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Sensitising Grass Roots Leadership on Health Issues

Experiences of a Pilot TV Project

In 1998 a pilot training project to orient panchayat members on health issues took off in Karnataka's Chitradurga district. The 'experiment' received wide acclaim, as the methodology employed was participatory and post-training evaluation revealed higher levels of awareness and self-confidence in local participants in the programme. This paper analyses how a follow-up training project was developed soon after to create awareness on reproductive and child health issues using the medium of television. Informal channels such as television proved effective in initiating important attitudinal and behavioural changes at grass roots level, where a majority of people may have had little formal education.

T V SEKHER

Decentralisation is widely viewed as a way to make government more efficient and responsive to people's needs in the delivery of public services. Such a people-centred grass roots level development process not only needs devolution of powers to the rural masses, but also sensitising them, particularly the leaders, so that they can act on their own behalf for their own common weal. Sensitising people at the grass roots level on development issues is, thus, an integral instrument of the development process used to design and execute welfare activities by the people, for the people. Rightly, the 73rd constitutional amendment offered the much needed impetus for local government through the three-tier system of governance with zilla panchayat at the district level, taluk panchayat or block panchayat at the intermediary level and gram panchayat at the village level. The members to these bodies are elected directly by the people with one-third of seats reserved for women, and another third for the members of the weaker sections such that all sections of people are given an opportunity to participate in planning their own development. Thus, a great aspiration and expectation is laid on their functioning effectively.

Need for Sensitising Elected Representatives

The elections for Panchayati Raj Institutions (PRIs) are regularly held at stipulated intervals and there could be around three million elected members in panchayats (rural self-governments) and nagarpalikas (urban municipal bodies) in India. Among them, one-third elected members would be women and another one-third the weaker sections. The policy of reservation has provided a unique opportunity to the weaker sections, particularly women, for political participation and decision-making in the local governance process. Most of these members would be taking up the role of decision-makers for the first time and they need to be educated, motivated and trained about their rights and responsibilities. Considering the wide divergences and the element of heterogeneity in their social, economic and educational backgrounds, it may turn out to be a difficult task. Given the relatively lower educational attainments of panchayat members, lack of exposure to any kind of governance outside (overwhelming majority of the women members are housewives and belong to deprived communities) and political inexperience, their participation in

the PRI system and ability to discharge their responsibilities would not be very effective. Therefore, in order to make decentralised democratic planning effective and functional, it is imperative to sensitise these grass roots level leaders about their new roles and responsibilities through motivation and education.

The devolution of powers to plan development has automatically placed a great responsibility on the panchayats in prioritising, planning and implementing the social development programmes. At the same time, it calls for a certain level of expertise and skills, which the new members may not possess. The task of training and reorienting the large number of the panchayat members may, thus, require innovative approaches to support them function effectively. In 1993, the government of India appointed an expert group, under the chairmanship of M S Swaminathan, to draft a national population policy. The group suggested a paradigm shift and conceptualised population policies within the context of overall social and economic development agenda with greater devolution of authority and responsibilities to the panchayats. The expert group pointed out that development strategies must address the totality of the way people live, think and work. People must have a central role in deciding how they live. Population policies should, therefore, be viewed in the broader context of social development. The expert group suggested that it is necessary to adopt the principle of "think, plan and act locally and support nationally". The New National Population Policy (2000) reiterates the crucial role of panchayats in planning and implementation of health and family welfare programmes. The National Health Policy (2002) further highlights the need for devolving programmes and funds in the health sector through different levels of the panchayati raj institutions.

The planning tool recommended by the expert group for grass roots level social development is a socio-demographic charter (SDC). To be used at the village, town or city level, this tool helps the elected members of the local bodies to prioritise their basic minimum needs and develop feasible strategies for fulfilling such needs within a stipulated time. The grass roots level socio-demographic charter was to be based on a "pro-nature, pro-poor, pro-women and pro-democratic choice" orientation to developmental planning. The major aim of the socio-demographic charter is to assist the local communities to develop an action plan that will help in achieving and continuously improve in the quality

of life, while living within the carrying capacity of the supporting ecosystems. The group also felt that particular attention should be provided to the basic minimum needs in the areas of primary education, primary health care, reproductive health, environmental hygiene, safe drinking water and household nutrition security.

