted several meetings in the last few days, and talked about the development possibilities that we discussed over the last few years. Some of them were – assistance for agriculture and animal husbandry to boost domestic economy, craft-training for youths and female villagers, constructing wooden stretchers for transporting patients and elderly people safely, and building a community hall for social and cultural interaction. After knowing the amount of funds available for this research-project, we discussed those intervention-options with all the families to arrive at a final decision accepted by all. Yesterday evening we discussed all the options once again in great depth. After in-depth discussion, we, the villagers, finally decided to construct a mini-hospital.

To reach a collective decision, Chunabhati villagers conducted several community-level meetings which members from all families attended. Situated in an isolated village in mountainous terrain, community members shared generally good relationships and frequently sought help from each other in their struggles to survive. The intra-community power-distance was low among Dukpa populations, which facilitated cultural participants’ open participation in the initiative. The research conversations took place without significant interaction challenges. During village-level meetings, seniors and members of VDC mostly initiated the discussions, and/or introduced discussion-topics. Rooted in traditional cultural practices, villagers made their decisions through consensus. Doubts and disagreements were resolved through lengthy and detailed conversations (e.g., the church-property related conflict – discussed later).

The villagers dialogically formed teams focused on particular tasks such as, woodworking, purchasing materials, and liaising with outsiders to effectively implement the initiatives. Each team conducted separate meetings following community-level decisions. Team members raised questions and shared thoughts during meetings, where other villagers listened carefully as they collectively explored subsequent courses of action. In some cases, villagers with previous experience or expertise (e.g., in health services or construction) were informally invited to attend. At other times, villagers telephoned well-wishers and doctors to learn from their knowledge and experience. These inputs were valued during the collective decision-making process. During detailed interactions, villagers carefully weighed and critically examined ideas and proposals by paying attention to their contextual needs, aspirations and urgency. The cultural participants’ engagement in the dialogic/deliberative process gave them discursive control in the grounded and bottom-up community organizing (Richardson & Razzaque, 2006).

During subsequent focus group sessions, villagers shared reasons for choosing a local-centric health intervention. Naju, a senior villager, believed that building a mini-hospital was necessary to save lives, as villagers could gain access to health services whenever needed. She stated:

People are suffering a lot in absence of any health facility. We need a hospital here. If we had a hospital we could have saved peoples’ lives. And, if we get some medical treatment here, we could save transportation cost ... therefore we would benefit economically too.

From the early research interactions, villagers identified the absence of local health infrastructure as a major issue and expressed a desire to participate in such an initiative. It was the villagers’ critical awareness (Friere, 1970) of structural inequities, which guided them to identify health inaccess as a crucial issue warranting a community intervention.
During the decision-making process, villagers as co-researchers took ownership of the intervention by making several independent planning and strategic decisions. In both community interactions and focus group discussions, villagers discussed the health-care facility’s details, such as location and required resources. Keno, a community member, stated:

After deciding to construct a mini hospital, we made a preliminary estimate to calculate the cost involved in the project. We also understood that the fund is limited; that is why we decided to volunteer for this project. This is the villagers’ project. Therefore, we all will work for this project.

The processes of mutual discussions and active deliberations helped villagers identify various project options and critically evaluate their feasibility (Ganesh & Zoller, 2012). Later during phase II, community members allowed me to attend several meetings where they discussed the mini-hospital’s construction and accessories. For example, Sima, a village midwife said, “We need a blood pressure measuring instrument in the hospital. We also need a toolkit set for the midwives.” I wrote in my research memo:

In this local-centric project, the villagers decided to use locally available woods as basic materials for making hospital beds, tables, benches and chairs, which would be economical and sustainable. For instance, in government hospital, iron beds are used; villagers would make wooden beds by maintaining standard dimensions. … Midwives and female health-workers of the village contributed in preparing a list of medical equipment and hospital accessories, e.g., first-aid kits, medicine-shelves, hospital cleaning kits, stretchers, and patient-beds.

