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How can community health programmes build enabling environments for transformative communication?: Experiences from India and South Africa

Working paper

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Abstract

Whilst much research has examined how to empower poor community members to identify the social roots of health problems and articulate demands for health-enabling living conditions, less is known about how to create receptive social environments where the powerful are likely to heed the voices of the poor. This paper seeks to characterise the social environments in which community-led health programmes are most likely to facilitate effective and sustainable health improvements, using three dimensions to characterise social contexts: material, symbolic and relational . We distinguish between technical communication (the transfer of health-related knowledge and skills from experts to communities) and transformative communication (a more politicised process, where marginalised groups develop critical understandings of the social roots of their ill-health, and the confidence and capacity to tackle these). Drawing on secondary sources, we compare two well-documented case studies of HIV/AIDS management projects. Both sought to use technical communication about HIV/AIDS as a springboard for developing transformative communication skills amongst marginalised women. The Entabeni Project in South Africa sought to empower impoverished women to deliver home-based nursing to people with AIDS. Whilst it performed a vital short-term welfare function, it did not achieve its goals of leadership by local participants and long-term sustainability. By contrast, the Sonagachi Project in India, which started as an HIV-prevention programme targeting female sex workers, has achieved both these outcomes. We examine the way in which pre-existing social contexts in West Bengal and rural KwaZulu-Natal impacted on the possibility of effective mobilisation of excluded women in each case. We also highlight the strategies through which Sonagachi, but not Entabeni, was able to alter aspects of the material, symbolic and relational contexts of participants' communities in ways that opened up significant opportunities for project participants to articulate and assert their needs, and motivated powerful actors and groups to heed these demands.

Key words: India, South Africa, communication, community health, volunteers, sex workers, empowerment, Freire, HIV/AIDS

Introduction

What social contexts best support and enable transformative communication in marginalised communities, and what role can public health and social development projects play in facilitating these? Much attention has been given to the challenge of empowering poor people to identify the social roots of health problems and articulate demands for more health-enabling living conditions (Vaughan, 2010; Wilson, Dasho, Martin, Wallerstein, Wang, & Minkler, 2007). However, less work has been done on characterising what constitute 'receptive social environments' in which the powerful are likely to heed the voices of the poor – the focus of this paper.

We position ourselves as critical social and community psychologists interested in the potential of participatory communication in the Freirian tradition to facilitate health in marginalised communities (Freire, 1970, 1973). Our starting point is our interest in promoting community involvement in health projects, in the light of our belief that people are more likely to take control over their health when they have experiences of being in control of other areas of their lives (Wallerstein, 1992). We use the concept of 'transformative communication' to conceptualise the pathways to the social changes needed to empower poor people to take greater control over their health and well-being, and to successfully demand access to the political and economic power that would enable them to improve their lives. Rather than seeking to transfer skills and expertise from active and all-knowing outside health professionals and development agencies to passive and ignorant poor communities we argue that projects seeking to facilitate transformative communication should focus on both (i) facilitating the capacity of poor communities to communicate forcefully and effectively about their needs (building 'voice'), and (ii) creating social environments that are open to hearing what the poor have to say (promoting 'receptive social environments') (Campbell, Cornish, Gibbs, & Scott, 2010).

We distinguish between 'technical communication' (Freire's 'extension', 1973) and 'transformative communication'. The former involves the transfer of factual knowledge (such as AIDS awareness) and technical skills (such as acquiring and using condoms). The latter is a more politicised process, through which marginalised groups develop critical understandings of the political and economic roots of their vulnerability to ill-health, and the confidence and strategies for tackling them. We do not deny the importance of technical communication. However, on its own, it is a necessary rather than sufficient condition for sustainable improvements in poor people's lives. Health projects should regard technical communication as a stepping stone towards the development of more politicised transformative communication, rather than viewing it as an end in itself, as is often the case. In the absence of opportunities for transformative communication, projects are unlikely to achieve sustainable access to the political and economic power necessary for long term health-related empowerment.

To explore this distinction, we present a secondary analysis of two contrasting case studies using peer education as the starting point for involving highly marginalised women in HIV/AIDS management. The Entabeni Project, in rural South Africa, used peer education to train women volunteers in home nursing skills to assist people dying of AIDS. It enhanced women's technical knowledge and skills, enabling them to offer vital nursing support to desperately suffering individuals and households. However it was less successful in its goals of using AIDS-related skills-building as a springboard towards the wider social and political empowerment of volunteers, including their ability to sustain the project after its three-year funded period. The Sonagachi Project, in urban Kolkata, India, focused on HIV prevention in the context of commercial sex, and began by employing twelve sex workers as peer educators.. In contrast to Entabeni, however, this health-related work served as the starting point for a wider process of empowerment of sex workers to take control of the project, and of their lives beyond the confines of HIV-prevention.

