From Presence to Decision-making: Understanding 'Participation'

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Abstract

Community 'participation' or 'consultation' or 'discourse' are a few terms that always mark their presence in the policy documents prepared under present welfare programmes. There are legal provisions meant to ensure people's participation in both rural and urban areas to promote democratic governance procedures. The target population is often encouraged to engage in dialogue with the recognized 'agents' of change belonging to both government and non-government organizations. However, there is a difference between the idea of participation as understood in democratic governance and how it is really practised. Instead of taking initiative in planning, based on their needs and culture, people generally end up doing 'role plays' or being dummy participants. This paper tries to arrive at the core of the concept of participation as understood by NGOs, funding organizations and the government. It brings into focus the right/power of members to take decisions as an important element of participation. With the help of data gathered during the field work around the creation processes of communication material on a national health programme (i.e. National Vector Borne Disease Control Programme), the study aim to reflect upon the standardized procedures that are developed and maintained by a private communication agency to ensure participation by the targeted beneficiaries.

Introduction

'Participation' as a concept appeared for the first time during the late 1950s; it achieved currency in international discourse on development in

1960s and became popular in 1970s. Around this time (1978) WHO recognized 'community participation' as the key principle for its programmes dealing with Primary Health Care (PHC) in all its member nations (Mpolokeng, 2003: 62; Rifking, 2009: 31; Schwab, 1997: 2049). In addition to a great emphasis given by United Nations' agencies, 'participation' and 'dialogue' were seen as critical elements of 'communication for social change' by a famous Brazilian educator and philosopher named Paulo Freire (Figueroa, *et.al* 2002). However, the term was most spoken about and researched upon from late 1980s to early 1990s when itwas revived again after a lull. At present, starting from the involvement in identifying collective needs and concerns to actual moderation of welfare programmes, citizen participation is recommended as one of the important communication tools (USAID report on BCC tools) among development circles, essential to conduct successful programmes.

On the one hand, the government aims at following various participatory mechanisms to ensure people's engagement and, on the other, it has started outsourcing the creation of communication media to private communication and advertising agencies. These practices provide us with a unique example of how the understanding of 'participation' and targeted 'community' in advertising travels and moderate the same in communicational procedures aiming for development. While most of the studies around participation talked about the democratization of development process, modes of participation, stages of development programmes and, communication between policy and 'beneficiaries', less has been said in relation to the development of communication media. This paper aims to present the nature of participation as observed during my field work around the creation processes of communication material developed under one of the national health programmes in India.

The perspectives to look at people's engagement are generally shaped by international understanding of factors affecting citizens' welfare, especially in underdeveloped or developing countries. These include mainly the sponsors who provide funds for developmental programmes in these countries. Standard formats for assessment, processing and evaluation are also imparted by these sponsors. However, participation by people happens mainly through dialogue; the present paper revolves

around the nature of communication forming this dialogue. How is people's participation in the developmentof communication media sought? Who all really participate? Who facilitates their participation? Where does the participation lead to? What is expected out of various participatory procedures? What does participation actually contribute to? In order to find answers to these questions, communication processes facilitated by one of the 'Behavior Change Communication' (BCC) agencies for national vector borne disease control programme, under the guidance of Ministry of health and family welfare have been traced and described in this paper. *Designing Communications* (name changed) identifies itself as a 'social communication' agency that does communication research, creates media and publishes reports for various government departments; they believe that 'social advertising' (and marketing) is a misnomer for the range of activities that they do primarily because of a commercial angle attached to it. However, this paper shows the existence of research practices similar to mainstream marketing as adopted in the field of development that contribute towards the understanding of 'community participation'.

Background

The Ministry of Health and Family Welfare, Government of India, was granted financial assistance by the World Bank under a project called "National Vector Borne Disease Control and Polio Eradication Support Project" for a period of five years (2008-2013). At the national level, the project was further divided into two sub-projects dealing with vector borne diseases and polio separately. Under the category of vector borne diseases, they focused on Malaria and Kala-azar. Eight states (Gujarat, Maharashtra, Madhya Pradesh, Chhattisgarh, Odisha, Jharkhand, Andhra Pradesh, and Karnataka) and three states (Bihar, Jharkhand and West Bengal) were selected for malaria eradication and for kala-azar elimination respectively, making it a total of ten states with Jharkhand included in both the groups. North-eastern states where the disease burden is high are covered under 'Intensified Malaria Control Programme' (IMCP) sponsored under 'Global fund to fight AIDS, Tuberculosis and Malaria'. Surprisingly, Goa and Rajasthan that have high malaria incidences according to the annual parasite incidence (API) in 2004, are not included under the project. Even in the selected ten

states, the project is being implemented in 'World Bank districts for phase 1 and phase 2'. The Directorate of National Vector Borne Disease Control Programme (NVBDCP) is a special wing created under MoHFW that further divided the responsibility among many national level organizations which are said to have good experience in the health sector, given that the project had to complete a full cycle beginning from assessment to evaluation.