In creating infrastructure in a local-centric way, villagers focused on available skills and raw materials. Collectively sharing experience and expertise, along with a willingness to learn from each other and from local examples, guided villagers in making meaningful decisions and strategizing implementation (Galdeano-Gómez et al., 2011). Moreover, villagers’ leadership, participation, and control in material and discursive spaces allowed them to contextually customize their health organizing.

**Collective consciousness and project implementation**

From the start, the villagers were cognizant about the limited availability of material resources. In accomplishing the health organizing, collective consciousness and commitments at the margins were instrumental. Importantly, the villagers decided to volunteer, which benefited the project economically. They collectively addressed material issues (e.g., property-related conflicts, discussed below) to avoid potential legal disputes. Such participatory attempts to overcome contextual challenges, both culturally and communicatively, as well as sharing resources for the common good, were crucial for the project’s efficient implementation. Community-led human resource planning helped them to coordinate and mutually distribute the tasks, which was local-centric and culturally meaningful.

Because villagers had never participated in building a rural hospital, implementation was guided by education, explorations, and experiences. Villagers sought to learn how to build a rural hospital. Given the exploratory nature of the process, learning from local examples was crucial. Accordingly, we (villagers and I) visited health facilities and gathered information about the resources required for a mini-hospital. Dimu shared:

First, we met a local doctor at Damanpur, and visited his mini-dispensary. We got some idea about the size and dimensions of bed, saline stand, etc. The doctor advised us to visit Southern Health Improvement Samiti’s (SHIS) Rajabhatkhawa health center. We went there and met one doctor. He explained and demonstrated everything in detail about hospital operations. Then we went to Family Planning Association (India)’s (FPAI) clinic. Then we came back to our village. Immediately we started drawing a plan of the proposed health facility without wasting any time.

The villagers used both situated tacit knowledge and they painstakingly learned about hospital construction and operations from local (re)sources. Such involvement helped them to devise their action plans in an informed, meaningful, and effective manner (Walker, 2007).

During implementation, the villagers used collective dialogue and deliberations to make several decisions to mobilize their human resources. To create a culturally meaningful and effective process, they divided volunteers into subgroups and appointed a formally educated and experienced young village facilitator to facilitate day-to-day planning. Facilitators were responsible for maintaining attendance records despite the fact that all work was voluntary. Villagers unable to perform labor-intensive work instead cooked and served free food to the volunteers. Pipu narrated:

Villagers collectively made decisions about duties and responsibilities. For example, Salu maintained all the records … such as attendance, donation of construction materials, cooking and serving free-food for villagers, etc. Cico was in charge of all the carpentry jobs; he also maintained record of timber usage. Luma was heading the team who built the wooden beds, chairs, tables and other furniture. Kancha and Kejo were the leaders of the teams for building a wooden-bridge.

To equitably distribute work responsibilities, the villagers relied upon individual and collective skill sets and previous experience. Accordingly, they formed groups with independent responsibilities. Collective participation, ownership, and leadership were instrumental to implement the initiative in a culturally appropriate way (David et al., 2013).

As noted, to negotiate with limited resources and other contextual challenges, the villagers decided to volunteer to build the local health infrastructure. They demonstrated their agentic commitment by prioritizing collective interest and responsibility over individual gains and monetary profits. Kalu, one of the volunteers, said:

Kalu: It was our dream to build a hospital for this village. An outsider is spending so much for our village. As an insider of this village, I decided to volunteer for this project.

Me: While volunteering, you were losing daily wages. What was the motivating factor?

Kalu: No monetary loss … we had not lost anything. The hospital is our own. Even if we could not earn money by contributing to this project, we do not consider it as
a loss; because we volunteered for a good purpose. It is a gain, because finally our dream is fulfilled. That is the profit. We are born here; it was our opportunity to do something for our own people.

This narrative demonstrates how their collective motivation and determination made the health initiative successful. By constantly negotiating against situated odds such as an impoverished economy, villagers selflessly participated as volunteers. Such commitment, action and engagement were instrumental to accomplish collective aspirations and satisfy community interests.

