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Community Organizing for Health: *A People-Centered Vision of Health*



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In the present article, we problematize (1) the bio-medical notion of a diseased body, and (2) the role of “expertise” in healthcare, especially in the countries of Asia, Africa and Latin America, where very few trained medical doctors exist, or are willing to serve. We argue for a social conception of healing that goes beyond the treatment of the physical body, analyzing two well-known community-based healthcare projects – the Chimaltenango Development Program in the Mayan Highlands of Guatemala, and the Comprehensive Rural Health Project (CRHP) in Jamkhed, India. Our analysis, steeped in the discourse of community organizing, questions the tenets of the bio-medical approach to healthcare, and advances a more holistic conception of culturally resonant healing.

“Medical doctors have started treating images rather than patients. The relationship between a modern doctor and his patient is to methodically decompose the patient, converting him into a set of laboratory findings. The ‘shadow’ patient is then reconstructed from the results of such laboratory tests as urine, blood, ECG, x-ray, et cetera. The best healers are driven not by detached scientific efficiency, but by communication and supportive human outreach.”

– Dr. P. K. Sethi, the medical doctor who popularized the famous ‘Jaipur Foot’ in India (2001, p. 1).

“Saturday is the day of the weekly market in Jamkhed, Maharashtra (India). People from the nearby villages come here to sell and buy vegetables, animals and other essentials. They also bring in patients to the clinic or to the hospital in Jamkhed. One such Saturday, after I had finished seeing patients, I strolled into the market. I saw a big crowd in front of a grocery shop. I peeped in and saw somebody with a stethoscope, examining patients. I recognized that man. He had previously worked with a doctor as his assistant and was now posing as a doctor and treating patients. I was angry. Here I was a trained medical doctor and instead of coming to me, these people went to him, an untrained doctor. I asked him what medicines he prescribed to treat basic communicable diseases. I realized that he prescribed the same medicines that I did. After some thought I felt that he was meeting an important need of the village. By going to the people where no doctors were willing to go, he was serving the community. Then I realized that if such a man was given proper training, he would be far more useful. That’s how the idea of training village health workers (VHWs) in Jamkhed took seed.”

– Dr. Rajanikant Arole, Co-Founder, Comprehensive Rural Health Project, Jamkhed (personal communication, July 5, 2004).

“If you wish to serve, go to the people. Live with the people. Learn from them. Love them. Start with what they know. Build on what they have. When the task is finished, the people will say, ‘we did it ourselves.’”

– The late Dr. Carroll Behrhorst, founder of the Chimaltenango Development Program in the Mayan Highlands of Guatemala, drawing his inspiration from a Chinese saying (cited in Luecke, 1993, pp. 183-184).

The above quotes from three internationally-recognized medical doctors, who champion a community-based, people-centered approach to healthcare, raise important questions for scholars and practitioners of health.

Has modern scientific medicine – with its CAT scans and MRIs and single-minded focus on curing a diseased body – forgotten the human being behind the veneer of his medical charts? What happened to the “art” of healing – the important

non-technological stuff – which included talking to the patients, holding their hand, standing by them and their family members, providing comfort and reassurance? Is healing only the healing of the physical body? Or more?

What is the role of expertise in healthcare, especially in the remote areas of countries in Africa, Asia, and Latin America where no trained medical doctors exist, or are willing to serve? Have we so privileged a conception of doctor-driven, expertise-centered, technology-based medicine that we are unable to see culturally-grounded, contextually-appropriate healthcare possibilities for the 60 to 70 percent of the world’s population, who do not have access to trained medical doctors (Singhal & Rogers, 2003)?

The present essay addresses the above questions by analyzing two well-known community-based healthcare projects – one in Guatemala and the other in India. In Guatemala, we examine the work of the late Dr. Carroll Behrhorst who established a community-based healthcare project in the Department of Chimaltenango, serving over 150,000 Mayan Indians. In India, we analyze the work of Drs. Rajanikant and the late Mabelle Arole, co-founders of the Comprehensive Rural Health Project (CRHP) in Jamkhed, Maharashtra. We analyze how the Chimaltenango Development Program in Guatemala and the Comprehensive Rural Health Project in India engaged the local community in practising self-informed healthcare, promoting a holistic conception of health and healing.