In India, there exists significant inequities between states and regions within the states with regard to health care facilities. To overcome these imbalances, the government of India has established national health norms and directly funds many health and family welfare programmes. Despite the existence of an extensive rural health infrastructure, a vast majority of rural population in India have no access to basic health care facilities. For example, with regard to many health and demographic indicators, considerable regional disparities exist in Karnataka [Sekher et al 2001]. In this context, decentralised planning assumes importance to address issues like regional disparities in health care facilities [World Bank 1993]. Comprehensive health care cannot be provided through public sector health services alone. Experiences all over the world suggest that one precondition for enhancing health status is the community participation. This, to a great extent, can be ensured through the active involvement of democratically elected local leaders in health programmes. The involvement of PRIs in implementation and management of health services would facilitate focused attention on vulnerable social groups, more emphasis on preventive measures, and the programmes can be reoriented to meet the specific local needs. Any meaningful involvement of grass roots level leaders can only be possible by creating awareness in them and training them about their duties and responsibilities in the provision of primary health care in their communities.

The ICSSR/ICMR report of 1981 categorically states that the overall improvement in health conditions is only possible under the PRIs. This would rightly entrust the health and illness care to the people who understand the needs of their communities much more better than anybody else. It was observed that, in Karnataka, an overall improvement in mobilising local resources for strengthening the health infrastructure and greater accountability of health workers under the decentralised set up [Sathishchandra 1993; Sekher 2001a]. In an analysis of decentralised health planning in two districts, Murthy (1998) has argued that even within the existing administrative structures, the district health planning can be made meaningful by focusing on the implementation constraints of service delivery and meeting the needs of the communities. In fact, most of the health problems can be resolved at the local level by imparting health education and provision of primary health care within a relatively affordable cost [Antia and Bhatia 1993]. The major pillars of health care are education, water supply, sanitation, hygiene, environment and availability of food with nutrition. There is, therefore, a need to develop an integrated action plan at the local level on health, nutrition, hygiene, environment and education with sensitivity to gender and population issues. Accordingly, the elected members of the local bodies have to be trained so as to ensure their participation in the process of social development. This training will help the elected members to develop an understanding of the specific needs of their communities and prepare a socio-demographic charter on the lines of the Five-Year Plan at the central and state governments. This charter will help the elected members of local bodies to prioritise their basic minimum needs and develop a feasible strategy for implementing them within a stipulated time frame. In Karnataka, the task force on health and family welfare has emphasised the necessity to orient the elected members to formulate model health plans and village health committees [Government of Karnataka 2001].

In view of the foregoing discussion, a need was felt to evolve suitable methodologies for the training of the panchayat members including the development of training materials. Reportedly, all the state governments have set up training institutes for panchayat members. Presumably, their number, capacity to handle a large group, training content and methodologies, and professional competence would be inadequate to undertake such a task. Generally, training institutions under the government are bureaucratized whereas the need is for it to be innovative and flexible. Moreover, the number of panchayat members in every state would be far greater than the capacity and network of training institutions to handle such a large training load. In a situation like this, where we have to train a large number of elected representatives in each district (preferably during the first three months of their tenure), the government alone cannot handle this task. It is, therefore, imperative to look for more effective, acceptable, participatory and less time consuming training methodologies at the grass roots level.

The Karnataka Experiment

The first phase of the training and orientation of panchayat members on health issues in Karnataka started in 1998 when Institute for Social and Economic Change (ISEC), Bangalore, undertook a pilot training project in Chitradurga district on issues related to social development. By using locally available resource persons and specially developed training modules and video documentary, a new training methodology was evolved with the cooperation of local NGOs. The training, arranged in the informal atmosphere of the villages, facilitated greater participation of local leaders. The local volunteers, who imparted the training, were familiar with the local situations. It gave an added advantage to the training exercise and ensured that their services would be available to the elected members any time in future. The involvement of voluntary organisations in this innovative programme ensured better participation of the representatives of the local bodies. It also facilitated a convergence of expertise and skills of government and non-governmental sectors for a better and a more effective training exercise at the grass roots level. The Chitradurga experiment received wide acclaim from trainers and the government. The methodology was found to be participatory and less time-consuming. The post-training evaluation revealed that the training contributed significantly not only towards enhancing the level of awareness and self-confidence among the local leaders, but also towards improving their performance with regard to the provision of basic health care [Sekher 2001b].