I witnessed important strategic planning moments during project execution. For instance, on the second day of construction, when large rocks interfered with the digging of the foundation, the villagers collectively decided a new location for the project – a dilapidated church. Specifically, the community members dealt with legal issues regarding land and property transfer. A united initiative to dialogically overcome barriers facilitated the villagers’ ability to achieve common goals. I wrote in my research memo:

It was early in the morning; Kejo, Salu, Ishu started digging the foundation. Soon, they found several very large stones embedded in the ground. As they could not remove them, the construction work stopped. Therefore, they collectively decided to change the location of the project. The villagers then identified a dilapidated church as an alternative location. One senior member commented, ‘there are so many trustees; so, getting permission will not be easy.’ After a brief discussion, several villagers and I went to meet Amma [a common term for Grandmother], a senior trustee. As per her financial proposal, we paid Rs. 8,000 ($125) for the church and she donated the building for the hospital project. Later, in the evening, the matter got complicated. Kejo informed that the landowner did not agree with Amma’s decision. Then, I realized that the property had two owners; one landowner and the church-owner (i.e., Amma). Some senior villagers met the landowner to resolve the matter. After a very long discussion (in local Jongha language), the land-owner agreed to donate the land free of cost. Accordingly, the land and property agreement was signed by the villagers. We resumed construction work the next morning.

These narratives demonstrate how the villagers’ engagement and commitment guided them to communicatively resolve property-related conflicts and complications (Richardson & Razzaque, 2006). Because they reached mutually agreeable solutions independently, project implementation work proceeded efficiently. This is important as complicating issues and delays could have indefinitely derailed the participatory health organizing process.

For many villagers, contributing to the collective effort was often initially an uncertain journey. This was particularly true for those with limited relevant experience. Collective agentic power gradually and experientially guided the community to pursue a meaningful and effective project implementation. Some participants, after initial skepticism, become actively involved in the work. Disu, a young villager, said:

At the beginning, some of us were skeptical about the success of this project. Personally, I was not very hopeful about finishing construction of the mini-hospital. Gradually people started contributing to this project, and at the end, we were successful. However, it was not an easy process … communicating with and motivating all the villagers for accomplishing a common goal was crucial. Initially, at the villagers’ meeting I got some information about this work. When the seniors approached me, I said, ok … I’ll volunteer for it. After all, it is a project for this village. Then we started discussing about our specific tasks and roles and participated accordingly. Now we have experienced it … now, we can do more such works collectively in this village to solve local issues.

Through collective participation and experiences, villagers overcame a history of dependency on hegemonic assistance and resources. Gradually conquering their hesitations, they reasserted their faith in individual and collective agency (Foot, 2001). Teamwork also allowed villagers to learn via shared knowledge, preparing them to become future leaders.

Post-project leadership

While construction of a healthcare center was an important aspect of the health organizing, running the facility with practically no economic resources has been a major challenge from the time the center opened. Shared responsibilities and contributions from community members and well-wishers aided the cultural participants in overcoming situated challenges. The villagers worked closely with local practitioners and organizations to provide health services as sustainably as possible. The community also relied on alternative health practices that were available in the vicinity to serve local residents. In addition, they envisioned the facility as a space for health education and awareness that emphasized preventative health and improved health behavior (Ford et al., 2009).

Villagers reaffirmed their faith in their collective agency for collective dialogic actions in the post-implementation phase. Realizing that building health infrastructure was but a first step towards developing a full-fledged health service, villagers shared future plans and programs for improving the village’s collective health. Improving overall health is a continuous and permanent process for the marginalized population. It became evident that the achievement of this one project was encouraging to villagers; more importantly, independently building this mini-hospital marked a new journey for many of them. Cico, who took important roles in the project, commented on the future:

This is the first step … it is a long journey … we need to work hand-in-hand to improve health facilities in this village. Some new possibilities have been created through this initiative. Some well-wishers told that they will help us in getting medicines and paramedical workers for our hospital. Right now, our goal is to run the hospital effectively. Two of the villagers have some training and experience to do nursing work. More young people of the village could take training to become health workers to serve fellow villagers … and would provide health services in local Jongha language. Additionally, they could teach us about community hygiene and preventive health measures … for example, the importance of drinking boiled water, cleaning households,
etc. Most of the villagers are illiterate and uneducated … they could learn health-lessons from trained health workers.