The National Vector Borne Disease Control Support Project (NVBDCP) went in search of a Behaviour Change Communication (BCC) agency in the year 2010, and requested for proposals, for its national level communication project. After analyzing the technical and financial proposals that all the applicants had submitted, the directorate selected *Designing Communications*. Apparently, the company is one amongst the best working on BCC. However, as informed by many *Designing Communications* professionals, it was their extensive and interactive use of *jatra* and *pala* – two popular folk art forms – in Odisha for *Malaria Niyantran Abhiyan* (Malaria control programme) that set the background for them to get this huge budgeted project. The majority of rural population in Odisha still enjoys *jatra* and *pala* for entertainment; and it is almost impossible for any programme not to use these media while considering the local media. As part of researcher's field work, the researcher did an internship with *Designing Communications* for six months and was closely associated with the creation process of the media that was developed for the programme. By the time the researcher joined *Designing Communications*, the formative research for the project was already done and the content for the media was to be created. Therefore, the data used in this paper is primarily based on reports and interviews while presenting the information around the formative research.

One year before starting the project in 2008, the World Bank had come up with a vulnerable communities' plan, for vector borne disease control, with assistance from government of India. In the policy document published online, the 'vulnerable community' was described as being those "groups with social, cultural, economic and/or political traditions and institutions distinct from the mainstream or dominant society that disadvantage them in the development process" (Vulnerable community plan, 2007). The group mainly included Scheduled castes, Scheduled Tribes and people who are below poverty line (BPL). These

groups are seen as socially and economically disadvantaged, as having less or no access to health services, and therefore more prone to vector borne diseases and lack of treatment. Among these groups, as mentioned in the report of 'Social and Beneficiary Assessment' (SABA) done by an independent agency in four states (Andhra Pradesh, Chhattisgarh, Madhya Pradesh and Odisha), it was found that about 50% of the sample villages were out of reach under the previous information campaigns. It was also stated that 'community participation' in the said programme was weak. In the light of this information, another non-government health organization was involved for better social mobilization and service delivery amongst these groups. Moreover, to ensure the involvement of the said population, it was made sure that people belonging to these groups got represented in the meetings done for initial survey and pre-testing done by *Designing Communications*.

The above-mentioned or any other report did not explain the term 'community participation'. Moreover, the term 'community' also sometimes becomes an umbrella term for all the target audiences under the project and is sometime being referred to as a site. Therefore, this paper seek to understand the specific and general usage of these terms in different contexts. The nature of participants and participation, the anticipated outcome of participation for the state, the purpose of participation for the 'community', and the degree and the process of participation have been focused upon to understand the practice of participation. On the one hand 'community participation' is seen as a right of the population whose interests are at stake under a given programme in the light of liberal political theories; on the other, trends in media preparation show that inputs from the audiences are taken to avoid any sign of the failure of the campaign. The theories of behavior change try to understand the possible barriers and motivating factors for a group to adopt a new behavior. This individualist approach tries to arrive at the 'will of all' by adding individual responses and ignores the collective will deriving from a specific culture. Therefore, the present example of media preparation for a government health programme puts across a special case of community participation within the broad health planning while exploring the idea of 'participatory communication.' Participatory 'development communication' is a tool specifically employed by non-government organizations to ensure the involvement of ultimate target

population with the help of all - mass, traditional and inter-personal communication techniques.

The complete project of NVBDCP had to go through the entire stages of planning, implementation, monitoring and evaluation and this was amongst one of the fewer cases when a separate communication project was planned. 'Baseline surveys' or formative research, pre-testing and evaluation are three ideal stages in the creation process of communication media where audiences are involved directly. Baseline surveys are done in the beginning of any project in order to collect data around standard formats so that it is easy to calculate and compare it across variables. However, it is only the former two that are practised in majority of the cases. The vector borne disease control programme did not see the evaluation stage since the project got over even before the implementation. The communication material did not get printed and it was sent to the respective states. The latest report made publically available by World Bank states the overall bank and borrower (i.e. government of India) was found unsatisfactory as per the 'Implementation Completion Report' (ICR) that the bank prepares for each lending year. The formative research done by *Designing Communications* not only helped them to plan a BCC strategy and create media around malaria and kala-azar, but also helped the directorate of NVBDCP with relevant information around health services and infrastructure that went into the complete project planning.