Data Sources

Our analysis of Dr. Carroll Behrhorst’s Chimaltenango Development Program in Guatemala is based on (1) a close reading of a repository of archival materials on the project including several books on the topic [e.g. Barton, 1970; Luecke, 1993; Steltzer, 1983] (2) conversations and correspondence with former associates of Dr. Behrhorst at the Tulane University’s School of Public Health and Tropical Medicine in New Orleans, Louisiana, and Behrhorst Partners for Development, an NGO in New Jersey founded to continue the work of the late Dr. Behrhorst in Guatemala and beyond, and (3) a viewing of several videotapes on the life and work of Dr. Behrhorst provided to us by Ms. Pat Krause, Executive

Director, Behrhorst Partners for Development.

Our analysis of the Comprehensive Rural Health Project in Jamkhed, India draws upon (1) the autobiographical narration of the Jamkhed CRHP, a project written by Drs. Mabelle and Raj Arole [e.g. Arole & Arole, 1994, 2002] and other project documents available at the CRHP library in Jamkhed (2) the completion of a three-week course in community-based healthcare by author Chitnis in Jamkhed in the summer of 2004 (3) about six weeks of intensive fieldwork conducted by author Chitnis in a dozen villages of Jamkhed in the summer of 2004 including interviews with Drs. Rajanikant and Shobha Arole (the daughter of Raj and Mabelle Arole who now directs several activities of CRHP), other CRHP staff, and Jamkhed community members; and collection of observational data from village health workers training sessions, farmers' club meetings, and others, and (4) correspondence with various people associated with CRHP in India and the US including officials of the Jamkhed International Foundation located in North Carolina.

The Chimaltenango Development Program in Guatemala

The town of Chimaltenango, located 50 kms from the capital Guatemala City in the Mayan Highlands of Guatemala, is home to the Behrhorst Clinic, established in the early 1960s by a US-trained medical doctor, Dr. Carroll Behrhorst. While Dr. Behrhorst (commonly called the "good Doc") passed away in 1990, the clinic in Chimaltenango (that bears his name) symbolizes the model of a people-centered approach to healthcare worthy of emulation (Luecke, 1993).

Known as the Albert Schweitzer of Guatemala, Dr. Behrhorst realized within a year or two of practising medicine among the Cakchikel Mayan Indians that his bio-medical training in the United States, which viewed "body as disease" (in need for a physical cure), was unsuitable for serving local residents (Barton, 1970). He learned that the Mayan conception of health was not just the absence of disease, but rather the performance of several positive functions - good appetite, hard work, enjoyment of nature, and participation in social activities (Luecke, 1993). Good health meant a restoration of the patient's dignity, self-

respect and pride (Crawshaw, 1993). Healing was not purely physical (a point of view that his medical training privileged), but also social, spiritual and psychological.

Dr. Behrhorst was disillusioned by his initial focus on just curing patients. Curing the sick in clinics and hospitals was "like trying to empty the Atlantic Ocean with a teaspoon," he noted (Ajquejay, 1993, p. 32). The root cause of illness in Chimaltenango, he realized, was poverty which resulted in poor sanitation, contaminated water supply and chronic malnutrition. Having treated over 25,000 patients in his first year alone, Dr. Behrhorst characterized his initial work as running an ambulance service at the bottom of a hill where automobiles regularly fell off. Proper care, he realized involved treatment of causes, not the amelioration of pain. The clinic's community outreach activities included the training of several hundred village-based health promoters in the Mayan Highlands, and through their local presence in the communities where they lived, the establishment of home gardens and poultry farms, gravity-based water wells that provided clean potable water, as well as animal husbandry, agro-forestry, literacy and income-generating projects (Behrhorst, 1993). Community members played an instrumental role in planning and conducting these social development initiatives, mindful of practicality, relevance and usefulness to local contexts.

Respect for Local Culture

The design of the health clinic in Chimaltenango, the centerpiece of the people-centered approach to healthcare, exemplified a holistic approach to healing. The clinic, constructed by donated labor of the local residents, had airy rooms and open corridors which opened in a courtyard, much like the Mayans' dwellings. The rooms were designed so that families, who often traveled long distance to be in Chimaltenango, could stay with the patients, take care of them, and learn first-hand the basics of health, hygiene, sanitation, first aid and home-based care. A roomy kitchen, located at the end of the corridor, allowed family members to cook corn tortillas, a local staple food nutritious in carbohydrates, protein, and essential vitamins and



minerals. Family members were encouraged to bring their handlooms to the clinics where they could weave cloth while the patients rested. Cooking for loved ones and cloth weaving for income-generation bestowed on patients and their families a sense of home, comfort, self-respect and dignity. A poultry coop in the clinic provided eggs for consumption and gravity-based water wells in the courtyard (constructed through voluntary labor of local residents and patients' family members) brought clean potable water for drinking, washing and bathing (Behrhorst, 1993).

