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Change and resistance to change – community development in a rural caste community in South India

Frank Tesoriero

Introduction
This paper describes a community development project in rural south India, the Healthy Districts Project, and analyses it in terms of its processes and outcomes, and the forces at play which facilitated change and which resisted change. The approach used was a strengths-based approach, Appreciative Inquiry (Ashford & Patkar, 2001). The Project was a partnership between Australian social workers, a local Indian NGO, an Indian School of Social Work and the local community.

The term ‘local community’, when examined, serves to hide great diversity, power differentials and forces which exclude. In the local community in which the Project was undertaken, as well as there being eight villages and hamlets, there are two dalit (outcaste, untouchable) communities. These two communities are physically segregated and their members experience exclusion from the social life of caste communities, which manifests itself in many forms, notably in such forms as separate religious ceremonies and celebrations, omission of dalit community members from development projects, fewer educational and income generation opportunities for young dalit women, and subtle discouragements to adopt leadership roles in the local community. Added to these exclusions is significant economic dependency of dalits, who are landless, dependent on caste landowners for employment as day labourers.

The community development project, based on principles of social justice and human rights, challenged the exclusionary caste practices of this community and so built in significant tensions which had to be addressed constantly throughout the process. The paper analyses the processes at
the community level. It examines the gains, losses, learning and implications that emerged from the Project, and the processes and complex array of forces which interplayed to produce a multifaceted and contradictory set of outcomes.

The paper draws on core values and particular theoretical bases to describe the process of the Project and to analyse the process and its outcomes. These values relate to social justice and human rights and the theoretical bases revolve around a structural view of social issues. Community development and Appreciative Inquiry are the major frameworks which guide the discussion of the Project process; and participatory action research and reflective practice provide the scaffolding for analysis and drawing conclusions about the Project. Caste, gender and hierarchy, so endemic in rural India, have been constant and powerful dynamics governing social relations; and these dynamics came to the fore as the Project achieved some outcomes, alongside more positive changes resulting from locally-based strategies of participation, local decision making and inclusion. This interaction of competing forces has led to changes and resistances to change; and has resulted in the maintenance of traditional practices and power relations, as well as the discontinuation of some of these in the same form.

Literature Review

Health and development
The Project which is the focus of this paper worked primarily with women in a rural Indian setting, and included women from two dalit communities. Of the total female population in India, 77% live in rural areas (Raveendaran, et al., 2002). Because of practices such as female foeticide, there are considerably less women than men in the total population (National Commission on Population, 2001). In some areas of Rajasthan where this situation is most acute, when a woman is married, the husband’s brothers also participate in the relationship, as a response to the disproportionately low number of women to men.

In underdeveloped countries, women are poorer, less healthy, more marginalised and more oppressed than any other groups. In every aspect of living, women are excluded and exploited in favour of other groups. In
India, when a young woman marries she is expected to be an economic commodity in the husband’s family. The illegal practice of dowry still persists and bride deaths in retaliation for inadequate dowries still occur. Within the family, women eat meals last, ensuring men and children have access to nutritional food first. Gender oppression against female children, adolescent girls and women manifests itself in many forms, including social stereotyping and violence at the domestic and societal levels (National Commission on Population, 2001). Dalit women experience a double jeopardy of gender and caste oppression.

In development, women have been afforded low status. Development programs have often been imposed from the top down, and externally from foreign donor organisations and foreign aid. Women, being denied access to credit and having an insignificant economic status, have been ignored by development agencies. This has been the case to such an extent that Shiva (1988) refers to the effects of development on women in developing countries as maldevelopment. Conventional approaches to development, which privilege those who hold power and resources, must be challenged.

‘Health’ and ‘development’ are very closely related and each has impacts upon the other (Phillips & Verhasselt, 1994, p. 3). It therefore makes theoretical sense, and contributes to effective practical outcomes, to ensure that approaches to working with communities are holistic in the sense of encompassing both dimensions of the human experience – health and development. This is particularly important when working with marginalised or exploited groups. To take the example of women, theory and practice has come to recognise that promoting women’s health is more than addressing maternal and child health matters, and must include ‘reproductive rights, political participation and social equality’ (Phillips & Verhasselt, 1994, p. 25). Not only are these factors important for the physical health of women, but they are necessary if women are to be liberated from gender exploitation and from carrying an unfair burden of disease, such as HIV. To extend the situation of women to disadvantaged groups more generally, health and development are, together, concerned with human rights, equality, participation and liberation, as well as prevention of disease. Interventions aimed at promoting health and development within disadvantaged groups must address issues of structural relationships between these groups and the economy, society and culture (Lewis & Kieffer,
1994, p. 123). Only when these broader, structural issues are successfully challenged will outcomes at the more local, community level be sustainable over the longer period. The World Health Organisation’s Commission on Social Determinants of Health is unequivocal in its stance that reducing inequities in health status requires more than technical, medical solutions, and that intervention for their improvement needs to include ‘empowerment of individuals, communities and whole countries’ (Commission on Social Determinants of Health, 2007, p. 15).

**Conceptualisations of health and health promotion/interventions**

The Healthy Districts Project takes a clear community development approach and is in no way a medical intervention. Implicit in this ‘Healthy Districts’ concept is the notion of ‘health’ as something more than simply the absence of disease, but rather a notion which encompasses emotional, social, economic and political dimensions. This social view of health was formulated in the 1978 World Health Organisation’s Declaration of Alma Ata (World Health Organisation, 1978) and was restated by the People’s Health Movement in Dakka, Bangladesh in the year 2000 (People’s Health Assembly, 2000).

The People’s Charter for Health, endorsed at the first People’s Health Assembly, states:

> Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalised people. Health for all means that powerful interests have to be challenged, that globalisation has to be opposed, and that political and economic priorities have to be drastically changed (People’s Health Assembly, 2000, p. 1).