Considering the initial Chitradurga experience and the necessity to train grass roots level leaders, there was a felt need to evolve suitable strategies and methodologies for training gram panchayat members. It may be pertinent to mention at this stage that the primary focus of the training programmes has to be on empowerment of the panchayat members to enable them to perform their role effectively rather than on training of the individuals. Besides, the methods of training also needed to ensure long term sustainability of the programme that can be achieved through effective follow-up and evaluation mechanisms. More specifically, there is an urgent need to inform, train and motivate the members on issues related to female literacy, public health, sanitation, nutrition, family planning and women's status.

In this context and keeping in view its earlier experience in developing a suitable training methodology in Chitradurga district, a follow-up pilot training project for gram panchayat members to create awareness about reproductive and child health (RCH) issues using the electronic mass media was undertaken by ISEC

at the request of the Population Foundation of India. Mass media, despite the initial costs of production, usually reach a large audience at a relatively low cost per person. Television is a very popular form of mass media and has a vast reach across all the categories of population. According to National Family Health Survey-2 (1998-99), at the national level, 46 per cent of women watch television at least once a week. Six years back, the figure was just 32 per cent. The rapid increase in exposure to television has been accompanied by decrease in exposure to radio and visits to cinema halls. In Karnataka, 58 per cent of women are regularly exposed to television. In a country like India, where a significant proportion of population are illiterate or have little formal education, informal channels such as television can play an important role in bringing about changes in their attitudes and behaviour. The role of video films is very crucial in communicating with the semi-literate and illiterate panchayat members [Bose 2000].

Accordingly, the main objective of the exercise was to train the members of the PRIs, community leaders and health workers through the medium of television. Its aim was to educate and sensitise the panchayat members and service providers towards health and population issues (empowerment of women, literacy and education, communicable diseases, reproductive and child health, family planning methods and population and development) and about their roles and responsibilities.

Training Methodology Adopted

As a first step, a need was felt for a comprehensive handbook or reference manual on Reproductive and Child Health Issues (RCH) for the state. There are a few government publications, but, they generally focus only on one or two aspects of RCH. Many field level staff of the government, particularly ANMs and anganwadi workers, are not familiar with various components of RCH. They are also not in a position to clarify the doubts raised by villagers on various health problems. In this context, the ISEC project team in collaboration with the department of health and family welfare, government of Karnataka, prepared a comprehensive handbook on reproductive and child health for the use of the field staff, NGOs and panchayats in Karnataka. The handbook was prepared in consultation with leading health-education and medical experts of Karnataka. A one-day workshop was organised at Bangalore to discuss the contents and presentation of the handbook. About 25 ANMs and 20 anganwadi workers from various districts of Karnataka were invited to the workshop to present their views and suggestions. Besides the consultants, a panel of medical and health education experts interacted with the participants to understand their requirements at the grass roots level so that the handbook could address the issues more specifically. The handbook, that was subsequently prepared, contains 13 chapters covering – adolescent health and personal hygiene, age at marriage and importance of women's education, pregnancy and pregnancy care, delivery and post-natal care, care of new-born babies, importance of breast milk and supplementary feeding, children's immunisation, diarrhoea and respiratory infections in children, family welfare, abortion and post-abortion care, reproductive tract infections, nutritious food and iron deficiency anemia. This multi-colour, 132-page handbook in Kannada also gives pictorial illustrations and examples in a lucid language for ready reference of the grass roots level service providers. The state government has printed and distributed 47,000 copies of the handbook to all ANMs and anganwadi workers in the state. The copies of the handbook have been

sent to the individual workers at their address. The health training institutions and NGOs in the state use this handbook as a standard reference material for training field workers. ISEC has received wide appreciation for the handbook from NGOs, health workers and anganwadi workers from all over Karnataka on the accuracy of information, besides its high quality and user friendly presentation. This handbook served as an important reference material for NGO volunteers in this training project to clarify the doubts raised by panchayat members after viewing the TV programmes.

