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SENSITIZING PANCHAYATS ON HEALTH ISSUES THROUGH TELEVISION: EXPERIENCES OF A PILOT PROJECT

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SENSITIZING PANCHAYATS ON HEALTH ISSUES THROUGH TELEVISION: EXPERIENCES OF A PILOT PROJECT¹

T V Sekher*

Abstract

A pilot project was undertaken in six districts of Karnataka by ISEC to train and sensitize the Gram Panchayat members on various health issues, using television as a medium. With the help of Voluntary Organizations, Panchayat members were brought to television sets in their villages for group viewing and discussions. The post-project evaluation indicates that this training methodology was acceptable and effective, resulting in a significant increase in the health awareness of members and their readiness to undertake health promotion activities.

Introduction

Decentralization 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 involves sensitizing them, particularly the leaders, towards activating them for their own common weal. Sensitizing people at the grass-roots level on development issues is, thus, an integral instrument of the development process adopted 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 of these bodies are elected directly by the people with reservation of seats for SCs and STs in proportion to their population. One-third for the OBCs and the rest are left to the general category. Within each of these categories, one-third of the seats are reserved for women. The seat reservation on this pattern is to give an equal opportunity to all sections of the people to participate in planning their own development.

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Need for Sensitizing Elected Representatives

The elections for Panchayati Raj Institutions (PRIs) are regularly held at stipulated intervals with around three million elected members in Panchayats (Rural Self-Governments) and Nagarpalikas (Urban Municipal Bodies) in India. Most of these members are 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, their participation in the decision – making process 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 (an 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 decentralized democratic planning effective and functional, it is imperative to sensitize these grass-roots level leaders to 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 prioritizing, 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 panchayat members may, thus, require innovative approaches to help them to 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 in the planning process and conceptualized population policies within the context of the overall social and economic development agenda with greater devolution of authority and responsibilities to the panchayats (Govt. of India, 1994). 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 prioritize their basic minimum needs and develop feasible strategies for fulfilling such needs within a stipulated time. The grass-roots level socio-demographic charter is 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 continuously improving the quality of life while living within the carrying capacity of the supporting ecosystems. The Group also felt that particular attention should be given 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 exist 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 in addressing 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 pre-condition for enhancing health status is 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 Panchayati Raj Institutions in the implementation and management of health services would facilitate focussed 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 be made possible by creating awareness in them and training them in their duties and responsibilities in the provision of primary health care in their communities.

The ICSSR / ICMR (1981) report categorically states that the overall improvement in health conditions is possible only under the Panchayati Raj Institutions. This would rightly entrust the health and illness care to the people who understand the needs of their communities much better than anybody else. In Karnataka, there is an overall improvement in mobilizing local resources for strengthening the health infrastructure and greater accountability of health workers under the decentralised set-up (Satishchandran, 1993; Sekher, 2001a). In an analysis of decentralized health planning in two districts, Murthy (1998) argues that even within

the existing administrative structures, district health planning can be made meaningful by focussing 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 by providing 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 nutritious food. 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 emphasized the necessity to orient the elected members to formulate model health plans and village health committees (Govt. 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 is inadequate to undertake such a task. Generally, the training institutions under the Government are bureaucratized instead of being 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 was started in 1998 when the Institute for Social and Economic Change (ISEC), Bangalore, undertook a pilot training project in Chitradurga district of the state on issues related to social

development. By using the locally available resource persons and specially developed training modules and video documentaries, a new training methodology was evolved with the co-operation of the local NGOs. The training, arranged in an 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 organizations 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 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, a need was felt to evolve suitable strategies and methodologies for training the Gram Panchayat members. It is pertinent to mention here 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 the 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 the 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 (NFHS-2), at the national level, forty-six per cent of the 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 a decrease in exposure to radio and visits to cinema halls. In Karnataka, fifty-eight per cent of the women are regularly exposed to television. In a

