Study on Increasing Community Involvement in Reproduction and Child Health Programme

Contents

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We would consider this study to achieve its objectives if it can help in providing a direction to improving the Reproductive and Child Health situation in the country.

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Abbreviations

ANM	Auxillary Nurse Midwife
BPHC	Block Primary Health Centre
CSSM	Child survival and Safe Motherhood
FP	Family Planning
FW	Family Welfare
ICDS	Integrated Child Development Services Scheme
MCH	Mother and Child Health
ORT	Oral Rehydration Therapy
PHC	Primary Health Centre
PR	Panchayati Raj
RTI	Reproductive Tract Infection
RCH	Reproductive and Child Health
SC	Sub Centre
SCs	Scheduled Castes
STs	Scheduled Tribes
STD	Sexually Transmitted Disease

Executive Summary

The International Conference on Population and Development, held in Cairo in 1995, endorsed the concept of a reproductive health approach. In 1997, the Government of India followed up the international endorsement with a national programme on Reproductive and Child Health (RCH). However, since the operative principle of the RCH approach is intrinsically integrated with field level planning and implementation, and is a major shift away from a client and target oriented approach to a participatory decentralisation approach, the local self governance structures of the Panchayati Raj, as embedded in the 73rd Constitutional Amendment, were seen as the most obvious vehicles for implementing the RCH programme.

In order to assess the present functions and capacities of the panchayats, with the objective of formulating guidelines and recommendations for strengthening training, information and communication capacities of the Panchayats to implement the RCH programme, a study was undertaken in selected districts of five states in India by CINI.

The main purpose of the study was to:

(a) assess the current and future functions of the Panchayats in the implementation of the RCH programme;
(b) ascertain the knowledge and attitude of the Panchayat members with regard to their future role;
(c) analyse the above to make recommendations for strengthening the Panchayats to act as effective promoters and implementers of RCH; and,
(d) to develop training guidelines for IEC.

The study was conducted in the sates of Gujarat, Karnataka, Orissa, Tamilnadu and West Bengal.

The main findings of the study in the above areas were as follows:

(a) It was very clear from the study that the current functions of the Panchayats vis-à-vis health are not in place as yet. The Panchayats have not been fully entrusted with health functions, although this is an area of responsibility that has been outlined in the formation of the sub-committees of the Panchayats across the states. This ranges from a state like Tamilnadu which has a fairly weak tradition of Panchayat system to West Bengal which has a stronger tradition, and does have a committee in place to supervise education, health and ground water supply, but have so far only been involved in providing community mobilisation support for immunisation, or during epidemics such as diarrhoea or malaria. But none of the studied Panchayats, at this point of time, were either actively involved in, or even understood what their present or future role in being implementers at the field level of any sustained health initiative, including the RCH. The main issue here is one of orientation. The panchayats have been constituted, but there are still many gaps in their orientation regarding what their specific roles, as well as allocation of funds to carry out these roles, would be. Most of the panchayat members did not even

know what comprised RCH, and in some cases where they did, it was inadequate understanding of RCH as a family planning programme only.

(b) In all the states studied RCH orientation were seen to be incomplete. The existing health personnel at the panchayat level, such as the health department, the ICDS workers, the ANMs, etc., were also not clear about the RCH programme and the target free approach, or even regarding the role of the Panchayat members in their programmes. There is lack of interaction between Panchayat and Health in the planning stage. This points to a serious lacuna in the co-ordination of health inputs at the field level. In almost all instances the panchayat members were limited to providing local assistance during the implementation of existing programmes such as immunisation and Family Planning. Most of the interventions seem to be done independent of each other, except in areas such as immunisation or epidemic control. Most of the panchayats as well as the health officials do not seem to approach the issue of health from the concerns of the villagers, but are more or less operating from directives regarding specific programmes from the top. There is still therefore a need to put the community at the centre of planning and to initiate programmes such as the RCH from a participatory, bottom up approach.

(c) Most panchayat members were not aware of reproductive health problems of women. In their own ranking of the various health problems the issue of reproductive health got a low priority. This could be attributed largely to the lack of knowledge and sensitisation regarding the importance of women's health issues.

(d) As regards the existing information, education, communication training and availability of materials. Panchayat members did not have any training nor do they posses materials to fall back on for dissemination of knowledge and awareness for different health programmes like MCH and other National heath programmes. Most of the people interviewed felt that these materials were not attractive enough for the target group. Occasionally wherever printed materials were used, it often did not reflect the life style of the local community particularly in case of the tribal areas visited during the study. While most of the health functionaries (but none of the panchayat members) had received training in IEC(1-5days), yet the training seems to have been in more traditional areas of IEC such as the use of flash cards, posters, etc. But there is very little alternative, indigenous use of local communication modes such as folk plays and songs, group discussions,and other interactive modes of communication. Where such attempts have been made, they have been through the initiatives of NGOs, and this has not been sustained or internalised within the health department or the panchayats. It is also seen that lack of training and required support system to the Panchayat restrict any innovative locally relevant approach for enhancing the effectiveness of the communication process.

Recommendations

Although the study findings, in some ways, present a fairly bleak picture of the existing roles and strengths of the panchayats in implementing the RCH approach, yet one has to see this in the historical context of the stage of growth and development of the panchayats. While most of the panchayats have been in place for some time, yet they are still fairly new entities in terms of the capacity of the panchayat members to play the roles they are envisaged to play. And the potentials of these panchayats cannot be underestimated. They are powerful vehicles for decentralised decision making and implementers of community based initiatives.