The core issue in relation to health is the inequities between groups in terms of health status.

The World Health Organisation’s Commission on Social Determinants of Health describes health as socially produced and as intervention being at four different levels in the chain of the social production of health:

1. At the highest level, addressing issues of structural inequalities by decreasing social stratification in society
2. Ensuring that disadvantaged people’s specific exposure to factors which perpetuate ill health are reduced

3. Intervening to ameliorate particular conditions which affect the health of disadvantaged people and so lessening their vulnerability to ill health

4. Organising healthcare in ways that ensure there is greater equality of access to health services for those disadvantaged people who are ill and to prevent further eroding of their economic status (Commission on Social Determinants of Health, 2005, p. 40).

The social determinants of health have been further highlighted by the UN Millennium Declaration (United Nations, 2000) and Project. This Project reinforces the interrelatedness of many health, economic, social and environmental issues which have an impact on development. Interrelated issues require interrelatedness of strategies and of solutions – coordinated and intersectoral collaboration.

The ideas of intersectoral collaboration and community participation in health planning form central planks in many approaches to health and development activity (see Shaw & Martin, 2000; Roussos & Fawcett, 2000; Delaney, 1994; Ashman, 2001; Babacan & Gopalkrishnan, 2001; Mosse, 2001; Teck et al., 2001; Weinberger & Jutting, 2001). The health sector and medicine have little impact on health outcomes. While they treat illness, health is determined by social and structural contributors, as well as local and individual factors. Therefore, solutions which can be sustained over time have to engage the decision makers, power holders and policy makers in those sectors (World Health Organisation, 1986; 1997). If poor housing, for example, contributes to respiratory illness in a community, medical intervention alone will not address the health issue. The housing sector must be involved in addressing the issue. The engagement may be more or less collaborative, depending on context, but nevertheless, intersectoral engagement must occur. Joined up issues require joined up solutions (Cappo, 2006). This is also a central plank in the Healthy Districts approach. The Millennium Development Goals (MDGs) underscore the interdependence of health, social and economic factors. Targets for poverty reduction, hunger reduction, education, women’s empowerment, environmental sustainability and global partnerships for development are closely intertwined with health issues (United Nations, 2000).
‘Healthy Districts’ approaches
The particular Project which is the subject of this paper, named ‘Healthy Districts Project’, has its genesis in the World Health Organisation’s ‘healthy settings’ approach to health promotion (World Health Organization, 1999; 2000) and a social view of health (South Australian Health Commission, 1988; 1989) which acknowledges the structural contributors to health and wellbeing.

A Healthy District is one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential. (Hancock & Duhl, 1988)

A Healthy Districts approach, then, is one which facilitates, enables and assists people to improve the conditions of the rural district in which they live. It is clearly aimed at building the capacity of communities to support their members’ health and wellbeing (Baum & Tesoriero, 2001).

This particular Healthy Districts Project intervened mainly in the first and second levels (1 and 2 above) in the chain of production of health. In the context of rural Indian communities, it attempted to address the power inequalities and exclusionary practices of caste and gender and to lessen factors such as poverty and migration for employment which erode the social support systems of individuals and groups, and the capacity of communities to sustain changes gained, in rural India. These support networks are critical social determinants of health (and also ill health) in rural south India and in many majority countries (Commission on Social Determinants of Health, 2007, pp. 19–21).

Rights-based approaches to health/development
Now, more than ever, ‘human rights’ is critical to health and development work. The notion of human need refers to ‘must haves’, such as food, clothing, shelter, water, safety, health and so on and can be provided by the private, for-profit sector. From the 1980s many governments, including India from 1990, opened their countries to the global market. The accompanying deregulation of economies, the privatisation of public resources and the demands of structural adjustment programs all represented a neo-liberal paradigm, where economics became dominant and
the world was constructed as a marketplace. Within this global marketplace, more and more needs are placed on the market to be bought, and such things as education, water, transport and health have been privatised. Public resources have become private goods. While human needs continue to be met in this paradigm, access to resources depends more on ability to pay and inequity increases, with the most disadvantaged missing out. Furthermore, issues of human rights, social wellbeing and health are rarely, if ever, on the agenda of private providers. Within the neoliberal political context and the marketplace paradigm, health rights too have become commodified, and even the World Health Organization’s official health reports tend to disguise inequities and inequalities amongst different groups behind bland national indicators of improvements in health (Breilh, 2005, pp. 13–14). However, as Uvin (2004) cogently argues, it is because of the very fact that there are many powerful agents over and above nation states, created by globalisation, that human rights obligations and the role of the duty bearer can be directly applied to non-state entities, including NGOs, for-profit organisations and civil society. Uvin goes on to argue that mechanisms of accountability distinguish ‘rights’ from ‘needs’ approaches and distinguish charity from claims. Those duty bearers who violate human rights must, he asserts, be held accountable. Following on from this, human rights-based health and development work will, by definition, focus on ‘social structures, loci of power, rule of law, empowerment, and structural change in favour of the poorest and most deprived …’ (Uvin, 2004, p. 131). This focus is further operationalised in the development practice literature on rights-based programming (Theis, 2003; Jalal, 2005; CARE, 2005, Save the Children, 2005; Office of UNHCHR, 2006).

Rights-based programming is based on principles which are consistent with the other theoretical foundations of the Healthy Districts Project, namely equity, participation, inclusion, empowerment, capacity building of system, addressing social determinants and gender equality. Such programming must have two central foci. It both holds powerful people and institutions accountable as duty bearers and it supports rights-holders to demand their rights and participate in societal, political, economic and social decisions.

For activities and projects that subscribe to a rights-based approach, it means incorporating long-term goals and sustainable outcomes and
adoption of holistic goals rather than compartmentalised objectives. It also means a commitment to equity by working with the most marginalised groups, strengthening the accountability of those in power, ensuring people participation and working in alliances and collaboration.