country like India, where a significant proportion of the 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 Panchayati Raj Institutions, community leaders and health workers through the medium of television. Its aim was to educate and sensitize the Panchayat members and service providers to health and population issues (Empowerment of Women, Literacy and Education, Communicable Diseases, Reproductive and Child Health, Family Planning Methods and Population and Development) and to 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. The few government publications that are available generally focus only on one or two aspects of RCH. Many field-level staff of the government, particularly ANMs and anganawadi workers, are not familiar with various components of the RCH. Neither are they 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 organized in Bangalore to discuss the contents and presentation of the Handbook. About 25 ANMs and 20 anganawadi 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 the following subjects: adolescent health and personal hygiene, age at marriage and importance of womens' education, pregnancy and pregnancy care, delivery and postnatal care, care of new-born babies, importance of breast milk and supplementary feeding, children's immunization, diarrhoea and respiratory infections in children, family welfare, abortion and post-abortion care, reproductive tract infections, nutritious food and iron deficiency anaemia. This multi-colour, 132 page Handbook in Kannada also gives pictorial illustrations and examples in lucid language for ready reference of the grass-roots level service providers.

The Government of Karnataka has printed and distributed 47,000 copies of the Handbook to all ANMs and anganawadi workers in the state. The copies of the Handbook have been sent to the individual workers. The health training institutions and NGOs in the state use this Handbook as standard reference material for training field workers. ISEC has received wide appreciation for the Handbook from NGOs, health workers and *anganawadi* workers from all over Karnataka on the accuracy of information, besides its high quality and user-friendly presentation. This Handbook served as important reference material for NGO volunteers in this training project to clarify the doubts raised by Panchayat members after viewing the TV programmes.

Second, 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 "*Thiliyavva Thangi*", the serial covered various aspects of RCH and 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 of 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 from 6.00 to 6.30 PM. on Thursdays during June - September 2002. As per the agreement, twelve episodes were telecast during this period. Sufficient publicity was given before the commencement of the project through Doordarshan, NGOs and Primary Health Centres.

Third, for the successful implementation of the project, it was felt that the training programme for the Panchayat members should be carried out by a lead voluntary organization working in the district. This was perceived as having the following advantages – (a) generally, NGOs work and live closely with the people and thus are better able to perceive and internalise the felt needs, and appreciate 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 were 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. These 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 organizations 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 was also organised at the headquarters of the NGO concerned to sensitize the volunteers of the six NGOs on the following issues:

- ◆ to discuss the modalities to bring the Panchayat members to the TV viewing sessions in each village;
- ◆ to familiarize the volunteers with the contents of each TV episode;
- ◆ to organize a meeting of all gram panchayat presidents and secretaries to finalize the venue for group viewing and make 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 on making 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 organize a pre and post-telecast evaluation by administering a well-designed questionnaire supplied by 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 facilitating discussions in each village. This new training methodology was appreciated by both panchayat members and volunteers. This programme also facilitated the creation of a pool of trained and committed volunteers in the villages and their availability 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 organizing 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 a good rapport with the grass-roots level functionaries.

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 telecast on Thursday, June 20, 2002. The active involvement of volunteers and constant supervision by NGO leaders helped in ensuring the participation of a 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 the general public, a few practical operational difficulties were encountered —.

- a) Many times there was no power supply to operate 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 where 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 some villages that had access to cable TV, DD-1 channel was not relayed at all.

To understand the level of awareness (among the panchayat members), of various health problems, a questionnaire was canvassed prior to the telecast of the programme. The same questionnaire was administered again after the telecast of the episode to the Panchayat members who had gathered to watch the TV programme. The questions were related to the particular episode telecast. Individual questionnaire for each episode was 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, carried out by ISEC, shows very interesting observations and findings:

- a) The awareness level was 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 immunization schedule for children.
- b) The level of awareness and knowledge increased significantly after viewing the TV episode. In some cases, it increased by about 50 per cent. It was found that the awareness level was comparatively low among the members of Scheduled Caste/Tribe category. On most of the health issues, the level of awareness among female members was slightly better than that of male members of a similar socio-economic background.
- c) A majority of the members were able to grasp the messages from each episode easily.
- d) A good number of panchayat members had wrong notions about various health aspects relating to breastfeeding, family planning methods and adolescent health problems. After viewing the TV programmes, these misconceptions were corrected to a large extent.

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 the 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 gave the correct answer to the question that was announced after the telecast of the episode every week. Viewers from all over Karnataka, including Panchayat members, responded to these questions by postcards. The names of the recipients of cash awards were announced during the telecast of the subsequent episode.