Both case studies have been studied in detail by each of the authors, and the resulting publications are our source of information. The work of other authors on the Sonagachi Project has also informed our work, and we cite it where appropriate. While individual case studies are good at highlighting the local complexities of health and social development in practice, we locate this paper within a paradigm of comparative case studies, which seek to construct more general understandings which transcend individual research sites (Yin, 2003). Such a paradigm may include a variety of comparisons, e.g. projects with similar approaches but different outcomes (e.g. Cornish & Campbell, 2009), projects with similar outcomes and approaches (e.g. Cornish, Shukla, & Banerji, in press). Our selection of cases for the present paper follows the rationale of 'dichotomous case comparison' in which very different cases are compared as a means of exploring the reasons for the variation between the cases (Schensul, Schensul, & LeCompte, 1999).

Conceptual framework

Both projects used peer-to-peer communication strategies to disseminate information and skills. 'Peer education' assumes people are most likely to change health-damaging attitudes (e.g. AIDS stigma) and behaviours (e.g. unprotected sex) when they see liked and trusted peers changing theirs. However technical information and skills alone have little ability to change people's behaviour where negative social circumstances (e.g. poverty, gender and other power inequalities) limit people's control over their behaviour. Peer education needs to be backed up by the development of 'health-enabling social environments' –contexts which support and enable health-enhancing attitude and behaviour change (Tawil, Annette, & O'Reilly, 1995).

'Power is never conceded without a demand', however (Douglass, cited in Seedat, Duncan, & Lazarus, 2001:17). Dominant groups seldom voluntarily relinquish power without vociferous demands from the excluded. A key strategy for building health-enabling social environments

is that of building the capacity or voice of poor people to challenge unequal social relations placing their health at risk. Elsewhere (Campbell, Foulis, Maimane, & Sibiya, 2005) we have highlighted three intertwined, but analytically distinguishable, dimensions of social context that enable or limit the likelihood of effective transformative communication: symbolic context, material context and relational context. We use these three dimensions to frame our discussion here.

Symbolic context refers to the world of culture: the meanings, ideologies and worldviews circulating in particular social settings, through which people understand themselves, others and the activities they engage in (Valsiner, 2007). The symbolic context frames how different groups are valued and respected. For instance, within a patriarchal society, ideologies about gender limit how women and men understand the potential of women to make significant decisions or take leadership roles. The concept of recognition is crucial in understanding the symbolic location of a marginalised group. Recognition of an individual or group's worth, dignity, concrete achievements and legal rights to equality constitute vital components of empowerment (Honneth, 1995).

The symbolic realm is closely intertwined with the material and relational realms. Two aspects of *material* context are relevant to health – the first linked to resource-based aspects of agency, and the second to experience-based aspects. Resource-based agency relates to the extent to which poor people or women have access to money, food, paid work or funding for development projects. These are not only a foundation for pursuing health, but also bolster symbolic recognition and esteem. The second understanding of material context relates to concrete opportunities for people to put their skills or agency into practice. Wieck (1984) warns against defining problems so broadly as to preclude action to tackle them, arguing that 'small wins', provide the experiential and material basis for further action. The problems undermining women's health in both Entabeni and Sonagachi are rooted in poverty and gender inequalities. From Wieck's perspective, it is helpful to first identify relatively quick, tangible first steps (e.g. facilitating local responses to AIDS) only modestly related to grander political outcomes (e.g. promoting fundamental social transformation through effective challenging of power hierarchies). Small-scale successes then provide a material and experiential basis for more ambitious future action.

Various *relational* dimensions of social context are deeply implicated in the possibility of transformative communication. The first is democratic and accountable leadership, recognising the rights of poor people to fight for political rights and advance their economic interests. A key step involves full participation of poor people in leadership of social development projects. Another key determinant of project success relates to project ability to mobilise and build bonding social capital (strong within-community support for project goals), and bridging social capital (supportive relationships between marginalised communities and outside individuals and agencies with the political or economic power to assist them in

achieving their goals) (Putnam, 2000). The unequal distribution of social capital (defined by Bourdieu (1986) as people's access to networks of socially advantageous inter-group relationships) is a key driver of poverty and gender inequalities that often drive ill health.