The nursing staff at the Behrhorst Clinic, consisting of local Mayan women, were chosen for their bilingual skills in Spanish and Cakchikel and trained in primary healthcare (Barton, 1970). These friendly nurses could look at the embroidered fabrics of their patients, as also their gait, and tell what part of the highlands the patients hailed from. Further, Dr Behrhorst's "Healing house" in Chimaltenango never used white sheets as were used in the "white man's hospital" in the capital Guatemala City, 50 kms, where few Mayan Indians would go. Instead, a transparent plastic was used over mattress pads which gave the beds the appearance of the sleeping platforms that the Mayan Indians used in their huts (Barton, 1970). For the "good Doc", attending to such details conveyed respect for his patients (Logan, 1993). To be disrespectful to the cultural traditions of the Mayan Indians constituted "sin" in Dr Behrhorst's book (Aquejay, 1993, p. 38).

In sum, the conception of good health in Dr. Behrhorst's primary healthcare project in Chimaltenango was not just based on the physical absence of a disease but included a holistic approach to physical, mental, social, and spiritual well-being. The role of the doctor was reframed from a "curer" to "healer". Dr. Behrhorst emphasized that the doctor's main responsibility was to leave a bit of his heart with the patient: "First humanity, then technicality," he said (Crawshaw, 1993, p. 10). Further, as noted in one of the quotes at the beginning of this chapter, Dr. Behrhorst believed that the role of the "expert" (or an outsider) was to start with where people were, to be respectful of their cultural traditions, and to involve them in collectively realizing the

local pathways to wellness and well-being (Singhal, 2003).

The Comprehensive Rural Health Project in Jamkhed, India

While Dr. Behrhorst was launching his health clinic in Chimaltenango, Guatemala in the early 1960s, two young Indian medical doctors, Rajanikant and Mabelle Arole, trained at the prestigious Vellore Christian Medical College, began their medical practice in a missionary hospital at Vadala, a rural town in Maharashtra, India. During the five years of back-breaking medical work at Vadala – spanning 14 hours a day, seven days a week – the Aroles realized they made little difference in improving the health of the local people. At best, they treated the symptoms of disease, and that too temporarily. Children at Vadala continued to die of diarrhea, women continued to deliver low-weight babies (many died during delivery), and most of the local residents complained of a persistent hacking cough, a symptom of chronic tuberculosis (Arole, 1972; Arole & Arole, 1994). Questioning their focus on treatment, not on prevention, the Aroles, much like Dr. Behrhorst in Guatemala, were convinced that the doctor's main responsibility was to intervene at the source of ill-health, rather than wait to cure patients in hospitals, when it was often too late. Like Dr. Behrhorst, the Aroles realized the importance of implementing a model of healthcare that focused on preventing illness by addressing the root cause, such as poverty. To do so, they felt the need for more training in community healthcare. So, after a stint in the US which included a master's degree in public health at Johns Hopkins University in Baltimore, MD, the Aroles returned to India in 1970 with a dream to launch a comprehensive rural health project focusing on the needs of the poorest of the poor (Arole & Arole, 2002).

A member of the District Health Committee in Jamkhed, Maharashtra, who Aroles knew from their Vadala days in the mid-1960s, invited them to launch operations in Jamkhed, a township located in the drought-prone area, about 400 kms east of Mumbai, in Ahmednagar district of Maharashtra (Arole & Arole, 1994). With a population of 110,000 and with no health facility in a 40-kms radius, the community surrounding Jamkhed was

Table 1. Changing Health Indicators in Jamkhed Over Three Decades of CRHP.

Indicators	Jamkhed (1971)	Jamkhed (1976)	Jamkhed (1986)	Jamkhed (1999)
Infant Mortality Rate ¹	176	52	49	26
Crude Birth Rate ²	40	34	28	20
Basic Immunization ³	0.5%	81%	91%	99%
Malnutrition – weight for age	40%	30%	5%	5%
Antenatal care ⁴	0.5%	80%	82%	97%
Deliveries by trained attendants	<0.5%	74%	83%	98%
Couples practising family planning	<0.1%	38%	60%	60%

Note. ¹Infant mortality rate is number of children dying per 1,000 live births before they reach the age of one.

²Crude birth rate is the number of children born per 1,000 women in the child-bearing age.

³ For children under-five years of age

⁴Percentage of women aged 15 to 49 years who were attended at least once during pregnancy by skilled health personnel (doctors, nurses or midwives).

Source: *Comprehensive Rural Health Project (2003)*.

in a desperate need of Aroles' services. Moreover, due to frequent droughts, the people of Jamkhed had little regular work and income and dismal health indicators (Table 1).