'Formative Research' – Making the Initial Contact

Communication research in India has borrowed the tradition of logical positivism from the West which sees it as an applied discipline to be used for communicating development. As a result, communication policies also followed the market logic, that is, to promote a product or service in the society that further gave importance to the required attitudinal change among the targeted population (Bel, *et. al.* 2005). The communication policies for welfare programmes in India gave rise to behaviour change communication media in order to bring the required attitudinal change amongst the masses. Research around BCC and health follows various models, of which the most celebrated one is called 'health belief model'. As mentioned by *Designing Communications* in their 'BCC strategy report', 'health belief model' is a psychological

model that predicts people's attitude and behavior based on several factors including 'perceived susceptibility', 'perceived severity', 'perceived barriers', 'perceived benefit/action', 'cues for action' and 'perceived self-efficacy'. The other approach that *Designing Communications* based its communication strategy upon is called 'diffusion of innovation' that takes into account the factors that affect the thoughts and actions of people regarding a new idea or product. The tools developed for data collection during the formative research were based on these perceived factors.

The objectives of formative research, as stated in the reports prepared by *Designing Communications* were:

> [T]o assess the current knowledge levels, perceptions of barriers regarding malaria, and more specifically with reference to disease prevention, control and treatment; to identify and delineate the different sources of health information, preferences and the factors that influence health seeking behaviour and suggestions for making the public health system more accessible to people; to understand the socio-economic and cultural and behavioural factors with reference to disease prevention, control and treatment.

During one of the meetings the 'creative consultant' working for *Designing Communications* said that the biggest:

> difference between social sector people who are advertising to the same audience and the commercial sector people who are advertising for the same audience and the film maker of Bollywood who is making the film for the same audience…. they don't dilute the film and make a subtitle to make them understand it, whereas people who are in social sector, they think too much of themselves, they think that they are gods, they believe that the guy at the end of the line is an idiot…

The 'creative consultant' said the above sentences with regard to the representation of information as done in various forms of media such as flipbook and booklets. However, the belief that 'the population out there has attitudes and practices that are not good for them and they need to be taught the right way' becomes the premise of any pre-planning survey.

Formative research for the said project started with the collection of all the relevant information via secondary/desk research/review. Based on the acquired information, interview schedules, questionnaires and guiding points for 'Focused Group Discussion' (FGD) were prepared. Among these were Key Informant Interview (KII) formats (for medical officers, 'opinion leaders' and service providers), Household Questionnaires and FGD guide were the major research tools employed to gather information. These included people like religious leaders, local healers, teachers and NGO members. Before finalization, all these tools were pre-tested in Odisha. These tools were to guide the discussions and cull out information around specific issues. For example, the guide to FGDs was divided into three major sections focusing on community knowledge, attitude and practice for malaria treatment, and perception on health service providers and sources of information. A great emphasis was given on the use of mosquito nets in the project. The table for participants' details which included their names, age and occupation also had another column asking if people regularly sleep inside mosquito net in addition to few more questions related to these nets in section one (that was named as knowledge, attitude and practice). Therefore, health can simply be stated as an absence of disease, in the programmes like this, where the presence of a given measure (such as LLIN) becomes synonymous to 'health'. Interestingly, during one of the pre-test meetings, while discussing about the importance of taking care of the insecticidal net, the Chief Medical Officer asked the local health workers and other people not to wipe wet hands with the net as they did with any other cloth in the house. The reason behind this was to ensure the longevity of mosquito net; however, the discussion on the probable side-effects of ingesting insecticide did not take place. The issues related to the use and maintenance of the mosquito net deal only about specific tasks such as how to properly tie the net with the charpoy/bed and how to store it when not in use; the above was an example of common cultural practices do not get reflected in the structured survey formats and go unattended most of the time.

In all the formats (except FGD guide) an 'Informed Consent' letter was included in the beginning, to be read out in front of the possible interviewee to introduce the survey to him/her, informing them about the importance of his/her participation and his/her right to say no if he/she

does not wish to continue with it. It promised confidentiality and also stated that:

> [T]he survey will not give any direct benefit to you; but as a whole the results of this assessment will help the health service providers to better plan services aimed at improving health and well-being of the community, mothers and children in particular in your area.