Secondly, keeping in view the wide coverage throughout the state, it was decided that Doordarshan may be the most appropriate medium to reach out to the rural leaders and field workers. It was, therefore, decided to prepare health education programmes for telecast through Doordarshan. Once again, besides the earlier collaboration to prepare the handbook on RCH, ISEC collaborated with the state health department in the production of a TV serial on health issues. As a part of this collaboration the department of health and family welfare, government of Karnataka, funded the production of a TV serial on health education and empowerment as an activity under the Information Education Communication (IEC) component of the India Population Project (IPP) – IX. Titled as 'Thiliyavva Thangi', the serial covered various aspects of RCH. This TV serial was used for educating and orienting gram panchayat members in this training project. ISEC approached Bangalore Doordarshan Kendra for re-telecasting the serial for this purpose and an agreement was reached with the Prasar Bharathi corporation in this regard.

Considering the convenience for the panchayat members to assemble in a common place in their village wherever television sets are available, it was decided to schedule the telecast in the evenings between 6 to 6.30 pm on Thursdays during June to September 2002. As per the agreement 12 episodes were telecast during this period. Sufficient publicity was given before the commencement of the project through Doordarshan, NGOs and primary health centres.

Thirdly, for a successful implementation of the project, it was felt that the training programme for panchayat members should be carried out by a lead voluntary organisation working in the district. This was perceived as having the following advantages: (a) generally, NGOs work and live closely with the people and they would have greater ability to perceive and internalise the felt needs, and greater appreciation of the interests and attitudes of the people in their respective areas; (b) it was considered that the NGOs can evolve an appropriate training methodology for the purpose as well as ensure the participation of all concerned; (c) the expertise of NGOs in conducting such training programmes and their familiarity with local conditions, was perceived as the positive aspects of this type of methodology. Accordingly, it was decided to implement the training project in six districts of Karnataka selected on the basis of their various socio-economic characteristics, health and development indicators and geographical locations. The six selected districts were Gulbarga, Dharwad, Mysore, Bidar, Bangalore rural, and Bijapur.

Based on their experience in providing health care services and their expertise in imparting health education, the following six voluntary organisations were selected for the project implementation in the six selected districts:

- Family Planning Association of India, Dharwad Branch (Dharwad district)
- Swami Vivekananda Youth Movement, H D Kote (Mysore district)
- Jayanthi Grama Women and Children Welfare Association (Bijapur district)

- Grameena Abyudaya Seva Samsthe, Doddaballapur (Bangalore rural district)
- Family Planning Association of India, Bidar branch (Bidar district)
- Action for Rural Reconstruction Movement, Shorapur (Gulbarga district)

A two-day workshop was organised in May 2002 at ISEC to design the strategies for project implementation. Selected NGO personnel, health education and media experts, and government officials participated in the workshop at which the modalities for implementation of the project were finalised. A one-day orientation programme to sensitise the volunteers of the six NGOs on the following issues was also organised at the headquarters of the NGO concerned:

- to discuss the modalities to bring the panchayat members to the TV viewing sessions in each village;
- to familiarise the volunteers about the contents of each TV episode;
- to organise a meeting of all gram panchayat presidents and secretaries to finalise the venue for group viewing and making necessary arrangements before the telecast of the first programme. The idea was to seek their cooperation and active involvement as well as to give sufficient publicity for the programme;
- to brief volunteers to make necessary arrangements for group viewing, arranging discussions and clarifying the doubts raised by panchayat members after every episode of the TV serial;
- to enable them to organise a pre and post-telecast evaluation by administering a well-designed questionnaire supplied by the ISEC; and
- to supervise the implementation of all aspects of the programme in the project areas (selected gram panchayats in six districts).