The projects

The Sonagachi Project

The Sonagachi Project was initiated in 1992, with a remit of reducing the sexual transmission of HIV between sex workers ('prostitutes') and their clients in Sonagachi, the largest red light area of Kolkata, India (Jana, Basu, Rotheram-Borus, & Newman, 2004). Dr Smarajit Jana, an occupational health doctor from the All-India Institute of Hygiene and Public Health was given the task of establishing the project. Peer education and sexual health clinics formed its backbone. Twelve sex workers were initially recruited to serve as peer educators, to disseminate information regarding HIV transmission and prevention, promote condom use, and encourage sex workers to attend the project's sexual health clinics.

However, as the project developed, the conceptualisation of its remit and its members. roles changed, enabling more transformative forms of communication. Two dimensions of politicisation emerged: building relationships within the project that embodied a more politicised form of communication, and making political demands for wider social change (Cornish, 2006a). In 1995, in parallel to the sexual health intervention, a sex workers' organisation (Durbar Mahila Samanwaya Committee, DMSC) was formed to unite sex workers to fight for their rights and to represent their interests in negotiations with more powerful groups. At the same time, sex workers were empowered to take on leadership roles within the project, and in 1999, DMSC took over responsibility for the sexual health intervention (Jana et al., 2004). The project expanded its focus from clinic-based sexual health promotion to a range of social interventions, including the establishment of a co-operative bank for sex workers, advocating on sex workers' behalf in relation to police, brothel managers (madams), or exploitative local men, and influencing opinion leaders such as journalists and politicians (Cornish & Ghosh, 2007).

The project has led to increased condom use and decreases in sexually transmitted infections (Basu, Jana, Rotheram-Borus, Swendeman, Lee, Newman et al., 2004; Jana et al., 2004). These findings, along with the impressive achievements in empowering sex workers, have led to it serving as a model project for replication throughout India and beyond (Blankenship, Friedman, Dworkin, & Mantell, 2006; NACO, 2006).

The Entabeni Project

The Entabeni Project (Campbell, Gibbs, Maimane, & Nair, 2008; Campbell, Gibbs, Maimane, Nair, & Sibiya, 2009; Campbell, Nair, & Maimane, 2007; Campbell, Nair, Maimane, & Nicholson, 2007; Campbell, Nair, Maimane, & Sibiya, 2008; Nair & Campbell, 2008) was

established by an alliance of grassroots health volunteers in a South African rural community, and HIVAN, a university-based NGO two hours drive away. Entabeni has minimal access to roads, electricity and clean water, some distance from towns or formal health facilities, with 35% of pregnant women HIV positive. Residents survive through subsistence farming in a rocky, hilly area, with frequent drought. A traditional chief governs the area, with power in the hands of adult men.

HIVAN initially spent a year in Entabeni researching how people were coping with HIV/AIDS. The next year was spent discussing research results with local groups (e.g. women, youth, church), leading to a project proposal. HIVAN raised funding from an international agency to implement this proposal for three years (2005 to 2008), accepting the community's invitation to serve as 'External Change Agent' for this period.

The main support for people dying of AIDS were volunteer women, working without training, payment or recognition from local community residents, health or welfare departments or NGOs. They had been working for several years when HIVAN arrived, but were battling to keep going, demoralised by the excessive demands of their work in a context where HIV/AIDS was highly stigmatised.

The project had three aims: (i) to help this long-standing but flagging group develop home nursing, peer education and counselling skills to offer more effective home-based care support – through volunteer-run peer education programmes; (ii) to build recognition and support for their work amongst other community members; (iii) to build bridges between volunteers and external support agencies in the public and NGO sectors. The latter would hopefully come to constitute a formal and permanent 'partnership' structure to sustain the project after HIVAN's withdrawal.

Over 3 years, the project's peer education component trained 'cascading' groups of local volunteers in counselling, home nursing and assisting people to access hard-to-reach welfare grants and medical services. This led to a tremendous increase in the confidence and profile of the volunteers, strongly increasing their effectiveness. The project also had some success in mobilising the participation of local church leaders.

However, it was less successful in mobilising the support of traditional leaders and men – the most powerful local groups. It also had little success in mobilising young people, originally anticipated to form the pool of new volunteers, given high levels of youth out of school and work. Furthermore, although increased numbers of volunteers participated in the training courses, drop-out rates were high once the work started.