A ‘human rights’ approach to health and wellbeing programs places the issue of rights and obligations, of social injustice, oppression and inequity on the development agenda (Tesoriero, 2004). If health intervention and development work are underpinned by the notion of health as a human right, then the change process becomes one directed towards addressing violations of human rights and social injustice, with this dual focus on rights claimants and duty bearers.

**Action research for health promoting community development**

If health is a political concept, amongst other things, and a focus on human rights underpins activity, then health intervention and development work become political activities, a change process, in dialogue with marginalised groups and in favour of liberation of the oppressed (Freire, 1972). At the community level, such health intervention has the potential for achieving development and building capacity. ‘Health’ becomes a useful concept for community change and community work.

Action research which is participatory has its roots in *majority world* countries, particularly South America and Asia, and in rural communities, and has been associated with activism and community development. The approach has three core features: (1) shared sense of ownership of projects between community and Project team/researchers; (2) a community-based analysis of issues and problems; and (3) an orientation towards action, change and transformation.

Kemmis and McTaggart (1988; 2000) refer to action research as ‘low tech’ research: ‘it sacrifices methodological sophistication in order to generate timely evidence that can be used and further developed in a real-time process of transformation’ (1988, p. 591). The ‘goodness’ of action research is not dependent on sophisticated research technologies, but on the quality of the evidence, through reflection, and its ability to contribute towards the transformations that are represented in the goals of the community development projects. The measure of good data is, after critical reflection, the assessment of its accuracy, relevance, appropriateness and
pertinence to the purposes of the participants and its contribution to the transformative/social change goals.

Transformation and change are embedded in the notion of action research. It is in relation to creating change and transforming the conditions in which marginalised and disadvantaged groups live, that Appreciative Inquiry takes on a particularly important role in the Healthy Districts Project’s processes for change. Appreciative Inquiry (Ashford & Patkar, 2001) is a change strategy which identifies the strengths and resources within people, groups and their communities rather than taking as the starting point either problem identification or needs assessment. It draws on these strengths to effect positive changes through strategies which are implemented cooperatively with members of the community. Because it is a strategy, it must be one part of a larger development process. It cannot, alone, achieve sustainable and overall development goals in communities. The strategy is a cyclical process which consists of four stages, namely Discovery, Dreaming, Design and Delivery. Strengths, as an approach, has much to offer a change process, but depends on identifying resources indigenous to a community and utilising them for change.

Appreciative Inquiry carries some constructionist (Crotty 1998, p. 42) assumptions. ‘Reality’ is shaped by what is being focused on and the language that is being used, and therefore, can result in multiple realities. Reality is created in the present, but what is brought from the past will help shape current realities. Therefore, bringing positive aspects of the past, resources, and strengths, is important to health and development (Ashford & Patkar 2001, pp. 42–45).

The notion of strengths emerges as a theme in the theoretical underpinnings of the Healthy Districts Project. It is, however, more than an obtuse theme; it has been developed as an intervention approach. The Strengths Approach supports theoretically the aims and processes espoused by Appreciative Inquiry. It ‘is a philosophy for working with people for change, an approach dependent on positive attitudes about people’s dignity, capacities, rights, uniqueness and commonalities’ (McCashen, 2005, p. v). As such, it makes a positive contribution to the Healthy Districts Project because this approach supports other central concepts underpinning the Project, including a rights-based approach, and it is consistent with, and complementary to, health promotion which focuses on building on
the capacities already existing within individuals and communities. The Strengths Approach’s philosophy is one that acknowledges people’s agency in engaging in change and the role of workers in creating the structural conditions to enable their participation in change processes. While this approach is in stark contrast to other, ‘deficit’ approaches, it does not deny problems. In fact, it acknowledges and challenges power imbalances and rights violations, and addresses structural, cultural, organisational and personal constraints on people’s abilities to create change.

The conceptual tools offered by Appreciative Inquiry and Strengths Approach bear directly on the analysis of the processes and outcomes of the Healthy Districts Project. Knowing people’s strengths and resources enables an understanding of how change has happened in the past; an acknowledgment of structural factors and barriers enables an understanding of how change was resisted and thus how and why the sustainability of community outcomes may have been eroded. Together, an understanding of change and resistance to change provides some insights into alternative ways forward.

**Alanganeri Healthy District Project**

**Aims**

The Healthy Districts Project aims to develop, implement and evaluate health and development interventions (strengths-based community development strategies) in selected local rural South Indian communities. These interventions give primacy to community participation through developing a partnership between community members and the Project team. Within this partnership, issues of importance to the communities are jointly identified by community members and the team, strategies to address the issues agreed upon, and the outcomes of these strategies measured/evaluated in terms of extent of achievement of relevant goals.

The Project also aims to strengthen the capacity of local communities to promote and maintain health through establishing community structures, such as women’s self-help groups, health committees, youth groups, and any other structures appropriate to issues identified. Furthermore, these structures are to be substantially led, organised and maintained by local community members who together hold appropriate and sufficient skills (for example, meeting skills, advocacy skills, organisational skills) to ensure the structures are durable over time.
Project setting

A panchayat is an administrative unit which sits below the Block level (a Block sometimes comprises about 400 villages, and within the Block, panchayats usually consist of approximately 10 villages each), the District level and the State level in Indian governance structures. It is where Indian democracy plays out at the local level. The Alanganeri Panchayat, the setting of the Healthy Districts Project, is located in Tamil Nadu, South India and is about 160 kms north west from Chennai (ex Madras). It is reasonably typical of most panchayats and consists of one main village, eight hamlets, field huts and two dalit (outcaste) colonies. Dalits and caste Indians are physically separated within the Panchayat. Dalits, or ‘untouchables’ remain a cruel aspect of the Indian caste system. There are many theories about their origins, ranging from religious, through economic to colonialist. However, they have always been regarded as polluted and so any contact with caste people resulted in the defilement of those caste people. Consequently, physical separation was common and often total: separate drinking water and wells, separate housing, prohibition from entering temples and so on. Dalits generally had no rights and were subjugated economically, socially and psychologically. In states such as Bihar, the killing of dalits still persists. In Tamil Nadu, there are less strict attitudes to dalits, but separation still persists in many forms. There are many coffee houses that have separate drinking vessels for dalits and for caste people. Many Panchayats maintain separate ‘colonies’ for dalit communities.