The volunteers of selected NGOs were trained in various aspects of health care and health education and each one was entrusted with the responsibility of bringing PRI members to the TV viewing sessions for group viewing and facilitate discussions in each village. This new training methodology was appreciated by both panchayat members and volunteers. Through this project, we are also creating a pool of trained and committed volunteers in the villages and their services will be available for future health care programmes.

In the districts, the respective NGO convened a meeting of all the gram panchayat presidents and secretaries to discuss the modalities of organising the group viewing sessions. Considering the convenience of local leaders, the venues were decided and a time schedule of the telecast and contents of each TV episode were distributed to them well in advance. Through this process, the NGO and the volunteers were able to establish good rapport with the grass roots level functionaries.

Accordingly, the fourth step involved the telecasting of the health programmes. After completing the orientation programme for NGO volunteers and discussions with gram panchayat presidents and secretaries, the arrangements for group viewing were finalised by the volunteers in their respective villages. The schedule of the telecasting and a summary of each episode were given to the volunteers and panchayat members well in advance. Doordarshan also made all efforts in giving maximum publicity for the programme. The first episode was telecasted on Thursday, June 20, 2002. The active involvement of volunteers and constant supervision by NGO leaders helped in ensuring the participation of majority of gram panchayat members from the project areas. Altogether 110 gram panchayats from six districts were covered in the programme.

Though the TV programmes received appreciation from panchayat members, volunteers, health workers and general public, few practical operational difficulties were encountered:

- (a) Many times there was no power supply to switch on the TV sets. The frequent power failures in some areas caused inconvenience to the viewers.
- (b) In a few villages, TV sets were not available. Even if available, the reception was not very good.
- (c) In some areas, where the villages were scattered (particularly in tribal areas like the H D Kote taluk in Mysore district), it was extremely difficult for members from different places to assemble at one place for group viewing, that too in the evenings.
- (d) A reluctance on the part of panchayat members belonging to different castes to assemble in one place was observed in one or two villages.
- (e) In few villages which there was access to cable TV, DD-1 channel was not relayed at all.

To understand the level of awareness (among panchayat members), about various health problems, a questionnaire was canvassed just before the telecast of the programme. The same questionnaire was administered again after the telecast of the episode among the panchayat members who gathered to watch the TV programme. The questions were related to the particular episode telecasted. Individual questionnaire for each episode were prepared and distributed by ISEC to the NGOs. The local NGO volunteers were given the responsibility of administering the questionnaires (both pre- and post-telecast) in their villages. An analysis of the pre- and post-telecasts was carried out by the ISEC and shows very interesting observations and findings:

- (a) It was found that the awareness level is quite low among the panchayat members about certain health aspects like care to be taken during pregnancy, problems of adolescent girls, high-risk pregnancy and delivery care, iron-deficiency anaemia, and immunisation schedule for children.
- (b) The level of awareness and knowledge increased significantly after viewing the TV episode. In some cases, it has increased by about 50 per cent.
- (c) Based on the analysis, it was observed that a majority of the members were able to grasp the messages from each episode easily.
- (d) Good number of panchayat members had wrong notions about various health aspects relating to breast feeding, family planning methods and adolescent health problems. After viewing the TV programmes, these misconceptions have been corrected to a great extent.
- (e) It was found that the awareness level is comparatively low among the members belonging to scheduled caste/tribe category. On most of the health issues, the level of awareness among female members was slightly better than male members of the similar socio-economic background.

By and large, the TV serial received good viewership from the general public in the project areas. Particularly, in villages where the local NGO volunteers took initiative, the response was overwhelming. Where combined efforts were put in by NGO volunteers and the local ANM, excellent participation of villagers was observed. But in certain areas it was found that the public were not aware of the programme. Villages where cable connections were available and people had access to many private channels, the Doordarshan programmes received little attention.

In order to increase the viewership, ISEC introduced a cash award of Rs 500 each to five respondents, to be picked up out of those who give correct answer to the question that was announced after the telecast of the episode every week. This was

introduced with the telecast of third TV episode. Viewers from all over Karnataka responded to these questions by sending their answers in post cards and on an average, about 400 responses were received by ISEC every week. The names of the recipients of cash awards were announced during the telecast of the next episode. Altogether 45 individuals from various parts of the state, including panchayat members, received prizes.