The project's two key disappointments were firstly its inability to mobilise the long-term commitment of external partners in health and welfare departments and local municipal

structures. The second disappointment was its failure to organise payment for volunteers. Despite government promises that volunteers would receive stipends, efforts to secure these were unsuccessful. After three years, external participation in the partnership committee remained patchy. Volunteers doubted they could sustain the project without HIVAN's support.

Building contexts for transformative communication

Both projects sought to empower marginalised communities. They began with the technical skills of peer communication, but with an ethos that wider social change was needed – in the form of helpful networks with powerful groups, improved access to resources and services, and more democratic and cohesive relationships within their local communities. Both sought to promote community ownership of the project, and to build the organising skills of the grassroots group beyond peer education, in activities including chairing meetings, producing reports, and working effectively with external stakeholders.

Creating symbolic contexts for transformative communication

How did the symbolic context of each project shape the possibility of transformative communication by marginalised women, through facilitating their voice or enhancing the likelihood of receptive social environments? We touch on two inter-related dimensions of context here: the pre-existing symbolic context, and the impact of project discourses and activities on this context.

Challenging the stigmatisation of women

In both cases, women (sex workers and volunteers) initially occupied a highly stigmatised position, which stood in the way of potentially transformative project goals of (i) community ownership of the project and sympathetic local identification with project goals; (ii) effective peer communication; and (iii) establishing recognition of the community's legitimacy by more powerful potential external partners.

Three forms of stigma undermined the Entabeni Project. Firstly, AIDS stigma and denial led many to ignore or undervalue the volunteers' work. The project strove to tackle this through promoting AIDS awareness; facilitating 'safe social spaces' where peers could tackle their fear and denial; lobbying for better formal health and welfare services for AIDS-affected households, building local confidence in peoples' agency to tackle the problem. However it had little impact. The second form of stigma lay in local peoples' unwillingness to recognise the value of 'caring'. Caring was dismissed as the 'usual unpaid work women do', regarded as insignificant and invisible in a patriarchal setting which devalued women at every turn. The third form of stigmatisation was that of unpaid work. Men and young people sneered at volunteers who were 'willing to work for nothing', undermining their credibility and sense of achievement. Unable to procure a stipend for the volunteers' work, the project was powerless to tackle this.

The Sonagachi Project was much more successful in tackling stigma in a context where having multiple partners was considered dirty and shameful. Drawing on the occupational health background of its founder, HIV was framed as an occupational health issue, rather than a moral issue. It redefined prostitution as 'sex work', a legitimate economic activity through which women supported their families were are self-reliant (Cornish, 2006b; Jana et al., 2004), and redefined sex workers' struggle as a collective one. Sex workers elaborated an understanding of themselves as active, successful, legitimate workers, who needed to unite, like other labourers, to secure their rights.

What allowed this new positive definition of sex work to take hold? Part of the answer lies in the pre-existing context of West Bengal's political culture. A strong tradition of trade unionism and left wing parties provided familiar narratives of successful workers' struggles, reinterpreted by the ECA to provide inspiration for sex workers' efforts to organise themselves and to demand change (Cornish, 2006a; Ghose, Swendeman, George, & Chowdhury, 2008).

South Africa's lauded 'transition to democracy' had not filtered through to the remote Entabeni community. The chief holds tight rein on power. He allowed HIVAN to work there provided the project had no links to his political opposition. He appointed a local headman as formal volunteer leader and official mediator between HIVAN and the volunteers, to ensure project activities did not threaten his power base. Volunteers had no access to stories of disempowered women fighting for social recognition, and their attitudes to the possibility of democratic social transformation pessimistic.

Symbolic power of the projects' External Change Agents (ECAs).
Both projects had dedicated, high profile advocates. However Sonagachi's ECA had more clout. Entabeni's ECA was an experienced social worker, from a middle class background, with a long-standing network of powerful contacts, and exceptional skills and confidence to advocate for the project. She was female rather than male, however, a social worker rather than a biomedic, on a three-year contract to an NGO rather than having a permanent institutional base. This may have undermined her authority to enforce the project's agenda. In contrast, Sonagachi's ECA was a medical doctor located within an established public health system, leading a project that came with institutional backing (from the All-India Institute of Hygiene & Public Health) and significant funding. His biomedical pedigree and institutional backing would have given him greater legitimacy and authority.

Symbolic value of the project
The symbolic context shapes how external funders and facilitators understand a project's value. In both cases, the projects had symbolic value, operating in desperate poverty on a pressing health issue. This enabled them to win initial funding and support. The extent to which this translated into sustained and locally appropriate support varied however.