The Alanganeri panchayat consists of 414 households (73 in main village). The Panchayat is poor and the highest caste is ‘MBC’ (‘most backward castes’) to which 90% of the panchayat population belongs; the remaining 10% are dalits. Alanganeri is the most underdeveloped of the 39 Panchayats in this area and has the lowest health status amongst the other panchayats in the Block.

Methodology

The evaluative and reflective dimension of this community development process utilises principles and methods of action research.

As social/community development, action research involved the Project team and the local community members in planning, implementing, observing, reflecting, further planning and implementation of strategies identified to increase the social health of the community. These strate-
gies included social and economic development strategies. Community participation has been an essential feature of the processes. Central to the reflection is considering the extent to which such strategies are sustainable and capacity building over the longer term, as well as being immediately effective, in their own right and in the short term. In other words, at the community level, some strategies may appear to create positive and exciting changes in individuals and within the community, and indeed do so. However, consideration of how wider, structural factors may erode and undermine these local community changes provides a more incisive analysis and a more sophisticated understanding of the complexity of processes and the durability of outcomes. Reflecting on these complexities as part of an action research process, and including the insights of local community members in the reflection process, has enabled the Project team to forge a way forward amidst seemingly contradictory outcomes.

The steps which constituted the Project moved systematically from issue identification through to evaluation and replanning. These are, in effect, the elements of a participatory action research process and parallel to the principles and processes of Appreciative Inquiry, as a strengths-based community development process. While these may seem unremarkable, they have been critical to this Project because they have enabled meaning to be ascribed to the Project outcomes in ways which provide new options and generate new insights and pathways. The Project steps included:

1. *Community identification of issues, goals and aspirations to enhance our understanding of the communities.* This was carried out through a series of initial community meetings. The number and composition of meetings was guided by local community leaders and health workers to ensure cultural appropriateness and maximum inclusivity. Subsequently, ongoing identification of issues was within the arenas of more specific work groups.

2. *Prioritisation of issues in terms of action/implementation of strategies.* These were also developed in the community meetings. Prioritisation may not only result in agreements about the timing of activities, but in agreements about who will take responsibility. In other words, particular groups in the communities took responsibility for different strategies or different discrete community projects.
3. Community organisation/implementation. Organising for programs implemented by ‘project groups’ or work groups established in line with agreements made in the community meetings. Project groups decide their own modus operandi in terms of division of labour, frequency of meetings, roles of members, specific intended outcomes and so on.

4. Observation of processes. Alongside the processes of implementation, observations were made by team members as participant-observers. Observations were documented by each team member and compared and discussed in team reflective meetings. These documents were also discussed and checked with those community members being observed, immediately after the production of the documents, to ensure accuracy and that no person felt at risk by what has been documented.

5. Reflection on processes. Based on observations by researchers and community participants, discussions held within work groups critically examined the activities and processes, both in terms of their effectiveness of contributing towards the Project goals, and in terms of their contribution towards building the capacity of the community (individual participant skills and the collective capacity of the work groups). It was at these meetings, held twice weekly, that the records of observations were re-checked with the broader group of participants to ensure that there was agreement and that no participant felt vulnerable or at risk as a result of the documented observations.

6. Replanning. Based on the reflective process, and again, in the work groups, any decisions about revision of program planning were made, and the process continued again through phases 3, 4 and 5.

The Appreciative Inquiry Process – Giving Meaning to the Project Activity

The participatory action research process and the Project steps outlined above are parallel to the principles and processes of Appreciative Inquiry, as a strengths-based community development process. Appreciative Inquiry was chosen as an approach because it appropriately operationalised the ba-
sic tenets of participatory action research and was consistent with the core values and human rights focus of the Project. It provided a bridge between the values and theory, and the practice and activities of the Project. It also provided a tool for analysis of the activities and gave particular meaning to the process; a particular lens through which the activities could be viewed, given meaning, understood. It enabled informed practice. Furthermore, it was an approach successfully adapted for the rural Indian context and used by a major NGO for the last ten years with over 3,000 women’s self-help groups in south India. Consultation with the NGO was an invaluable experience and was a significant factor in choosing Appreciative Inquiry. The Appreciative Inquiry approach consists of four stages: Discovery (of individual and community strengths and resources); Dreaming (of a better future); Designing (planning to make dreams a reality); and Delivery (implementation). The approach builds in evaluation as an ongoing activity embedded in all stages.

**Stage one: discovery**

The Discovery stage consists of storytelling by members of the community about good and powerful experiences, and successful endeavours, in the group or community. The expertise and experience of the community is the basis for work, which gives centrality to their role and their participation. As people tell their stories, the facilitators draw out and name the strengths and resources implied in the stories and the conditions which assisted past achievements and successes.

The Discovery Stage of Appreciative Inquiry is a defining feature of the methodology. Good Discovery exercises create an opportunity for sharing stories that recognise individual merit and mutual strengths. This builds the bonds that are necessary for individuals to invest their efforts in collective action for extended periods.