Villagers emphasized three commitments: ensure the hospital’s continued operation, ascertain community health workers’ sustained service, and maintain contact with local organizations. Young villagers expressed willingness and agentic commitment to serve the subaltern community in a culturally and linguistically accessible way using local resources (Dutta, 2018). Many expressed interest in further health education and training. One of the village’s semi-literate health workers, Lusa, indicated that she is interested in such training to better serve poor patients:

I got some training from a local NGO. I can measure body temperature, I can perform antigen and urine test, and I know medicines for some common disease such as diarrhea, fever, malaria. Now, I will take more training and work free of cost at our hospital. I am committed to serve the patients, especially during the monsoon and at the times of emergency.

Her words demonstrated her dedication to the underprivileged villagers. Continued participatory efforts and commitments (both collective and individual) were evident in villagers’ voices. Their commitments at the margins were instrumental in sustaining such community initiatives. By enhancing knowledge and skills, villagers collectively sought to provide health services to the community as independently of external support as possible (Kemmis & McTaggart, 2000).

**Inviting local healers and modern doctors**

Villagers adopted an open and all-embracing approach to operating the mini-hospital. In addition to providing allopathic treatment, villagers asked local traditional healers – providers of Ayurvedic, naturopathy, and local medicines – to help operate the facility. Many villagers could not afford expensive allopathic medicines, so they relied on affordable traditional or local medicines, particularly for common diseases. Though modern medicine considers such practices unscientific, villagers consider them important for their survival. Villagers embraced both modern western as well as indigenous and traditional practices and epistemologies to serve fellow community members. Balu, a villager who practiced traditional herb-based treatments, commented, “We learned about traditional healing from our ancestors. People come to us for treatments. Oftentimes we ask knowledgeable seniors about their practices and learn from them.” While visiting the local healers at their workplaces, villagers specifically requested them to provide affordable health services to patients at the mini-hospital. A few doctors and local healers responded to their request. Grounded in local practices and available resources, such initiatives serve marginalized people in a practical and culturally meaningful way (Basu, 2010).

**Organizing health camps**

In addition to providing treatment, villagers collectively organized health camps and health awareness sessions that used local dialects to discuss preventative health. Lamu shared:

We maintain contact with local health and social organizations like Himserv and FPAI. With their support, we organized six health camps focusing on specific health issues, including eye-related and cardiovascular diseases. In general health check-up camps, doctors from SHIS participated. Five health awareness sessions, including maternity awareness and cardiovascular awareness sessions were also conducted. People from nearby villages attended these events.

By paying attention to preventative health and creating health awareness in local languages, the villagers as co-researchers envisioned the hospital as a space for health education, sharing health information, and dialogues about health. Such agentic efforts and actions supported the development of healthy behaviors and facilitated better understanding of health among the indigenous people (Dutta, 2018). Independent health organizing catalyzed the community’s motivation to work as a collective toward improving health access and adherence in the future.

**Discussion**

Theoretically and methodologically, the current study is grounded in principles of critical health communication and grounded practical theory. CHC theory and scholarship call for engaged and catalytic work to (i) enhance communicative capacities at societal margins and (ii) include local communities to co-design and co-create bottom-up and culturally meaningful health communication interventions (Zoller & Kline, 2008). In other words, while CHC is invested in foregrounding indigenous voices and agencies and local structural realities while emphasizing aspects of consciousness and social equity to create access to health care. An aligned framework for constructing practical theories to address local problems in participants’ terms, GPT is not only engaged in empirical investigation of communication problems, but also invested in improvement of communication practice. GPT guides the research to explore new courses of action and alternate avenues to transformations by embracing an applied approach.

Embracing both GPT and CHC theories and praxis (e.g., Craig & Tracy, 2014; Farmer, 2008: Lupton, 1994), this research study emphasized four key aspects: indigenous subalternity, local-centric, dialogue/listening, and action/participation. In addition, guided by Freire’s call for envisioning underserved populations as emancipatory agencies, this research valued central/active engagement from the grassroots through critical listening, dialogue and mobilization of community, and through the process of raising critical consciousness and addressing structural absences.