Understanding the Link between Poverty and Ill-Health

When the Aroles arrived in Jamkhed in 1970, the biggest problem facing the people in the region was water scarcity and hunger. To understand the link between poverty and health, the Aroles decided to live on the same amount of money that an average village family earned – the equivalent of US \$7.00 per month (Arole & Arole, 2002). In this context, lecturing people on eating nutritious food, boiling their water, and washing hands with soap was futile.

Having realized that accessing food and water was a far greater need for Jamkhed residents than the practice of good public health, the Aroles approached donor agencies that funded food-for-work programs, especially those that supported the building of small check dams to conserve water. Men and women of Jamkhed were employed as daily wage laborers to build the dams and were paid a bag of grain per week (Arole & Arole, 1994). Health and wellness lessons were incorporated in these construction projects.

For instance, the Aroles convinced workers to assemble an hour or two before the work began

to discuss how to implement home-based, low-cost prevention and care programs to enhance children's nutrition, prevent diarrhea, and control pneumonia (Arole & Arole, 1994). By providing basic medical care to workers and their children, the Aroles established initial trust with the residents of Jamkhed.

Finding Entry Points for Health¹

The Aroles soon realized that farmers in Jamkhed were more interested in improving their crop yields and their animal's health than improving their family's well-being and fitness. Realizing it would be difficult to right away convince villagers to launch village sanitation drives or build soak pits, the CRHP established Farmers' Clubs. These Farmers' Clubs brought together local farmers on a regular basis to discuss important cropping and animal husbandry topics and also to talk about other community well-being issues. Local bankers, agricultural experts and government officials were invited to these meetings. These Farmers' Club 'seminars' provided a forum for villagers to voice their concerns to local authorities and identify possible solutions (Arole & Arole, 2002). The CRHP used these Farmers' Club meetings to promote basic health education among community members, involving poor farmers in managing their public health environment.

For instance, while talking about the importance of immunizing dairy animals against



Table 2. Health Indicators Comparing Jamkhed with Rest of India and the United States.

Indicators	Jamkhed (1999)**	India (2001)*	United States (2001)*
Infant Mortality Rate ¹	26	67	7
Crude Birth Rate ²	20	25	17
Basic Immunization ³	99%	64%	94%
Malnutrition – weight for age	5%	47%	1%
Antenatal care ⁴	97%	60%	99%
Deliveries by trained attendants	98%	43%	99%
Couples practicing family planning	60%	47%	76%

Note: ¹Infant mortality rate is number of children dying per 1,000 live births before they reach the age of one.

²Crude birth rate is the number of children born per 1,000 women in the child-bearing age.

³For children under-five years of age.

⁴ Percentage of women aged 15 to 49 years who were attended at least once during pregnancy by skilled health personnel (doctors, nurses or midwives).

Source: UNICEF (2004) and Comprehensive Rural Health Project (2003).

foot-and-mouth disease, the need for immunizing children against measles and tetanus was discussed. By meeting the needs of the local residents through Farmers' Clubs and other forums (like mahila vikas mandals - women development associations), the CRHP found appropriate entry points for promoting good health in the region boosting Jamkhed's health indicators over the past several decades (Table 1).

Today, Jamkhed's health indicators are the envy of India, and comparable with health indicators of the United States (Table 2).

Focusing on the Most Vulnerable

When the Aroles launched CRHP in the early 1970s, caste distinctions cut deep into the social fabric of the Jamkhed community. The divide between the dominant Hindu high caste marathas (warrior group) over the lower caste Dalits was steep. The lower caste families – who were the poorest, the most exploited, and the most vulnerable – lived on the village periphery and were not allowed to enter the village temple or draw water from the well, and had the lowest health status (Arole & Arole, 1994; 2002). Shunned by the high caste, they were least likely to have access to drinking water, adequate food, or medical services. The Aroles were determined to find ways to integrate the Dalits into the larger Jamkhed community.

The CRHP began by initiating a process of dialogue with the villagers, gauging their perception of health problems in the community. The Aroles realized that most villagers were unaware that most children in Jamkhed were malnourished, or that pregnant women were anemic. Sarubai, a voluntary health worker (VHW) in CRHP who was trained by the Aroles and has served her community for over 20 years, remembered: “The doctors would come and sit with us and ask about the problems facing our community. We had no idea about the problems we had. So the doctors showed us malnourished children or pregnant women with swollen feet and asked us whether there are similar people in our village. Then we started understanding how to identify health and social problems in our villages” (personal conversation, July 15, 2004).