Programme Evaluation

After the completion of the telecast, it was decided to evaluate the effectiveness of the training methodology and its impact on panchayat members. This was expected to help in identifying the strengths and weaknesses of the project and lessons to be learnt. It was also felt that the insights drawn from the evaluation exercise would provide useful inputs for formulating training programmes in future and its successful replication elsewhere.

In order to examine the effectiveness of this training methodology and its acceptability among panchayat members and volunteers, a field level evaluation was carried out during November-December 2002. 117 gram panchayat members were randomly selected and structured questionnaires were administered. For this purpose, five gram panchayat members each from 24 villages, spread across six districts, were contacted. Their experiences, opinions and suggestions were recorded.

Using a structured questionnaire, 54 volunteers from six voluntary organisations were interviewed and their experiences and suggestions were elicited. Apart from this, detailed discussions were held with the NGO office-bearers and health departmental officials. Local functionaries like ANMs and anganwadi workers were also contacted at the time of evaluation to seek their opinions.

Based on the analysis of the information gathered from panchayat members, the following observations were drawn:

- (a) Television can be used as a powerful medium for orienting panchayat members as it provides audio-visual effects. Majority of the panchayat members felt that it was very effective in conveying desired messages.
- (b) Television sets are available in almost all the villages and the per cent of population frequently viewing the TV programmes irrespective of social, economic and gender background, is increasing day by day.
- (c) The local volunteers persuaded many panchayat members to view the TV programmes on a regular basis and this was appreciated by all.
- (d) Almost all panchayat members felt the TV programmes were very informative, useful and helped them in discharging their responsibilities effectively as community leaders.
- (e) The telecast helped in overcoming certain practices and superstitious beliefs, particularly with regard to puberty, breast-feeding and immunisation.
- (f) Eighty per cent of the panchayat members stated that the timing of the telecast was convenient for them. However, among members who owned TV sets a good number of them mentioned that anytime after 7 pm will be more convenient for them to view.
- (g) Ninety-two per cent of the panchayat members interviewed stated that they received information about the TV programme on RCH well in advance and the local volunteer informed him/her personally. Most of them mentioned that if there was no communication by the volunteer, they might not have known about the programme.
- (h) In many cases, a group discussion was conducted after watching the programme. Local volunteers were able to clarify

the doubts raised by the panchayat members. But, in some occasions, there was no group discussion and members left the place immediately after the telecast.

(i) Since the volunteer was most often from the same village, he/she was familiar with the panchayat members. Interestingly, after this project, panchayat leaders continued to consult and involve the volunteer in all the health related activities and programmes in their respective areas.

(j) Some panchayat members stated that the NGOs arranged video presentation of the serial in their villages. This was done mostly with the help of the gram panchayat president and secretary.

(k) Ninety-five per cent of the respondents stated that they want the TV serial on RCH to be re-telecast. Some of them suggested that instead of Doordarshan, even private Kannada channels could be used for this purpose.

The information gathered from the local volunteers and discussions with the NGO office-bearers provided the following broad conclusions:

(1) Eighty-seven per cent of the local volunteers involved in the project had some previous experience in implementing the NGO programmes on health. Most of them had undergone training on RCH issues either organised by the NGO or the government. at some time or the other.

(2) All the volunteers felt that the handbook on RCH provided to them in this project was very comprehensive, lucid and helpful in understanding various components.

(3) All the volunteers involved in this project attended the one-day orientation programme organised by the NGO. They had also seen the TV serial before the actual telecast of the programme and were familiar with the contents of each episode.

(4) Seventy-three per cent of the volunteers stated that they received good support and cooperation from the panchayat presidents and members for arranging group viewing in villages. But a few also reported the indifferent attitude of some panchayat leaders towards health education programmes.

(5) In some areas, the group viewing was arranged in the panchayat offices. But in other cases, it was arranged in a convenient location, either in the house of a member or any other person.