In this research context, health subalternity stems from several structural and communicative absences. These include strategic negligence/ignorance by dominant stakeholders; lack of basic needs at the margins; weak domestic and local economies; caste-based and other forms of socio-political discriminations; delegitimization of the subalterns’ agencies and voices; and communicative barriers. Moreover, hegemonic confinement of health to individual behaviors essentially deemphasizes the roles and significance of structure. This further marginalizes and communicatively incapacitates underserved populations (Robertson & Minkler, 1994). Cultural participants’ distrust and skepticism about externally formulated (i.e., top-down and less culturally meaningful) solutions to local health issues situate the issues of health
access at the center of indigenous peoples’ communicative choices. This combination of factors inspired community members to own, decide upon, and lead the health intervention.

In examining the communicative processes and actions in strategizing (RQ1) and implementing (RQ2) a local health-initiative, this research focused on three key aspects: (i) reflexive listening to foreground situated realities and narratives; (ii) engaged dialogue to foster processes of defining problems and co-developing plausible interventions; and (iii) community action to bring about meaningful transformations. Interplays among these three aspects not only situate cultural participants at the center in achieving empowerment and material change, but also build and enhance local agentic capacities (including communicative) to improve the overall health scenario at the margins. Mutual discussion and active deliberation aided participants’ ability to critically weigh various intervention options and careful examination of feasibility of each to organize a health initiative in a participatory and culturally appropriate way. By dismantling hegemonic delegitimization of subaltern agency, the indigenous participants self-governed/owned the process of building collective assets and operating a mini-hospital. They went beyond narrow self-interests and orchestrated communal human potential to create a local, alternate access to health. Such a collaborative research approach situates subaltern agencies, worldviews, and discourses at the forefront, and locates contextual aspirations and consciousness at the locus of community organizing (Chaturvedi, 2007).

These critical communicative moves differ fundamentally from neoliberal practices of consulting with a community to learn their thoughts and desires about health issues. In such consultations, community voices are strategically co-opted by dominant stakeholders to fulfill hegemonic agendas. Dutta (2016) argued that in such processes, underserved people are vulnerable and remain target of dominant interventions. Such strategies ultimately shift the “burden” into the hands of the subalterns. In contrast to neoliberal organizing, villagers volunteered to implement this project themselves and never took any remuneration (which made it possible to build the health facility with just $1,200). Embracing GPT and CHC scholarship, this study argues that listening to and dialoguing with as well as active participation of indigenous people at each stage of the health organizing – while opposing/resisting dominant, neoliberal development practices – results in a transformative process for marginalized communities.

It was never easy to overcome structural and communicative barriers to health access. Together, the villagers, as coresearchers, made sincere attempts to organize health by negotiating with situated communicative barriers, initial dilemmas and minimally available material resources. Moreover, local-centric approaches, another key aspect of this research, contributed to develop cost-effective solutions (Rahnema, 1992). These approaches also helped resolve conflicts and effectively implement decisions (Richardson & Razaque, 2006). In addition, indigenous ways of knowing, decision-making, innovation, and insights from the grassroots (including learning from outside stakeholders such as local doctors, health professionals, and organizations) – as well as applications of such situated knowledge (e.g., acceptance of traditional/indigenous forms of healing) – made their solution sustainable and affordable. Thus, less dependent on external aid, community led health communication initiatives at the margin essentially challenged externally dictated and aid-intensive interventions by dominant stakeholders.

Reflexivity is another key aspect of this community-centered research. Spivak (1999) reminds us to be critically reflective about our unearned privileges and inherent biases, as well as to forego our position as the expert. This reminder also calls for de-centering the unquestionable superiority of west-centric approaches to health communication, which epistemologically and ontologically manufactures deficiencies and primitiveness in underserved populations. It is also important for researchers to cultivate intercultural competence and empathy to create a meaningful coalition with cultural participants, as well as to make the research processes culturally sensitive and appropriate. To this end, the current research argues that it is crucial to (i) blur situated power differences between participants and researcher; (ii) remain constantly vigilant of taken-for-granted assumptions (e.g., about health subalternity and indigenous agency); (iii) be open and respectful to new viewpoints; and (iv) build solidarity for creating spaces for alternative health initiatives.