The investigators who did this survey were trained so that they do not offend the community and are able to get the maximum relevant information. They were also instructed to allow the respondents to relax and respond, to be respectful and presentable by following proper dress code, observing local etiquettes and maintaining the dignity of the respondents, to help them understand their benefits and to not make fake promises while conducting FGDs.

This survey was different from many other BCC surveys because NVBDCP had selected *Designing Communications* not only for media preparation but also for the launch of the prepared media along with relevant trainings of health and other community workers. Therefore, the survey included a variety of questions including those related to people's knowledge about malaria/kala-azar, the media that is preferred, their relations with community-health workers and also the availability of health services in their area. Hence, it was a mixture of need assessment and KAP survey. For example, the household survey was a 23 page interview schedule covering, classification data, demographic details, knowledge on malaria, relevant attitude and practices, environment, housing, health facilities, existing and preferred media forms, to name a few. It was also mentioned in the schedule that they avoid getting mere yes or no answers, but to probe the respondent into giving details about the subject as the format was that of a closed questionnaire.

The household questionnaire in itself was a very good detailed format getting almost all relevant information about malaria and the people's attitude towards it. However, if we see the nature of engagement that might have happened, we would realize that in order to get this huge set of questions to be answered one needs to have some rapport with the household or have a gate keeper who could facilitate the conversation. It

would be interesting to know the factors that motivated the population to answer, knowing that there was no direct benefit for them.

The participation of the people was expected about a given series of issues. While talking about democracy as representing legitimacy, Benhabib (1994) suggests upon the importance of institutional procedures that also include the openness of the agenda of public discourse whereas the agenda in this and other similar cases is often fixed. If we look at the motives of why people agree to respond to the questions, we find a variety of reasons. Government professionals have less choice to decline to any government project. However, for other community people, there is a wish to know and get connected to the government in ways available to them. Some hope that their responses will bring about a change in the future while some just wonder how and to what extent the information given by them is going to contribute towards this. The respondents inform the interviewer about their world and in many cases they merely answer the question; but they also participate in the conversation and exercise their power by asking some counter questions to the interviewer. To them the interviewer represents both the state and his/her subjective community. Even if people do not wish to communicate with the interviewer they cannot easily say no to a state representative who has the 'power'. The researcher used the term 'power' in relation to decision making. State-community relation, irrespective of various talks on democracy, still proves to be a power relation in practice.

Schatzman and Strauss (1955) talk about how social classes of the communicators affect the level and nature of communication. With the help of interviews taken with the victims of tornado in small Arkanas towns and adjacent rural areas, who belonged to lower and middle classes, they suggest that the differences are found amongst them in terms of perspectives, their use of 'classifying' and 'generalizing' terms and also how they relate to the interviewer. However, for the majority of welfare projects the respondents belong to underprivileged communities. Can we then say that they all would respond to the interviewer similarly? Do regional and cultural histories have no role to play? The next section deals with this idea of community that is categorized heterogeneously from inside but still identified as 'one' on the basis of similarities while putting against the privileged and the powerful.

Community as 'One'

Communication media around societal 'welfare' issues often target specific audience groups, be it youth, adolescent girls, old people, wage laborers or women; sometimes very broad yet specific categories. For this project on vector borne disease control, the target was everyone; but in selected districts, special emphasis was on pregnant women and children below five years of age. The message content in the communication material follows a pattern of commands that an individual should follow, e.g., do not allow water stagnation in and outside the house, go to the health worker at the very onset of fever, do not wash the mosquito net with warm water, etc. This creates a subtle dilemma for the people residing in 'rural' settings where there still exist communal social practices and many decisions are taken collectively. Although it was claimed by the content developers that the messages were designed so in order to bring more clarity of what one should do to get away with a targeted 'social ill', it places the onus of action on the individual. This approach resonates with western logical positivism that is also followed by bio-medicine. Scholars also mention that although medical science on the one hand, found out the cause of disease, it took away the responsibility and accountability of ill health from society and placed it on the individuals themselves… (Bel, *et. al*. 2007).

Moreover, the category (*i.e*., community) is already treated as 'one', close to a homogenous group on several occasions but in a broader sense. 'Close to homogenous' because the differences on the basis of caste, class, gender, age and disease catchment area are already being consciously taken into consideration but at the level of analysis a common referral term 'community' is used, irrespective of existing geographical and cultural differences. Even when realizing these differences, limited resources and personnel are cited as the biggest reason. Quite obviously these resources are spoken about in relation to the budget that a given programme has been assigned by the government and the staff who can be paid within that budget. Local resources are difficult to count because there is lack of ownership by the participants.