The opening questions of the inquiry can generate remarkable energy and valuable information. The questions that we ask set the stage for what we ‘find’, and what we discover (the data) becomes the stories out of which the future is conceived, conversed about and constructed. As such, selecting the focus of the inquiry and generating appropriate questions takes on particular significance (Ashford & Patkar, 2001, p. 11).
Effective Discovery, according to Ashford and Patkar (2001) should contribute to two complementary outcomes. The group or community should gain increased insights into their capacity as a group, and their contributions to the development of their community. Thus, the outcomes have an internal focus, and an external focus on community achievements. The following journal entry captures some of the insights the women from Alanganeri which they shared with the Project team about themselves and their context during the Discovery stage.

They told us how they liked their village, it was a nice place to live, with fresh air, fresh water every day; they had fresh vegetables, fresh fruits, how it was healthy to live here, no pollution, they had good coconut and papaya trees; there was a very good atmosphere in the village, everyone knew each other, they were all somehow related, very calm, no disturbance, no fighting, there was a good community spirit.

They told us about women's situation in India; women were kept down while men had full freedom. However, they said, ‘things are changing’. They said, their Self Help Group (SHG) would create awareness for women that they have rights. They had the Magili Kurus where women could go to report violence and ill treatment, and action could be taken against men. But women were reluctant to come forward because of a prestige problem. The husband is considered as a ‘god’, women cannot easily remarry and many women do not want to make their problems public.

They said that as they moved out from houses to be educated, they had been able to experience and discover the outside world; they could now talk to banks and at school meetings; they had greater confidence in facing the world; they felt happy and really comfortable now; they felt they could much better manage all aspects of the family – money, problem solving, taking on greater responsibility.

They said ‘we had water problems, no easy access to water in the village’, women had to carry water from a well about one kilometre away and this was difficult for them; but this problem had been solved, the SHG had done a lot; the members of
the SHG got together and met with the Panchayat leader; there were difficulties and opposition but they worked together and crossed the hurdles; the leader heard them out, listened and the problem was solved eventually; they were not hasty; they were polite and calm. They had water taps in the village now.

(Team journal entry of community meeting, held March 21, 2006).

The strengths and resources which the team identified as the people told their stories were reflected back to the participants. The team identified such things as confidence, collective strength in the SHG, an ability to endure hardship, an awareness of the positive aspects of their environment and the village and a pride in and happiness with it. Their stories indicated a good community spirit and harmony. They showed a high level of awareness of women’s situation in India and an awareness of member’s rights as women in India, in the world. They were also very aware of changes in Indian society, yet at the same time were cognizant of the pressures on women from society’s taboos. They had a good appreciation of the importance and impact of education and a keen desire to learn.

After having asked the group about their thoughts and if they agreed about these strengths, one of them said: ‘We were not aware of these until you told us, but now we can see how we can come up in life’ (Team journal entry of community meeting, held March 21, 2006).

The other women nodded and smiled, in agreement. It was clear that our reflection back to the women about their strengths resonated with them. However, that it took outsiders for them to see these strengths and the role those strengths had played in improvements in their lives attested to both the ability of their environment to perpetuate submissive identities and the importance of an externally introduced process to challenge and transform identities to ones of more powerful actors in their own destinies. With their increased awareness came an opportunity to progress and assert their rights. With the encouragement of the Project team came a confidence to dream a different future and an energy to work together to make specific plans for a better future. This, then, became an important foundation for the Dream stage.
Stage two: dream

In the Dream stage, people imagine their future where the group or community functions at its best, and makes its best contributions to its members. Dreaming consists of building on strengths to better the group and the community.

The group’s vision is likely to encompass social relationships, economic relationships, cultural traditions, the environment – natural and human made, governance structures, employment and income generation opportunities, and social infrastructure. The group’s vision of the future will represent a compelling possibility when built on the community resources – its strengths as they have emerged from the analysis of past achievements.

Two important types of visions emerge from the Dream Stage, according to Ashford and Patkar (2001, p. 19): (1) Visions of the internal functioning of the group; and (2) Visions of a long-term mission of the group in the development of the community/village. These visions encompass notions of empowerment and structural change.

The following extract from the Team’s journal and the list of dreams all relate primarily to the second type of vision because they are concerned with community and village developments, rather than visions of how the group may work more effectively into the future. Visions of internal functioning really only emerged later on out of tensions which arose during the planning and implementation of the Tamil Tendril Project (a tailoring unit set up by the women). In this Healthy Districts Project, it was in the Design and Delivery stages that addressing internal functioning issues became relevant for the participants.

They said they wanted a road, transport to the main road was a problem; they had gone to the Panchayat president but land owners were not willing to give some part of their fields for the building of the road. They needed this road to allow school buses to come and to give them options about which schools they sent their children to; children could go to better schools and have better future. This would be easier for everything and everyone. One woman said, ‘with the road many changes will occur’.

They said they wanted their children speaking fluent English.

(Team journal entry of community meeting, held April 10, 2006).
Other dreams which were added during discussions included (in no order of importance): to build a house next to the main road; a water tank; a hospital; a village shopping centre; a higher secondary school; maintaining the village’s natural beauty; more comfortable and well furnished houses; a computer; a university; improving children’s education; employment for people who had received education; a village tailoring unit – generating income collectively by drawing on their present skills, which included bag making, tailoring, garments making. They dreamed of building to an export quality (Excerpt from Project journal, April 4, 2006).

All of these dreams were prioritised through processes which were most inclusive of all community members. So for example, where people were not literate, strategies which rely on written language were avoided. After a long process (three meetings), the participants chose a tailoring unit as their first priority.

The choice of a tailoring unit was to hold particular implications for the Project. Firstly, a tailoring unit had the potential to transform economic conditions and social relations for women in the community. But with the attendance of dalit women from the two dalit colonies, existing and longstanding caste relations would necessarily be challenged. A tailoring unit, producing export garments, would also necessarily challenge existing dominant gender relations and power relations within the community. However, while there was now potential for tensions and resistance at the local level, the group rallied external support from nearby NGOs, other similar and successful community projects and the Panchayat Council. The formation of these alliances created power and made the priority dream feasible.