Entabeni initially received funding for one year from a US funder, who seemed willing to allow the project to evolve in response to community needs. During this year, it was visited by senior US government officials. Offering funding for a second year, they wrote of being honoured to have witnessed the project's mission, and the volunteers' dedication and humanity. Shortly afterwards however, HIVAN a new financial controller was appointed to the funding agency in Washington DC, who did not see project goals as relevant to the funders' agenda. When HIVAN insisted the project was building the capacity of a poor community to cope with AIDS, they were told this was 'not a deliverable of value to the US government'. The agency representative was honourable insofar as she arranged for the promised money to be routed to the project via another funding agency. However she emphasised no further money was forthcoming. Through careful budgeting the project stretched the second year's budget to enable it to run for a third year . Whilst the community was grateful for this funding, and whilst the project was able to put it to good use, it was clear that the funding agency was accountable to US officials and taxpayers, rather than to Entabeni residents or volunteers, who felt powerless in the face of the seemingly random process through which money was allocated or taken away.

The Sonagachi Project has also struggled with a potential conflict between funders' focus on direct, measurable health outcomes, and the project's commitment to more indirect empowerment activities. However, it has been much more successful than the Entabeni Project in shaping its symbolic context where sex worker empowerment is considered a legitimate effort to fund. It has done so through two means.

Firstly, it has promoted a positive, fundable image of itself. Its positive outcome evaluations, demonstrating impacts on HIV-related behavioural and biomedical measures (Basu et al., 2004; Jana, Bandyopadhyay, Mukherjee, Dutta, Basu, & Saha, 1998) are the most prized source of symbolic recognition in the funders' eyes. It puts much effort into its public image, inviting the media, other NGOs and opinion leaders to events (Evans & Lambert, 2008). It has gained positive coverage in regional, national and international news media (including coverage in the *New York Times* and *Scientific American*), academic articles, and UNAIDS literature (UNAIDS, 2000). It has made its name within the international HIV/AIDS community as an exemplary project, leading, for example, to efforts to replicate the project in Brazil (Kerrigan, Telles, Torres, Overs, & Castle, 2008).

Secondly, thanks to Dr Jana's national and international networks, it has had a growing impact on HIV/AIDS policy. The current government HIV/AIDS programme, NACP III, explicitly mentions the Sonagachi model as its inspiration, establishing community mobilisation as a required component of HIV/AIDS intervention programmes (NACO, 2006). Such symbolic recognition provides a strong counter-weight to the resistance which it has experienced from political and government representatives, based on moral disapproval of sex work.

Building material contexts for effective transformative communication

To what extent did a combination of pre-existing factors, and project efforts, create material contexts for transformative communication in each project?

Payment for involvement in project activities

Challenging stigmatisation and promoting respect of sex workers was achieved in Sonagachi not only through positively reframing sex work, but also by backing this respectability with material value. Peer educators in Sonagachi receive a small salary which reinforces the idea that their work is important. Whilst many work beyond the call of duty, peer educators would have been unable to give unpaid time to peer education, given the time involved in making a living.

The Entabeni Project did go some way to increasing the status and recognition of volunteers, through providing them with highly valued uniforms and skills training. Each training course was followed by high profile graduation ceremonies, with certificates, feasting and dancing. After the (polygamous) chief instructed his six wives to receive project AIDS training, he attended their graduation. This was a tremendous boost for the project's quest for community recognition given the high regard in which men held the chief. (Ironically, he used his speech at this event to insist there was no link between polygamy and HIV/AIDS, and to inform the audience that he had five girlfriends in addition to six wives.) However the project's failure to procure stipends meant that it didn't gain the type of recognition attained by Sonagachi.

Experiential backing for women's sense of agency: small wins

In settings where women lacked opportunities to exercise agency, projects may begin to provide these, through facilitating their concrete experiences of successful engagement in project activities. Sonagachi used sex workers' involvement in successful peer education as a first step towards promoting wider experiences of effective action to improve their lives. It quickly expanded its activities to address the women's pressing needs, including getting women released from police custody after raids, mediating in disputes with madams or clients, addressing their financial security through micro savings and micro credit, and helping to get their children into local schools. Sonagachi sex workers talk very proudly about their ability to 'speak' –at public events, to the media – and have learned how to negotiate with police and politicians. In all this, women expand their skills and their sense of achievement, beyond health-focused peer education, to deal with wider social issues. Their successes have increased women's confidence that sex workers have the power and capability to bring about change.