The use of the term community in the field of development refers to the disadvantaged group that is targeted as beneficiaries under a specific project. The referral while using the term has an element of distance inscribed in it. This distance exists at the level of space (nature of

residential setting), class and knowledge, created by those who employ the term. There is a subtle reiteration of power that one exerts over the other, that the state or other welfare organizations attain in relation to the targeted beneficiaries. This is the manifestation of the pre-existing 'humanitarian approach' (also known as dependency theory) that had posed science, technology and developed countries as the saviors of the poor, hence putting them in a position to decide for others (Bel, *et. al.* 2007). This becomes clear from the example of other programmes that are run for other target groups, *e.g.*, health workers who are not referred to as a 'community'. Hence, the community is a group of potential yet powerless people who can easily be replaced for one another.

'Participation' by the community is again seen as one kind of event happening at different times and places. The participants in this event only fulfill a role that can easily be done by others of the same demographic details. Interestingly, baseline research (KAP survey) and the pre-testing of the research tools and communication media were all done with different sets of people in different villages of the country. As claimed, this is the best possible way to include the maximum variety of the population in a diverse country like India; but does this do any justice to the purpose of all these engagements? What is a common base for the integration of various dialogues? To understand these practices, the process of pre-testing of communication at Chhattisgarh is discussed below.

Pre-testing the Content and Its Representation

On the basis of the information collected in formative research, *Designing Communications* came out with a compiled report that suggested actions to fill the information gaps via the communication material that *Designing Communications* had to create. However, two videos on Indoor Residual Spray (IRS) and Long Lasting Insecticidal Nets, along with an audio play, were already developed by the company. These included a flip book on malaria, a flip book on kala-azar, an FAQ (Frequently Asked Questions) booklet on malaria, a comic book on malaria, an A4 size pamphlet (only visual) on LLIN (Long Lasting Insecticidal Net), an A5 size leaflet on LLIN and a DL size leaflet on kala-azar.

The comic book did not result from the recommendations of the formative research report. It was decided by the senior professionals at *Designing Communications* to serve as a visual guide to complement the audio play that was written earlier for the children belonging to the targeted population. It gradually took the shape of a comic book. It was also planned that children would first learn and then enact the play at the district level as part of a skit competition. However, the plan could not be materialized as the project got over in between.

A flipbook is a book that is generally used by health workers for a small group of people to have a focused discussion. On the one side, it has pictures on the specific subject for the group members, and on the other side it has text related to those pictures for the facilitator. This side also has similar pictures in a miniature form so that it is easier for one to relate the responses given by the group with regard to the picture. The flipbook was to be pre-tested with both the health workers and people in general because it had both as target audiences. It served as a 'job aid' for the health workers. Leaflets and pamphlets were to be tested only with the larger population while the comic book was to be pre-tested with the school children and teachers who were to facilitate their readings.

It took around six months to come out with the draft of these media items. Before going to the audience for pre-testing it was shared with the directorate of NVBDCP for their comments. The team at NVBDCP comprised mainly of doctors who played the role of technical experts. They questioned the images and language wherever they found it necessary and the changes were made accordingly. In some cases where there was no consensus, things were left for audiences' reaction. Does that mean that community was put above both the directorate and *Designing Communications*?

Although two colour options for all the communication materials were made, one for each was printed for pre-testing. The selection of colour was done by *Designing Communications* as NVBDCP did not give any preference and were more interested in knowing the community's responses. Since Chhattisgarh is amongst the most endemic states for malaria and the disease is there seen as the foremost public health problem, it was selected for pre-testing the media on malaria.

Similarly, Bihar was chosen for pre-testing the communication material on kala-azar. However, in this paper discusses only the Chhattisgarh pre-testing procedures. *Designing Communications* contacted NVBDCP to finalize the districts and blocks for pre-test and getting in touch with area chief medical officers (CMO). Consequently, Kotami and Kodgar villages from Pendra block and Dhaniya and Khundra villages from Masturi block were selected in the Bilaspur district of Chhattisgarh.