**Stage three: design**
The objectives of the Design Stage are to assist group members develop the structures and strategies needed to take action on their short- and long-term goals. Practical steps are defined through intensive and methodical participatory planning to direct group and individual actions.

The design stage is intended to bring together the participants to prioritise goals and develop specific action plans through dialogue about creating their desired future: how to build social systems that might redefine approaches to leadership, governance, participation and capacity building. It
is clear that the action-oriented collective work at this stage is a vehicle for empowerment and advancing human rights.

As strategies are explored, participants discuss how to protect the qualities of community life they value and incorporate the relationships they want to achieve. Dreams turn into action by establishing roles and responsibilities, developing strategies, forging relationships with organisations and mobilising resources to achieve goals. Detailed planning begins at three levels: short term, easily achievable objectives; longer term strategies for more difficult goals; and thinking through structural changes to reinforce changes (Ashford & Patkar, 2001, p. 27). The following extract from the Team’s journal exemplifies the discussions about short term objectives and longer term objectives. Such things as tailoring training and locating necessary equipment were relatively easily planned for. More complex goals, such as establishing a viable export factory, required more thinking and discussion, including discussion with and support from other established and successful projects.

When asked how many villagers would be interested in tailoring training, they said ‘there was a list of women interested but it would be necessary to discuss with them again’. Asking how many women present at the meeting would be interested, ten raised their hands (Team journal entry of community meeting, held May 15, 2006).

Fifty women registered and joined the venture.

The women said ‘they needed further training, a tailoring unit, and tailoring machines’. We discussed about the location of the unit and they said ‘it had to be discussed with the Panchayat president, who would have first to approach the MLA and then see with the government if they could have some support to either get government land, or private land partly paid by the Tamil Nadu government’.

And then they said they ‘did not have much experience in business and did not know how to know what there was a demand for on the market; they needed to learn to understand this’. We said we knew about a successful tailoring unit in the area and asked who would be interested to visit this place. ‘We surely want to go, all of us,’ was the reply.
They said they ‘would prepare a list of interested people as well as a list of questions for the tailoring unit visit for the next session’.

(Team journal entry of community meeting, held May 15, 2006).

The interpreter translated into English the 11 questions or issues raised by the women:

1. The need for a location for the unit.
2. Obtaining legal permissions – which departments have to be approached?
3. How many people and machines will be needed?
4. What is the production capacity of each tailoring machine?
5. What is the minimum and maximum output per person per day for the unit to operate successfully?
6. What is the amount of capital needed to start the unit? Profit and production to be discussed.
7. Where can we obtain the capital needed for unit?
8. What are the issues about time management and working hours of the unit that we need to know?
9. What should be the daily income of each person in this Project?
10. What do we need to know about marketing products?
11. How should the unit be run? Who will manage the unit: committee, appointing a person?

(Team journal entry of community meeting, held June 5, 2006).

The discussion and planning of the Design Stage reflects the priorities set in the Dreaming Stage, and takes the dreams further by developing actions and tasks that will bring the Tailoring Unit closer to a reality. There is an emphasis on gaining knowledge and skills and building support from external sources. This is a significant emphasis because armed collectively with skills, knowledge and surrounded by a support network, the ability of the women to achieve their goals (empowerment) is strengthened. Of note though, is the absence of discussions about barriers and threats to
the planning. The effects of this were to be later felt when change was met with resistance to change by external power holders.

**Stage four: delivery**

In the Delivery stage, the action plans are implemented. In this stage group members mobilise resources, form new relationships, acquire new skills and implement action plans. Collective vision directs collective action; goal oriented collective action is an important conduit for building power and achieving transformation. All the while, resources which are inherent in the group are strengthened and harnessed, rather than building over-reliance (and therefore dependency and vulnerability, which are features that perpetuate disadvantage) on external resources.

Effective Delivery emphasises innovation, continuing learning, nurturing an ‘appreciative’ eye, institutionalising the appreciative inquiry process, self reliance, monitoring the progress and revising plans where appropriate, participation through shared responsibility for decision making, resource mobilisation and implementation, and transparency (Ashford & Patkar, 2001, p. 34). These emphases support a process and outcomes of liberating transformation through collective action and reinforce the relationship between health and development.

**Follow-up: keeping the cycle going**

As a cyclical process, a new cycle of discovery, dreaming, designing and delivering can occur at any point, at any time. Appreciating the strengths in people and their communities, and asking questions, listening to stories, and drawing out themes which identify these strengths gives people hope and motivation to realistically anticipate a better future and to better meet everyday challenges in their lives. Using the stages over and over fortifies gains made towards empowerment and asserting rights. The concept of ‘strengths’ is central to the process of Appreciative Inquiry.

**Successful Outcomes and Achievements**

The Appreciative Inquiry process used in Alanganeri was meticulously documented and evaluated in a manner consistent with participatory action research. There were mixed outcomes but several significant successful outcomes were identified by participants and facilitators.
The first outcome was the commencement of a tailoring unit, comprising 50 women from eight of the 10 communities in the Alanganeri Panchayat. The Unit, named Tamil Tendril (meaning Tamil Breeze), included 10 women from the dalit colonies amongst its members and the tailoring teacher was also from one of the dalit colonies. Twenty percent of the Project participants came from the 10% Dalit population of the Panchayat. The women negotiated for, and secured, 8 sewing machines from the local partner NGO and they secured a rental building (the rooftop and two rooftop rooms of a caste family home) in which it held tailoring and embroidery classes. The group was assisted with the legalities to enable it to form a society, with office bearers and a bank account. The women commenced skill training in areas such as collaborative decision making, conflict resolution, roles and responsibilities of group members, making linkages with outside organisations, finance and accounts.