Whilst Entabeni was successful in training women in peer education, home nursing and counselling, skills they were able to use effectively in project-related service contexts, it did not provide opportunities for them to 'export' their experience of effective action to situations

beyond training and services. As discussed below, the project's failure to build support for the volunteers either within the community (men, traditional leaders) or outside the community (external partners) hindered their goal of providing Sonagachi-type opportunities for 'expanded empowerment'.

Income generation

Poverty deeply undermined sex workers' health and sense of agency in Sonagachi. Their economic disadvantage in relation to clients meant that if a client insisted on condomless sex, they were powerless to refuse. Recognising this, the project set up their own cooperative 'bank', overcoming obstacles including sex workers' distrust of banking systems and official resistance to registration of a co-operative in the name of sex workers. The 'bank' helps women to save money, collecting small deposits daily. It offers loans at reasonable rates, when previously, sex workers were at the mercy of exploitative moneylenders. The bank enables sex workers to save or borrow money for crucial investments: building a home for their retirement, supporting their family, marrying off their daughters. This financial security improves women's morale and confidence.

The Songachi Project also sought to enhance sex workers' material security – and commitment to the project – by facilitating their access to government benefits. Leaders used connections with politicians to enable sex workers to access ration cards for subsidised foodstuffs, and registration cards for voting and citizenship rights.

The Entabeni Project had specific plans to improve people's material circumstances – partly through increasing access to government benefits. This was a complex issue, however. The chief was wary of his subjects receiving benefits from the rival ANC local government. In HIVAN's initial research, volunteers expressed frustration at the chief's refusal to accept emergency food the ANC government was providing drought victims. He argued that his community should be self-reliant, surviving through subsistence farming and small businesses rather than handouts. The volunteers commented bitterly that he was unaware of the extent of poverty and suffering of many households, where people dying of AIDS were not well enough to farm or run small businesses.

The project tried to strengthen links between volunteers and the Department of Agriculture worker, posted in Entabeni to help people improve farming skills, access to seeds and tractors. However, local people believed their hopes for a better life lay precisely in moving away from a dependence on farming in such unpromising conditions. Particularly young people saw their only hope of self-advancement through paid jobs in urban areas, regarding anything to do with living or working in Entabeni as 'backward' and hopeless. A key aspect of the project's failure to mobilise essential support was its failure to resonate with local peoples' economic aspirations. By contrast, Sonagachi was able to provide income generation opportunities that resonated with participants' identities and goals.

Creating relational contexts for effective transformative communication

To what extent did each project promote relational contexts for transformative communication? We look at two aspects of relational context. The first relates to the extent to which projects involve grassroots participants in leadership. The second and third relate to two forms of 'social capital' which are important for effective development communication: strong within-community relationships (bonding social capital) and bridging relationships, linking marginalised communities with external groups that have the political and economic power to support them in their social development goals.

Evolving power sharing

Both projects sought to implement empowering processes within the projects themselves, to increase women's power and sense of agency. Both ECAs sought to gradually hand over their leadership role to grassroots project participants. In Sonagachi this happened to some extent, with sex workers gradually coming to take on positions of increasing authority and influence, beyond their specific health worker roles. An egalitarian project philosophy holds sway, which respects sex workers and prioritises their empowerment (Cornish & Ghosh, 2007; Evans & Lambert, 2008). Sex workers are continually encouraged to take on further responsibility and challenging new tasks e.g. to solve problems locally rather than asking for assistance, or to give speeches in public, despite nervousness.

Despite the Entabeni Project's commitment to gradually transferring project leadership to women volunteers, the project became mired in pre-existing male-dominated power hierarchies. Mr P, the headman appointed by the chief to facilitate HIVAN's work, refused to relinquish his role as project leader – using it to enhance his own status. Whilst the ECA engaged in extensive counselling with volunteers to build their capacity to demand a voice in project decision-making, they never developed the confidence to do this, or to publicise their growing resentment of Mr P's authoritarian leadership style. Repeated requests by the ECA to Mr P to share leadership with volunteers were politely ignored. Reliant on him for their access to the community, the project would have been discontinued had its ECA challenged him too assertively.

The Sonagachi Project was also established in a pre-existing context dominated by organised groups of men (including local representatives of political parties and pimps). How did it create a relational context more accepting of sex worker leadership, and less prone to male colonisation? In the early days, the ECA carefully aligned the project with the interests of those holding power. He emphasised to local men that this was a modest health project which did not seek to change the structure of the sex trade, and that it was in the economic interests of madams, pimps and landlords/landladies for the sex workers to be healthy. By doing so, he sought to establish a project run by women from the outset, and which, by keeping a relatively low profile, would not attract too much interest or resistance from those in power.