Evaluation of the Programme

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 the Panchayat members and Volunteers, a field-level evaluation was carried out during Nov.-Dec. 2002. The number of Gram Panchayat members who were randomly selected was 117 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 organizations were interviewed and their experiences and suggestions were elicited. Apart from this, detailed discussions were held with the NGO office-bearers and health department officials. Local functionaries like ANMs and anganawadi 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:

1. Television can be used as a powerful medium for orienting panchayat members as it provides audio-visual effects. A majority of the panchayat members felt that it was very effective in conveying the desired messages.
2. Television sets are available in almost all the villages and the percentage of the population frequently viewing TV programmes irrespective of social, economic and gender background, is increasing day by day.
3. The local volunteers persuaded many panchayat members to view TV programmes regularly, and this was appreciated by all.

4. Almost all panchayat members felt that the TV programmes were very informative, useful and of help to them in discharging their responsibilities effectively as community leaders.
5. The telecast helped in overcoming certain practices and superstitious beliefs, particularly with regard to puberty, breastfeeding and immunization.
6. Eighty per cent of the panchayat members stated that the timing of the telecast was convenient. However, among the members who owned TV sets, a good number mentioned that it was more convenient for them to watch TV after 7 p.m.
7. Ninety-two per cent of the panchayat members interviewed stated that they had received information about the TV programme on RCH well in advance and the local volunteer had informed him/her personally. Most of them mentioned that had there been no communication by the volunteer, they might not have known about the programme.
8. 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, on some occasions, there was no group discussion and members left the place immediately after the telecast.
9. 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.
10. 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.
11. Ninety-five per cent of the respondents stated that they wanted 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 led to 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 organized either by the NGO or by 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 organized 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 got good support and co-operation 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 the panchayat office-bearers co-operated well with the volunteers, but that similar co-operation was not forthcoming from the Primary Health Centres. However, in a few villages, where they co-operated, the response and the impact were tremendous.
7. In some areas, the local volunteers were able to involve the anganawadi workers in the programme.
8. The monitoring and 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 were not telecasting the Doordarshan channel. This adversely affected the project in some villages.
12. It was also observed that in a 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 mobilized 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 to be shortly conducted of a girl aged 12 years in the village. The Gram Panchayat members decided to persuade the parents not to go ahead with the marriage. After much persuasion and some sort of threat that the matter could be brought to the attention of the police, the parents agreed to postpone the marriage and allow the girl to continue her schooling.
2. One women Gram Panchayat president in Dharwad taluk stated that she had no idea of how to breastfeed her twins. But after watching the serial on breastfeeding, she understood the method of breastfeeding 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 the 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 anganawadi 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 organized in 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 ISEC, were presented for discussion. The participants appreciated the excellent co-ordination of the project which involved NGOs, Doordarshan, Health department and ISEC. The project demonstrated that television could 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, unless 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 organized 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 who participated in the programme were discussed in the workshop. 25 volunteers and 40 Panchayat members participated in the discussions along with the representatives of the NGO, ISEC, and PFI. The overwhelming response from the panchayat members shows 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 organize video shows of this programme in their villages using the video cassettes supplied by 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 reached a crisis. They realized 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 to provide ante-natal care.

The volunteers were able to acquire the requisite knowledge and organizing skills which helped in the successful implementation of the project. Most of the volunteers had some previous experience in organizing training and imparting health education. This helped them to 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 a 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.

Suggestions Based on the Evaluation

In India, we have to train a large number of elected representatives of panchayats and create awareness of 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 organizations. This action project in Karnataka was an innovative effort towards this end. The following are some broad recommendations based on the Karnataka experiment.

1. There is unanimous view that this kind of health education programme should continue and extend to all parts of the state.
2. Narrow casting of health education serials should be considered an effective alternative for the Doordarshan in view of its low cost and easy and sustained implementation.
3. 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. As a result, most of the governmental initiative in carrying the message to the people is getting affected. 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.
4. 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 organized by various departments and agencies from time to time.
5. The Department of Health and Family Welfare in the states should play 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 realized 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.

6. 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 utilized to supplement the governmental efforts in health education and programme implementation.

Note

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