The flipbook and leaflet on malaria were pre-tested with both the health service providers (namely ASHAs, ANMs, AWWs - Anganwadi workers, malaria workers, multi-purpose workers and medical officers); booklet on frequently asked questions was tested with health service providers only; and the comic book was pre-tested amongst school children (of class 7 to 12) and teachers. Although a group of 8-10 members is said to be the ideal size for pre-testing any communication material, there were always approximately 35 people in each group, except those of children. This, on the one hand, ensured that there was feedback for each point that was asked; on the other hand, it reduced the degree of participation for each member. Since the pre-testing of a given set of media was done in combined groups, it was primarily health workers and a few village leaders who gave their feedback even on the media that was made for the general public.

All the members were first asked to sit on the mat in a circle (wherever possible) followed by the introduction of the *Designing Communications* team, as also the purpose of the gathering. Interestingly, there was no reference to the company but only the government of India.

> *Hum bharat sarkar ke rashtriya vector janit rog niyantran karyakram ki taraf se aye hai, unke liye hum kitab banate hai malaria or kala-azar ke upper, jankari dete hai logo ko, jaise malaria kaise hota hai, malaria kaise rok sakte hai, keetnashak machardani kaise use karna hai, ye sab likha hai isme, yaha pe hum char panch kitaben laye hai jo apke sath share karenge* (We have come from the national vector borne disease control programme from government of India; we make books on malaria and kala-azar for them, give information to people, like how does malaria spread, how to prevent malaria, how to use insecticidal mosquito net. All this is written in this book; we

have got four or five books with us that we will share with you).

One of the team members then displayed a particular visual media to the group and asked how they saw the given media.

Ye humne banaya hai malaria ke upper, or hamari is visit ka mudda ye hai ki apko samajh aa raha hai ki nahi, ye dekhna hai, or apko kya lagta hai iske bare me, kya acha hona chahiye, kya hona chahiye nahi hona chahiye, or acha kaise ho sakta hai (we have made this on malaria, and the purpose of our visit is to know whether you can understand it or not, to look at this, and what do you think about it, what else is to be added, what should/not be there, how to do it better, etc.).

Questions like 'what do you understand from these pictures? What are the shown figures doing? Is this picture really needed? What if this pictureis removed from the place it is given at? Do you like the colours? Does the text make any sense? Are the words used difficult? Is there any information that should be deleted, edited or added? Is the size of the text readable?' were asked to check the clarity, colour and acceptability of pictures and the clarity, length, sequence, language and acceptability of the text. The terms to check the effectiveness of pictures and the text were given on the format that was to be filled in after the pre-test meeting.

The participants responded to the questions that were asked; they also expressed their doubts with regard to whatever they could not understand; they even suggested the possible way of showing any image when it was not clear. For example, in order to show that malaria can also lead to death, a set of pictures was depicted in a circle to show what would happen if proper treatment of malaria was/not done. The image on one half of the circle showed a man who is lying on bed to show that he is unwell, people carrying the ill man to the hospital on a charpoy, the doctor treating the man and a happy family; on the other half of the circle, the ill man was followed by another image of a dead body that is covered with a white cloth and a wreath put over his body. The image of the dead man and wreath was not clear to the members of one group and some of them even equated it with the blood testing slide with few drops of blood when shown from a distance. Some of the members suggested

replacing the wreath of red flowers with some scattered yellow flowers and also to covering the face of the dead body.

> *Nai lag raha hai mar gaya hai, fool dalna chahiye, kafan ko upper tak dhak dena chahiye, ubhaar hona chahiye, chota chota do char fool dalna chahiye peela* (it is not clear that he has died, put some flowers, cover the face of the body with shroud, show some depth, put some yellow flowers).

Suggestions given by the respondents were all recorded and changes were done accordingly along with some additions. The funeral pyre could not be shown as it would have symbolized the Hindu culture; some of the communities do not put flowers on the dead body; therefore flowers were also not shown. The face of the dead person was covered as suggested. In addition, a photograph with a garland was put beside the dead body. However, one of the NGO professionals later informed that the tribal people in Chhattisgarh do not even keep the photographs of people, let alone the garland.

In another instance, diseased red blood cells were shown and the group could not understand it. One of the group members suggested giving names to the images. In his words,

> *Kuch cheej aisi hoti hai ki jab tak ap batayenge nahi to pata nahi chalta isliye nomination karna jaruri hai, background pe nomination hoga to jyada effective hoga, agar koi illiterate hoga to hum padhke bata sakte hai, aese to kisiko pata nai chalta agar nomination hoga to kam se kam padha likha to samajh paega'* (Naming is important because there are a few things that cannot be understood without you explaining them to us; it will be more effective if the designs has names; if there is any illiterate then we can read for them; nobody will understand like this; with names, at least the literate will understand).