Still, as in Entabeni, the ECA depended on local gatekeepers for access to the community, and these relationships had to be carefully managed. Local madams join the project as members, and take on official roles, including committee membership. However, powerful members are prevented from dominating over sex workers, in part, by the ECA retaining a position of authority in the project, and establishing (if not enforcing) the commitment to sex workers' empowerment.

Bonding social capital: building a supportive project community

Both projects operated with a sophisticated understanding of diverse local interest groups and the need to negotiate with local gatekeepers, but tackled this in different ways. The notable difference was in the degree of diversity within each project's initial conceptualisation of its project community. Entabeni tried to immediately mobilise a diversity of local supports, responding to the volunteers' view that AIDS stigma, combined with lack of support from the chief, headmen, local men and other community groups, undermined the effectiveness of their caring work. Youth had themselves expressed a strong interest in becoming involved at the formative research stage. Yet when efforts were made to mobilise the support of these groups none of them perceived any benefit from involvement, and thus were very difficult to mobilise.

Sonagachi, on the other hand, began by targeting a less diverse community, namely local sex workers. Sex workers shared stark problems, including economic insecurity, physical danger in the red light area, and (eventually) HIV/AIDS. It was immediately clear to them that they had much to gain through their involvement, and the rationale for working together was more obvious. Once a foundation of sex worker mobilization had been secured, the project later expanded its focus, seeking to mobilise sex workers' boyfriends, children, and other relevant actors, to join the collective struggle. The more diverse and unequal the project community, the more difficult it is to forge a supportive relational context.

Bridging social capital: building outside support for project activities

What was the quality of alliances projects were able to form with outside groups? In this regard, Sonagachi was considerably more successful. An explicit Entabeni goal was to build partnerships between volunteers and the public and NGO sectors. The project built strong links with two NGOs – small, with shoestring budgets, with project goals resonating strongly with NGO goals. The first was the local branch of a national counselling charity, which funded and provided all the volunteer training. The second was a local development committee – run by an individual missionary – which funded and built an AIDS hospice and crèches for AIDS orphans.

However the project failed to establish long-term partnerships with local government bodies, including health, welfare and municipality. The ECA worked long and hard to persuade

agencies that the project could help them perform their core functions more effectively. However, despite enthusiastic principled agreement, with several agencies pledging help and hoping the project might constitute a pilot study of 'best practice' to be replicated more widely, this enthusiasm failed to turn into any real long-term involvement. Public sector agencies were overworked and under-resourced. Hierarchical work structures prevented them from being responsive to the needs of small grassroots communities. Many personnel lacked training in community outreach skills, as well as personal motivation to engage with poor people as equals. They also lacked confidence in their ability to impact on what they regarded as the overwhelming problems of AIDS and poverty. The ECA lacked any institutional leverage to tackle this. Project success was totally dependent on increased public sector involvement in two ways. Firstly the project plan relied heavily on increasing peoples' access to public sector health and welfare services, grants and stipends in achieving its goals. Secondly, the plan had been to gradually 'institutionalise' the project through handing over its coordination from the ECA to a 'partnership' committee where public sector agencies would play a key role. Without these, the project's potential success was doomed.

By contrast, Sonagachi has gained impressive support from powerful Kolkata actors. They have persuaded officials to register their cooperative bank despite concerns that sex workers were not 'of good moral standing' – a legal criterion for groups to register a cooperative. They have built good relationships with politicians, leading e.g. to the city mayor donating municipal land to the project for a clinic. Good relationships with the media lead to positive news coverage. It is not easy to ascertain why the relational context was initially more facilitative in Sonagachi than in Entabeni. However, as the Sonagachi Project gained momentum, the women's unity and their emerging positive image became important resources supporting negotiations with outside groups. Politicians became interested to support the project because the unified sex workers were a potential vote bank, and because they could gain positive PR and media attention by showing they were doing good work for poor 'fallen women'. Police were more willing to take sex workers' complaints seriously, and not to abuse them, because the project could mobilise inconvenient protests with women chanting slogans at the police station.