As malnutrition among children was a major problem, CRHP decided that it would engage the community to provide nutritious meals to the children. However, Drs. Aroles wanted to establish the children's nutrition program in a way that it reduced local caste distinctions. The CRHP requested each student in the local school, who hailed from different caste groups, to bring a handful of rice. In school, each student put his/her rice contribution in the pot in which the meal was prepared. Once cooked, the meal was shared by everyone, irrespective of the caste. This

practice, conducted on a daily basis in front of students and their parents, helped dissolve caste barriers in a cooking pot. Once this practice was legitimized, the intervention was replicated at the larger community level by organizing community weddings. Shahji Patil, a CRHP Farmers' Club member since 1971 narrated: "The whole village would participate, cooking for and hosting the wedding guests. It did not matter what caste you were" (personal conversation, July 18, 2004).

Much like the Chimaltenango Development Program in Guatemala which trained village-based health promoters, the CRHP trained village health workers to serve as healers and social change catalysts in their own communities. The CRHP purposely chose village health worker trainees from predominantly lower caste, inviting them to the Jamkhed for training with other VHWs. Initially, health workers belonging to the upper caste found it very difficult to sit together, eat and stay for several days with the low caste VHW trainees. However, with time, these barriers crumbled. Further, at the CRHP training center, the Aroles invited all the VHW trainees to stitch a huge quilt. Once complete, this quilt, composed of patches stitched by women of both high and low caste groups, was used by all women to cover them during the night. Here again, caste distinctions were blurred under the folds of patchwork quilt (Arole & Arole, 1994).

Important Lessons

The CRHP Jamkhed experience points to some important lessons about mobilizing community members to achieve wellness and well-being (Arole & Arole, 1994; Papa, Singhal, & Papa, in press; Rogers & Singhal, 2003). First, people participate easily when their self-interest is served. Providing employment to residents through food-for-work programs which also synergistically helped community members to harness scarce water resources was crucial in generating community involvement. Second, the degree of peoples' participation is often seasonal or tidal. When villagers are busy during the farming season, one cannot expect active participation. However, when people are less busy, they are easily motivated to engage in community building tasks, especially if they can see its practicality, usefulness

and relevance. Third, children's health, or even animal's health, is often a good entry point to reach parents. Fourth, overcoming caste barriers and other community divisions is essential to build a healthy community. In fact, to improve the health of the community, the Aroles realized they had to begin from the most vulnerable segments and build up vertically in contrast to most top-down approaches to healthcare.

Conclusions

In his classic book, *Limits to Medicine*, Ivan Illich (1976) argued that it was unfortunate that all over the world more and more energies were being dedicated to extending the sick life for the haves, while basic primary healthcare was not available to most of the world's have-nots.

The work of the late Dr. Behrohorst in Guatemala and Drs. Aroles in Jamkhed India suggests that in poor impoverished communities (whether in developed or developing countries) doctors of modern medicine do not represent the "expert" custodians of health. Rather, the healing reins need to be more vested in community resources. That is, in areas where no doctors exist or are likely to exist, one should move from a model of expensive, expert-driven curative care to that which is inexpensive, culturally-resonant, community-centered, self-informed and self-caring. Such a people-centered vision of health, steeped in the discourse of "health as a human right and not a privilege," is also illustrated by the work of Dr. Paul Farmer, a Harvard physician and infectious disease specialist who founded Zanmi Lasante (Creole for "Partners in Health") in Cange, Haiti (Farmer, 1999; Kidder, 2003).

Dr. Farmer, a MacArthur Foundation "genius" awardee, envisions health in the broadest possible sense, arguing that "the first line of defense" for good health should be available at the community level including immunizations for children, safe drinking water for communities and a cadre of locally-based health workers who can take care of 75 to 80 percent of community's healthcare needs. What cannot be handled in the community can always be referred to medical doctors in clinics or hospitals. Dr. Farmer's life calling, much like Drs. Carroll Behrhorst's and the Aroles', is to bring good health through social and modern medicine



to people who need it the most – the poorest of the poor. In conclusion, the experiences of the Chimaltenango Development Program in Guatemala and the Jamkhed CRHP in India suggest that a community's well-being is determined largely by a focus on prevention of ill-health, not on curing a body that is already diseased. Why then does the world spend 95 percent of its health dollars for curing sickness, and only a measly five percent for preventing ill-health (Sidel, 1993). Are we not in need of a major reorganization of healthcare priorities in developing countries?

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Endnotes

1. The following sections draw partially from Arole and Arole (1994, 2002) and the information gleaned by one of the authors (Chitnis) while conducting field work in Jamkhed, India, during summer of 2004.

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