(6) The evaluation revealed that though the panchayat office-bearers cooperated well with the volunteers, similar response was not forthcoming from the primary health centres. However, in a few villages, where they cooperated, the response and the impact were tremendous.

(7) In some areas, the local volunteers were able to involve anganwadi workers in the programme.

(8) The monitoring and the supervision of the programme by the NGO were reasonably good. However, the evaluation indicated that better supervision would have yielded more positive responses from volunteers and panchayat members.

(9) Ninety-three per cent of the local volunteers stated that they were ready to help the panchayat members and were willing to undertake similar training programmes in the future.

(10) Some volunteers also suggested that the subject coverage of the TV programme could be expanded by incorporating topics like sexually transmitted diseases, AIDS, etc.

(11) It was found that in a few villages the private cable connection networks are not telecasting the Doordarshan channel. This adversely affected the project in some villages.

(12) We also observed that in few villages (in H D Kote taluk in Mysore district), the panchayat members at their own initiative, hired the antenna to view the TV serial on RCH.

(13) In some villages, the volunteers mobilised the support of women self-help groups and mahila mandals in arranging and

viewing the programme. Their participation generated lively discussion after viewing the TV serial.

A few cases illustrating the impact of the TV serial on viewers (panchayat members) in the project areas have been presented here:

(1) After viewing the programme on age at marriage (episode no:3), a discussion was followed in the Hosahalli gram panchayat in Doddaballapur taluk. One member raised the issue of the marriage of a girl aged 12 years in the village to be shortly conducted. The gram panchayat members decided to persuade the parents not to go ahead with the marriage. After much persuasion and threats then the matter would be brought to the attention of the police, the parents agreed to postpone the marriage and let the girl continue her schooling.

(2) One woman gram panchayat president in Dharwad taluk stated that she had no idea of how to breast-feed her twins. After watching the serial on breast-feeding, she understood the method of breast-feeding the twins.

(3) The orientation had a positive impact on the functioning of PHCs and sub centres. It was observed that the panchayat members started monitoring attendance of doctors and para-medical staff in some areas.

(4) The panchayat members started persuading the untrained dais in their villages to undergo training at the PHCs.

(5) In a few villages, it was observed that the panchayat members had started monitoring the functioning of the anganwadi centres (ICDS).

(6) During the training programme, the panchayat members learnt that oral rehydration salt (ORS) packets could be acquired and

stored by them for emergency use. Many members collected ORS packets from the health centres and started distributing them to their community members.

Lessons Learnt

To discuss the outcome of the project and lessons learnt, a state level workshop was organised at Bangalore on January 24, 2003. The representatives of the Population Foundation of India, state health department, state institute of health and family welfare, ISEC, six collaborating NGOs and health education and communication experts participated in it. The findings of the evaluation of the project, carried out by the ISEC, were presented for discussion. The participants appreciated the excellent coordination of the project which involved NGOs, Doordarshan, health department and ISEC. The project has demonstrated that television can be used as a powerful and effective medium for educating and training grass roots level functionaries spread all over the state. However, the mere telecasting of the programme would not yield the expected results. This should be combined with grass roots level efforts by the NGOs and field workers to inform and motivate the panchayat members about the advantages of the programme.

Another workshop was organised at Dharwad on January 25, 2003 in collaboration with the Family Planning Association of India. The opinions and suggestions of the volunteers involved in the project and the panchayat members participated in the programme were discussed in this workshop. Twenty five volunteers and 40 panchayat members participated in the discussion

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Explanation : It is a highly prestigious endowed Chair created recently with the financial support of the Ford Foundation. It is a termed position for three years extendable for two more years. Preference will be given to a female scholar of eminence belonging to North East India.

Qualifications :

- Master's degree in any discipline of Social Sciences
- Ph. D. or published works of equivalent standard
- 10 years of teaching and research experience
- Familiarity with field research
- Experience in conducting independently major research studies
- Experience of supervising Ph. D. scholars and other Junior Research Fellows

Job responsibilities :

- to conduct individual and Institute's research studies relating to peace and conflict resolution
- to organize seminars/conferences/workshop on peace
- to supervise research studies of Institute's Junior and Ph. D. research fellows

Selection procedure :

Selection will be made on the basis of bio-data of short-listed candidates.