With regard to a range of external relationships, contacts were established with possible retail outlets in Australia, with a view to the Unit becoming an export production unit. Support was requested from, and subsequently offered by, a close by community-based export tailoring unit and a local weavers’ cooperative agreed to supply cloth to Tamil Tendril. After discussions with the Panchayat Council, agreement in principle was obtained for assistance in being allocated land, and for State government and NGO assistance in providing building materials for a permanent Project office and a tailoring unit building in the Panchayat.

In terms of the Project objectives, these achievements are indicative of progress towards individual and group capacity building and generally represent the use of effective strategies to this end. In summary, the participants of Tamil Tendril organised themselves and worked collectively towards their dream. In so doing, they created a structure in their community which was not there previously, one which had the potential to support members of the community in a range of ways, from securing income to socio-emotional support. To this extent, structures and relations in the community changed.

Individuals also learned skills, which ranged from technical skills to those which increased their social power, such as skills of negotiation and harnessing resources. However, these achievements at the community and individual level are only part of the picture of change.
These achievements, as exciting as they were, must be contextualised, given the Project’s framework of social and structural determinants of health and wellbeing, and a human rights perspective which implies accountability of duty bearers. In other words, to what extent were structural relations of power, especially in relation to gender and caste, changed to the advantage of the less powerful?

Broader Forces, Sustainability Eroded

While the above outcomes are certainly positive outcomes at the community level, changes at this level do not occur apart from the wider socio-political context, and this broader context determines the level of sustainability of more local changes. In this wider arena, forces are at play which are well able to erode and undermine gains at the local community level and severely compromise the sustainability of any such gains.

Change which alters power relations can represent a threat to those who traditionally have held power. Therefore Appreciative Inquiry, as with any change strategy at the local community level, needs to be seen within the context of a larger development process, a broader and longer term development plan which addresses the broader forces, including those involving issues of power and powerlessness, institutional relationships of exploitation and oppression. Such a broad development plan must include the following factors for successful development outcomes: vision, values, strategy, capability, motivation and feedback (Ashford & Patkar, 2001, p. 38). All of these factors, together, can then contribute towards positive development outcomes. The absence of one or more of these factors will weaken efforts at sustainable development outcomes and compromise the outcomes themselves.

Appreciative Inquiry can be effective in establishing an inspiring group vision, articulating values, creating a sense of ownership, generating new ideas and action for sustainable change and providing a useful feedback tool. But Appreciative Inquiry does not, of itself, create new resources or transform broader societal power relations. Other strategies must be used to do this and other stakeholders must be engaged, particularly those that hold resources, whether they are social resources, political resources or material resources. Unless there is a broader development vision and process, traditional relations of power and hierarchy will persist and dominate despite any changes at the local level or challenges to those exploitative and oppressive relations.
In Alanganeri, the Project team had an explicit, clear, strong and persistent focus on including dalit people in the process. Their inclusion built unrelenting tensions into the process, tensions which were managed but which required seemingly never-ending effort, discussion, conflict management and negotiation, and compromises amongst participants. With this focused concentration on managing group tensions, attention was not paid to the broader implications of local people taking control and traditional caste practices being violated. In rural India, there are powerful and traditional oppressive institutional relations. Gender, caste, hierarchy, patronage and the elitism which comes with education and professionalisation of NGO workers, amongst others, remain prevailing and dominant. These forces infiltrated their influence in Alanganeri. Somewhat paradoxically, the critical set of resistance forces emanated from the local NGO, which was a partner in the Healthy Districts Project. The longstanding relationships between NGO workers and community leaders – all male and from caste communities – were central to the Project team’s work being accepted in the communities. However, these relationships also circumscribed the limits between acceptable and unacceptable interventions, and acceptable and unacceptable change. The NGO partnered in the Project because development was its core work and there was also potential kudos from achieving outcomes in an underdeveloped part of its patch. However, its approach to community development within a rural Indian context was highly patronising, in alliance with the traditional power holders, and one which over the years had cemented its status and power, and the status of its workers, who were almost exclusively professional, university-educated males from higher castes. Thus, despite engaging in community ‘development’, the NGO was itself an embedded part of the social structure and its activities reinforced and perpetuated traditional social relations and power balances. Within the NGO, the rigid hierarchical organisational structures, combined with autocratic leadership, shaped the workers’ activities in ways that ensured the ongoing approval of the organisation and the leader. Not only was the leadership autocratic, but the Director was new and had a clear focus on establishing his own power and authority in no uncertain ways. Hence, when the NGO became aware of the increasing power of people in the community, particularly dalit
women, and their demonstrated ability to work collectively, self-reliantly and to achieve goals, and heard more and more demands, it perceived its traditional position of power as being threatened and it began to withdraw its support. Its support of the Project was essential because it held long standing power and resources and so above all else, local people were afraid to risk its disapproval and suffer perceived, consequent losses. Accordingly, the NGO workers, keen to maintain their positions and alliances within the organisation hierarchy and eager to establish their relationship with the new NGO leadership, responded to subtle but powerful messages from their Director and withdrew support. Workers who had been critical allies in change began to actively but subtly undermine the Project work and so too, the achievements which had been made at the community level. While the workers’ actions were clearly a withdrawal of support, their personal feelings, as they expressed them in different ways, were very ambivalent.