Since this was in the context of a flipbook that is carried by health workers for community meetings, interpersonal communication was ensured and therefore naming was not done.

Some of the health workers were also asked to read aloud the FAQ booklet as well as the flipbook and make the rest of the group understand what was mentioned. They did it according to their own skills and ability. Since there was a loss of information during transmission, capacity building trainings proved to be an essential step. It was also important because inter-personal communication was going to be taken as one of the important communication media in the project. However, there was a clear difference between the knowledge level amongst the ANMs and ASHAs. ANMs who had taken nursing training could easily understand the information in comparison to the ASHAs. Even amongst the ASHAs, the younger staff was better in comprehension. During a casual discussion after the pre-test meeting, one of the ANMs told that she has never been out of the district and wished to go out and see places like Delhi. People like her enthusiastically come to these meetings that are held by outsiders also because it is a way for them to reach a world that is inaccessible to them otherwise. This is another motivation why people participate in these meetings as discussed earlier. Thus people from the 'community' participate differently and there are various examples and understanding of distinct participatory episodes.

Understanding 'Community Participation'

Social movements during 1970s brought into focus the idea of 'participatory governance' but it is only after the Alma Ata Declaration in 1978, that 'community participation' in the field of health was formally recognized and talked about. The declaration saw the engagement of local population as important in connection with preventive and basic curative measures. Therefore, para-professional health workers came into focus. It was suggested that people see health not only as their right but also a responsibility which meant that they should get involved in health issues right from need assessment to implementation process (Koonings, 2004; Morgan, 1993). However, this engagement of people at different stages in health planning and implementation is not seen as devoid of power and politics. According to Richard Adams, "participation is merely another way of looking at power". Also, international development agencies saw participation as 'one size fitting all' by avoiding the history and cultural differences amongst various countries (Morgan, 1993: 4-5). Similar trends are seen

in India when programmes are planned and implemented uniformly in different cultures and geographical areas. Present trends show some differences as culture has been given importance during both planning and implementation of welfare projects. Communication models have also come a long way from seeing the audience as just passive receptors to active media shapers. Nevertheless, the participants are consulted only to see how well those programmes could be carried out, and not as part of their right to decide.

The documents for the said project for vector borne disease control had talked about the special importance of traditional media forms in order to disseminate relevant information while giving less work to mass media. After the evaluation, standard media messages were created and planned to be communicated through traditional media forms. However, the processes of finalizing these media content seem to be a standard procedure that had to be followed even if it does not do the required functioning. There are studies done to check the efficacy of electronic media but less has been done for print media in the development sector. By bringing back the idea of treating the community as one, this paper wishes to bring into light that the various groups from the community are contacted only once and there is no established and informed route through which they could reach the media makers. The groups with whom the pre-testing of the research tools was done were from Odisha, the groups and individuals who contributed to the KAP survey belonged to all the project districts but not same as earlier. So, there is no continued dialoguing with any one group from the 'community'. Then how does this type of participation play any role?

Two kinds of answers can be given to the above question. One is that it is not feasible to go to one group again as the project is pan-Indian and it is also not feasible to go to many groups again due to financial and material limitations. As mentioned earlier, resource limitation is a very standard answer that one would get while questioning the similarity of media over the states. The other kind of response that one can get is that 'the responses are more of less same amongst the target audience'. This takes us back to the definition of vulnerable community given by the World Bank where people are seen only against those who are in the mainstream. Therefore, there is a need to re-consider the definitions like

this. The audience's culture is to be given due recognition always and not only during the surveys.

Researches done in the field of communication believe that messages imbibed in the media as sets of cultural meanings are effective as communication if they fit in the structure of cultural meanings held by the community (Salzman, 2002). There have been many instances where media created for welfare projects did not perform as expected because they were comprehended differently by the audiences. Singh and Bhardwaj (2000), in an article on communication, talk about a visual poster that was designed for a rural population to promote latrines in Orissa (now Odisha) by a communication consultant on the basis of linear perspective without considering the villagers' idea of representation; therefore it did not work. Similarly, the representation of a birth control contraceptive larger than its original size in the advertisement poster, made a rural woman fearful and sceptical of the product. In another example, a television commercial of *nirodh* (male contraceptive) failed due to its insensitiveness towards traditional value system (Bhatia, 2007). *Nirodh* was introduced by the Indian government under the family planning programme and was unsuccessful, but *kamasutra* (another male condom), produced by a private company called J K Chemicals, was successful because it stood for the pleasure of the audience. Where *nirodh* connoted government and control, *kamasutra* connoted enjoyment and self-realization (Mazzarella, 2003). This is the reason behind having a communication package considering its proper implementation, field testing and impact analysis while planning for any public health campaign (Singh and Bhardwaj, 2000). It asserts that an audience cannot be seen as any isolated group or individual. It acts on the basis of its group relationships, cultural linkage and the skills needed for comprehension (Schramm, 1964). This is the reason why dialogues and, as the World Bank states, 'consultations' with the community are important.