Application in the prescribed form enclosed with the advertisement, also available in the Institute during working hours, should reach the Director, Omeo Kumar Das Institute of Social Change and Development, Chenikuthi, K. K. Bhatta Road, Guwahati - 781 003, on or before December 10, 2003. The applicants need not submit their certificates/testimonials.

along with the representatives of the NGO, ISEC, and PFI. The overwhelming response from the panchayat members show that they wanted the telecast to continue and also suggested incorporation of some more health issues in the TV serial. The panchayat members also agreed that they would organise video shows of this programme in their villages using the video cassettes supplied by the ISEC. In some villages, the video shows were already arranged not only for the panchayat members, but also for the public. This TV programme undoubtedly had some impact on the attitudinal and behaviour pattern of elected members. It was really a learning experience for some of them since this was the first training in health issues for a majority of them. They acquired knowledge on various health issues and governmental programmes, irrespective of their educational and occupational backgrounds. Our field visits revealed that some of the panchayat members had already started putting their newly acquired knowledge into practice.

It was found that the women panchayat members expressed more interest and willingness to view the TV programme. They felt that regular health education programmes should be arranged for women. In rural areas, it is a well known fact that women and children are the main victims of lack of food, nutrition and health care. Many members expressed the feeling that in most cases the health needs of women got neglected and were attended to only when it becomes a crisis. They realised that timely advice and treatment could save the lives of many pregnant women and infants. Some women members asked the health workers to regularly visit their villages for providing ante-natal care.

The volunteers were able to acquire the requisite knowledge and organising skills which helped in the successful implementation of the project. Most of the volunteers had some previous experience in organising training and imparting health education. This helped them undertake the prescribed task in a relatively easy manner. They were constantly in touch with the panchayat members in their areas and were also invited and consulted on many occasions. They stated that the handbook on RCH was very helpful in explaining many health problems. The volunteers also felt that in some areas the panchayat members had a good understanding of health problems and actively participated in the discussions after viewing the TV serial. The volunteers opined that the active involvement of health department staff in the training was required for better outcome. Our evaluation shows that the project was able to create a pool of trained volunteers who were willing to help the panchayat members and were available in local areas.

Recommendations

In India, we have to train a large number of elected representatives of panchayats and create awareness about various developmental issues and programmes. State governments and a few training institutions alone cannot handle this gigantic task. It is, therefore, imperative to look for more effective and acceptable methodologies for orientation, including use of the powerful electronic media and involvement of voluntary organisations. This action project in Karnataka was an innovative effort towards this end. The following are some broad recommendations based on the Karnataka experiment.

- (i) There is an unanimous view that this kind of health education programme should continue and be extended to all parts of the state.
- (ii) Narrow casting of health education serials should be considered as an effective alternative for the Doordarshan in view of its low cost and easy and sustained implementation.
- (iii) In view of the spread of multiple private entertainment

channels even in remote villages, the cable operators in most of the villages are not telecasting Doordarshan programmes which is affecting most of the governmental initiative in carrying the message to the people. The Prasar Bharati Act prohibits the non-inclusion of DD channels by private operators. Steps should be taken to ensure that the cable operators compulsorily beam DD channels as per the act.

(iv) All the state ministries of panchayat raj should be persuaded to issue directions to all the panchayati raj institutions in their jurisdictions to participate in the developmental education programmes organised by various departments and agencies from time to time.

(v) The department of health and family welfare in the states should take an active role in such programmes by directing the functionaries from PHCs to sub-centres to actively participate in such programmes and to lend technical and other necessary support to make such programmes a success. It should be realised that this will also help the health department to implement their own programmes much more effectively as their participation in such programmes will build up the required support from all sections of the society at the grass roots level.

(vi) The governmental efforts alone in health education have been found severely limited. The experience gained in this programme suggests that several NGOs do have the capability and expertise which may be utilised to supplement the governmental efforts in health education and programme implementation. [17]

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