Relationships between grassroots people and the various outsider professionals with whom they need to work, such as doctors, schoolteachers, or bank officials are also a form of bridging social capital. Compared to Entabeni, the Sonagachi Project has established its own infrastructure, often parallel to mainstream services (e.g. its own clinics, banks, and education for children and adults). The possible disadvantage of this approach – that it requires continual financial input – is perhaps compensated for by the fact that the project has greater control and influence over the behaviour of the doctors, nurses and clinic staff, than they would have if trying to influence mainstream services. An attitude of respect and equal treatment for sex workers is explicitly part of everyone's job description.

Conclusion

In comparing the experiences in Sonagachi and Entabeni, we have sought to understand why the efforts at initiating transformative communication seem to have flourished in Sonagachi but failed in Entabeni. We have argued that transformative communication is unlikely to be practiced in a non-transformative context, and have illustrated how aspects of the material, symbolic and relational contexts of our two case studies profoundly shaped the possibility of successful transformative communication. Thus, we suggest that *creating enabling environments for transformative communication* is a crucially important, though often neglected element of community health programmes. We hope that our discussion may help to raise this aspect of community health programmes further up the agendas both of academics and of programme planners and designers.

What have we learned from our comparison regarding how community health projects may best create social environments that support transformative communication?

On one hand, we may point to pre-existing aspects of the social context in Entabeni which deeply undermined their efforts, compared to Sonagachi. Local power hierarchies dominated Entabeni's activities. Effective transformative communication would have been too disruptive of traditional social relations. Too many powerful local actors had a vested interest in preserving the very adult and male-dominated social relations that facilitated HIV-transmission, undermined effective care and disempowered the volunteers. In comparison, Sonagachi was located in a thriving cosmopolitan city, with a pre-existing political context that was not averse to social change, or unfamiliar with marginalised groups demanding rights. There was a less overwhelmed public sector, more willing to provide small but vital project-supporting benefits such as ration cards, and school places.

On the other hand, differences in the approaches taken to tackle their environments may also be illuminating. A key limitation of the Entabeni Project was its failure to secure the long-term material and relational support that should have been provided by public bodies (a stipend for volunteers, public sector involvement in the partnership committee, assistance with agricultural development and so on). The project was unable to incentivise project participation and support in a way that would mobilise key actors within and outside Entabeni. In Sonagachi, shrewd incentivising and a gradualist approach enabled the project firstly to be permitted by the powerful to exist, and only later to challenge that power hierarchy. Initially it aimed for no more than technical communication, and only through using incentives in line with the interests of the powerful did it gradually begin to implement transformative communication.

This difference in approaches to engaging with important stakeholders may be related to Sonagachi's relatively organic, evolutionary approach – from an initial goal of AIDS-awareness and condom distribution to a more ambitious commitment to communication for

social transformation. In developing a more complex agenda over time, project leaders and participants 'felt their way forward' in small steps over a 12-year-period. They moved at a speed that relevant actors and agencies could keep pace with.

The Entabeni Project was perhaps let down by an overly optimistic critical social theory of 'empowerment via grassroots participation and partnership-building'. Whilst the proposal was based on wide consultation of local residents, it was also filtered through ideals of transformative communication rooted in the ideas of thinkers such as Freire (1973), Habermas (2006) and activist interpretations of Foucault (Gaventa & Cornwall, 2006). Drawing on such work, the project sought to engage men and external groups in authentic dialogue and a shared commitment to social transformation, and aimed to secure sustainability within 3 years, by establishing a partnership of mainstream agencies to take the project forward. However, our comparison of Sonagachi and Entabeni highlights the practical reality that much work always needs to be done in adapting abstract 'theories of change' to specific social circumstances. The realities of poor, disrupted and disempowered communities militate against the possibility of women asserting confident and politicised voices, and of more powerful groups listening to them. The powerful are unlikely to respond to the needs of poor women simply through being invited to take part in a dialogue, but only if they see some personal, political or economic gain from doing so. Creating conditions in which poor people develop a voice, and in relevant social groupings are willing to listen, may more often be a case of *realpolitik*. We believe that a vital factor in Sonagachi's success has been its skill in capturing the personal, political and economic interests of the powerful in quite a calculating way – rather than from engaging them in mutually respectful dialogue as advocated by critical social theorists.

In sum, we have argued that transformative communication requires *both* the development of a community's 'voice' *and* the development of enabling environments for that voice to be heard. Sex workers or female volunteers are not heeded simply because they have developed an articulate voice, but because they are supported by a symbolic context that recognises their legitimacy, a material context that gives them the confidence as well as a secure basis from which to take risks, and a relational context in which their listeners have a clear interest in taking them seriously.

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