Analysis and evaluation are also important to be fed into the planning of the next project; it is the only stage where all the claims made by those channelizing any project are tested. However, there are very few cases where the project completes the full cycle of evaluation. Even when evaluation happens it is either done in relation to people's recall rate or other quantitative measures. How the community saw the media

and whether that encounter with the media contributed to their decision making is rarely tested. Therefore, participation at the state of evaluation is extremely low. Hence, the nature of participation varies on different occasions ranging from mere answering the questions to making suggestions. However, it never leads to decision making, specifically in national programmes like this. The reason behind this is the fact that the government projects are generally funded by international actors who, along with the government, decides the area of intervention without consulting with the assumed beneficiaries. So, the sense of ownership as well as the power to decide never gets transferred to the people. Even in the project under discussion, the panchayats or other local bodies were not involved as powerful local governance who could take actions for the society as a whole.

Conclusion

Scholars have talked about three kinds of participation; a) voluntary, bottom-up, informal or community supportive participation; b) induced participation that is sponsored or officially endorsed, and c) coerced participation that is compulsory and manipulated. The first kind of participation is from outside sponsorship and takes place in an unstructured way (Morgan, 1993). However, while talking about state programmes, it is almost impossible to have community participation that does not follow a structure. Given the fact that the people had choice to participate or not in the survey, it becomes 'induced participation' for the household members, whereas for medical officers and service providers, it is a kind of coerced participation, because they are government employees and cannot be replaced by any other person from the audience. However, even those who are given the right not/to participate in the survey do not actually have the power. What if they say no? They are out of something that is going to happen in their area. Even if they agree to be a part of the survey, do they have all the information?

We need to look at the nature of these communications as well. As stated by Wolpe:

> Give someone the right not to sign something, and then signing it becomes a clear symbol of autonomous choice. Autonomy can thus be upheld and dispensed in a ritual that reinforces the freedom of medical decision making without disturbing its

> underlying structural impediments. Informed consent may in fact 'shift the sense of responsibility for bad outcomes partially onto the shoulders of the patient, a desirable shift in the age of malpractice suits (Cited in Bel, *et.al*. 2007: 91).

Although Wolpe talks about informed consent in relation to the medical practices, it fits well in the context under concern. In case of health projects, people are expected to submit to the state or its representatives who are running the project.

At the local level it is the local people who also represent the governmental institutions; therefore, their relation with rest of the community will determine who will/not participate in the development discourse. For the FGDs organized by *Designing Communications*, there were clear directions to involve members who have pregnant women in their family, members who have children below five in their family, people who have had death in their family due to malaria, youth participants and key persons (for example PCO, tea maker, etc.). Similar to the way health belief model assesses the motivating and restricting factors for a behavior change, would not the people have barriers and motivations for any other action such as participating in a meeting? The intensity and nature of factors might be different; but people would have perceived risks, barriers, and benefits behind these actions as well. Local dynamics are always at always play.

"The people are less informed; therefore they need outside experts to take better decisions" is the general mentality of those working in the area. As also put by Rousseau, 'Of themselves, the people always desire what is good, but do not always discern it. The general will is always right but the judgment which guides it is not always enlightened….All alike have need of guides. The former must be compelled to conform their wills to their reason; the people must be taught to know what they require…Hence arises the need of a legislator.'

Benhabib (1994) objects to this understanding of Rousseau by questioning the selection of this 'legislator'; if the people can't make right judgments, they can't equally select a right legislator. She favors a deliberative model of democracy that, according to her, looks for legitimacy in the processes of participation through rationality that can only happen only if the participants are treated as free and equal.

Subjective hierarchies are not to affect the institutional procedures that provide platform to discuss about the conflicting values and interests. However, a model like this can only be successful if the participants have the power to decide; decide on the health issue, the intervention plan, the monitoring policies and also the communication media to be created. If communication media is to communicate with a given audience, they only should decide its form and content.

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