In the end, long standing dependency relationships proved to be the stronger forces. The perceived costs of gaining power at the local level were considered by local people as ultimately too great and so the sustainability of the Tamil Tendril as a self-reliant, income-generating project benefitting women from both caste and dalit communities was eroded. The intended expansion of community-building activities beyond Tamil Tendril to other groups in the community, such as youth, was now not possible. The resources which were held by the NGO or which it could harness externally to support the local people’s aspirations, were denied them. Hopes and expectations were not realised and old power relations remained intact. The most significant change which had occurred was that the local people had experienced, at least for a short time and to some extent, success, and were active in achieving their goals within a partnership model. Empowerment and asserting rights was realised, but not in a sustainable way. Appreciative Inquiry strategies had worked, but the broader development processes which should have supported those successes were not adequately or effectively attended to.

The turn of events in the Project highlighted the need to break those traditional dependency relations which make the cost and the risks of social change too great for local people. This requires broader strategies,
because dependency is not only social and political, but economic as well. Dalits, as noted previously, mostly depend on caste landowners for day work as their only source of income, which is meagre and often in-kind.

How did the Project fare in terms of human rights? The assessment sheet must conclude with ‘erratic’, if not inconsistent and variable. Proclaiming a human rights approach became far more challenging than the team initially anticipated and the Project fell far below the mark of ensuring human rights are not violated. However, it remained a powerful indicator, a clear monitoring mechanism and a commanding generator of insights to pave ways forward. In terms of participation, commitment to equity, capacity building, inclusion, gender equality and other aspects pertinent to the focus on rights claimants, the Project maintained a high level of consistency and achieved some transformations towards greater rights at the local level. However, it failed to effectively make progress on the second focus of holding power holders accountable for violating the rights of marginalised groups.

Where from here?
The changes achieved at the local level were severely corrupted. Continuing to work in the Alanganeri community was no longer viable. Turf had been reclaimed by the NGO.

And what remains of the Healthy Districts Project beyond Alanganeri? It has a continuing commitment to work from a human rights basis, including the right for all people to participate in development. It also has a continuing commitment to reflective practice and to search for effective strategies to transform oppressive power relations. The Project was forced to withdraw from the community in which it was working. Threats to the Australian partner meant that it was unsafe to continue, and this was also the assessment of Madras University in relation to itself continuing.

The Project has now sought new partners in South India and has entered into a multilateral partnership with the Department of Social Work at Madras University and five other international universities, including ones from Taiwan, the Philippines, Canada, USA, Africa, Australia and the Netherlands. We have interrogated each other’s values and have made a collective commitment to adopting a human rights perspective and an
international perspective. We have formed a consortium – the Centre for International Social Work. We have developed an explicit agenda to develop strategies that effectively take account of traditional power differentials, particularly caste and gender. We are building alliances with dalit organisations and with projects which have achieved some degree of success in breaking traditional relations of power and dependency.

Healthy Districts Project is now continuing in some tsunami-affected communities, working in a complementary way with another local project, but specifically working with youth to enable them to reach their aspirations. We are also working alongside projects which are creating such ventures as broad-based people-owned credit unions to offset the traditional dependency on day labour income from higher caste groups. Many puzzles remain to be unravelled and the struggles continue, but we are now struggling in alliances with local projects and movements, which themselves are addressing exploitation and oppression.

The commitment of the new set of partners to learning and the dissemination of learning is an investment in maintaining core values and a climate of discussion, reflection and discovery. A collaborative research project proposal has been submitted to the British Council in Chennai to engage in participatory action research to develop community development strategies that can effectively address local practices of exclusion, including dalit exclusion.

The context of the new setting (tsunami-affected communities south of Chennai) is riddled with complex forces. Of course, traditional social relations still exist; however, as a result of the tsunami reconstruction efforts, the Tamil Nadu State government has instituted new arrangements. For example, the newly constructed houses can no longer be solely owned by the husband; ownership is joint. Inheritance of the houses can no longer go to the eldest son, but must go to the eldest child. Many of the newly built fish drying and freezing units are run and managed by women. It remains to be seen, whether the massive natural disaster, which inadvertently alloed the state to challenge old gender relations, may also support local community development activity, such as that embarked on by the new Healthy Districts Project. However, consistency in reflective practice, underpinned by solid values, will generate insights that will lead to more sophisticated knowledge and more effective skills in social change.
The Healthy Districts Project has meandered, but reflecting on its meanderings has created new opportunities to further engage, with new partners and a renewed collective commitment to human rights work, in processes of discovery to generate new knowledge for social and community development in communities of exclusion – to seek out effective outcomes in the mire of change and resistance to change. The reflective process, as part of participatory action research, was central to creating new opportunities and generating new knowledge. Without reflection, the outcomes of the Project could easily, and too simply, have been labelled as a failure. Failure leads nowhere. Thwarted outcomes with reflection lead to new and emerging alternatives and ways forward.

Conclusion
The Healthy Districts Project attempted to create a healthier local community in rural south India through a community development/action research project. The process of change was guided by a strengths-based perspective and the Appreciative Inquiry process, underpinned by a social view of health and a commitment to human rights. These proved to be powerful resources which challenged some local exclusionary practices while at the same time being a catalyst for local people to raise their awareness of their own, collective capacity to create changes. Local people identified a collective income generation program as their goal or dream and then worked to achieve this. Social relations are complex and driven by strong agenda and interests. Processes of change are similarly complex. The multiple players and layers make change efforts at the community level a somewhat treacherous journey. Achievements are not simple, unilinear sets of positive changes for all. There are perceived winners and losers of change.

The achievements are paradoxical. In creating the necessary social changes which enabled women and dalits to participate in decision making about their destiny, broader forces and powerful interests were stirred and threatened. The Project failed to find ways to address these broader forces. This meant that the Project successes resulted in Project failure. However, the lessons learned have been taken into a different setting and the process of learning, being an ongoing process of reflection and action, gives rise to optimism that forces of oppression and exploitation can be effectively
dealt with. Furthermore, the aspirations of local people, including those who are now marginalised and excluded, can be reached and gains sustained through more effectively addressing the structural inequities which perpetuate disadvantage and powerlessness.

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