This research was a small step towards enhancing health infrastructural access in a Himalayan village in eastern India. Indigenous participants’ active engagement and involvement at all stages not only made their health organizing non-west-centric and non-hegemonic, but also dismantled hegemonic assumptions of subalterns as devoid of agency (Spivak, 1999). With limited resources, no governmental support, and minimal outside help from local well-wishers and organizations, the villagers took ongoing actions to provide sustainable basic healthcare services for their community.

By constructing a health-facility, the community also collectively provided concrete (as well as visual) evidence of their strength, which will remind them of their agentic capabilities long after this researcher left the field. Thus, the initial success of the community-led health organizing catalyzed locals’ conviction and determination to work continuously and sustainably towards improving local health and well-being. Through such collective organizing, community members emerged as mutual exemplars and inspirations to each other through celebration of agency. Indigenous participation in the health initiative was a display of their individual and collective confidence, commitment, and achievement. This will help them to raise their voices and fight for local health and socio-cultural demands in the future.

This research conceptualizes and envisions social change practices primarily in the realm of agency, culture, and communication. Drawing from CHC theories and GPT, this critical communicative study argues in favor of a bottom-up, community-led co-creative action grounded in local communicative practices to expand alternate access to health (and related areas such as education and transportation) at the margins. This research highlights the need for more academycommunity partnerships to create greater access to both curative and preventative health in underserved spaces. In the Global South, where such access (to basic health) and
available resources remain alarmingly inadequate, the health communication discipline needs to understand situated inaccess to health in a communicatively and culturally appropriate way. The discipline also requires engaging and catalyzing praxis-based health organizing to meaningfully address structural and/or infrastructural absences. Such health communication initiatives would potentially contribute to (i) creating access to health services and health information as well as foregrounding agentic-capacity to bring about changes in marginalized, under-represented, and/or under-researched contexts of the global south, and (ii) broadening the scope of such transformative initiatives in health-related domains such as communication for (international) development and environmental organizing.

Notes

1. As per Government of India’s 11th Five-Year (2007–12) Plan, “A large number of STs (indigenous people) who are living below the poverty line are landless, with no productive assets and with no access to sustainable employment and minimum wages” (p. 114). Also, the 12th Five-Year (2012–17) Plan document noted, “Most of them live in isolated groups in relatively remote areas” such as in “forests, hills, undulating inaccessible areas.” About indigenous spaces, it further commented, “not only poverty continues at an exceptionally high levels in these regions, but the decline in poverty has been much slower here than in the entire country” (p. 228).

2. Some of such disparities are – lack of fulfillment of basic human needs, poverty, weak local economy, lack of access to basic infrastructure, as well as various socio-cultural stereotyping and discriminations (Dutta, 2018).

3. Government-run healthcare (and PPPs) in India is largely privatized and western-influenced; it pays little attention to primary care. Increasingly, overseas institutions/ agencies are influencing health plans by prioritizing PPPs and interests of private sectors in contemporary India (Patil, Somasundaram, & Goyal, 2002). In remote underserved spaces, the reach of basic health services is limited; consequently, those spaces/populations are consistently neglected in policymaking. In spaces of dominant decision-making, indigenous voices and aspirations are still unheard and invisible in India; furthermore, the aspects of their inclusive involvement of indigenous people and their freedom is mostly ignored (Ashtekar, 2008).

4. Scholars opined that in rural Indian health contexts, the state lacks political will as well as failed to realize human potentials at the margins. Such moves made the rural health care system highly selective and centralized; also, considered indigenous people as objects of control (Ashtekar, 2008; Patil et al., 2002).

5. In contrast to bottom-up community-centered organizing, neoliberal organizing (i) co-opts the language of participation and empowerment, (ii) uses the façade of transferring power, and (iii) externally imposes their agendas and programs on the marginalized communities. In contrast, CHC argues that act of dialogue and listening local stories as well as foregrounding agency/action at the margins disrupt dominant depictions and misrepresentations.

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