Any community based initiative in training or IEC strategies cannot by pass the panchayats.

There are some areas of concern, which can only be addressed at the policy level. The main one is the issue of converging delivery systems at the field level. While this has been argued for a long time by a number of organisations working at the field level in the area of health, yet the mechanism to do this has not been available. But now with the institutionalisation of panchayats, the mechanism now exists. But operational shifts have not yet taken place at the policy level. These shifts cannot be addressed within any training or IEC initiative alone. All training and IEC interventions can only strengthen the convergence efforts.

At the project level, as far as the panchayats, and other actors in the area of health at the field level are concerned, it is recommended that a series of interventions, in a phased manner, which build on the existing situation are planned, as a preparatory phase to any training or IEC interventions. These have to build on the following:

1. It has to be understood that the panchayats do not operate in isolation of the existing health delivery structures. Any training/IEC strategy would have to develop this interrelationship, and build up a support team for RCH activities.
2. It also has to be understood that the panchayat members themselves are very new to their roles and responsibilities, and therefore need to be first oriented in more explicit ways of what these are and how they can be carried out. Any training intervention therefore has to focus not only on the RCH component but also on a totality of capacity building for the panchayat members.
3. While the panchayats are elected people's representatives at the field level, training interventions and IEC strategies have to move beyond panchayats and also focus on the community members, especially the women and the related departments.

Suggested modules

Even though preparation of details of modular training is outside the scope of the present study, few suggestions could be made based on the findings of the present study. The contents of the modules suggested are:

1. Understanding the roles and responsibilities of panchayats, specifically with regards to the implementation of RCH but also more broadly with regards to implementation of other health interventions and initiatives; their inter-linkages with the existing health delivery infrastructure at the panchayat level.
2. Specific components of RCH programme, and their relevance in the local context including the focus on women as the primary stakeholders.
3. Understanding elements of information, education and communications as strategies to involve community members in taking charge of their own health, and not only in the context of imparting messages.
4. Understanding of different participatory strategies for IEC starting from one to one individual interaction and interpersonal communication to wider awareness generation methods.
5. Developing IEC materials, with the help of available local resources, both financial and human, ranging from basic printed materials such as posters, etc., to developing plays, songs, puppet shows.

The above are some examples of the types of content areas to be covered. These can be further sub-divided in to modules for training. However, the thrust of the training interventions should not only be on building the capacity of the panchayats to carry out all of the above initiatives by themselves, but also to equip the members with the skills and understanding of accessing and utilising available resources such as other institutions working in the area, the existing expertise of NGOs in the area, the other training programmes being imparted to the ANMS, ICDS workers, etc.

Chapter-I

Introduction

1.1 Historical Background of Family Welfare Programme In India

The National Family Planning Programme started in 1951 was purely a demographic programme. Subsequently the element of public education was included to facilitate outcome. During the seventies, the programme was focussed mainly on terminal methods which received set back due to rigid implementation of a target based approach.

The experiences gained ,within the country and outside ,has amply established that health of women in the reproductive age group and small children (up to 5 years of age) is of crucial importance for effectively tackling the problem of growth of population which led to change in the approach from Family Planning to Family Welfare. Since the Seventh Plan implemented during 1984-89, the FW programmes have evolved on the health needs of the women in reproductive age group and of children below the age of 5 years as well as on providing contraceptives and spacing services to the desirous people. The main objective of the Family Welfare Programme for the country has been to stabilise population at a level consistent with the needs of the country's development.

Programmes like The Universal Immunisation Programme (UIP), started in 1985-86, The oral Rehydration Therapy(ORT)was also started in view of the fact that Diarrhoea was a leading cause of deaths among children. Various other programmes under Maternal and Child Health (MCH) were also implemented during the seventh plan. The convergence of these programmes was aimed at improving the health of mothers and young children and to provide them facilities for prevention and treatment of major disease conditions. The separate identity for each programme led to problems in its effective management and this also contributed to somewhat reducing the outcome. Therefore, in the 90s i.e. in the 8^{th} plan, these programmes were integrated under Child survival and Safe Motherhood (CSSM) Programme from 1992-93.

Since 1951, there has been substantial improvement in health indicators. The infant mortality has been reduced from 146 (1951-61) to 72 (1996), total fertility rate from 6.1 (1951) to 3.5 (1993), life expectancy at birth for female from 36.1 (1951) to 62.1 (1996), crude birth rate from 40.8 (1951) to 27.4 (1996), effective couple protection rate from 10.4 (1970-71) to 46.5 (1996), immunisation status of pregnant women with T.T. from 40 percent (1985-86) to 76.73 (1996), immunisation status of infants with BCG from 29 percent (1985-86) to 93.12 (1996) and measles from 44 percent (1987-88) to 78.91 (1996). However, the position is not uniform through out the country. Though states like Kerala, Tamilnadu, Goa, Maharashtra and Punjab have achieved a considerable higher level, the states like Bihar, Uttar Pradesh, Madhya Pradesh, Orissa, Assam and Jammu & Kashmir are performing much below the national level.

1.2 Reproductive and Child Health

The integration process of related programmes initiated with the implementation of the CSSM Programme was taken a step further in 1994 when the International Conference on Population and Development in Cairo recommended that the participant countries should

implement unified programmes for Reproductive and Child Health (RCH). The RCH approach has been defined as "People have the ability to reproduce and regulate their fertility, women are able to go through pregnancy and child birth safely, the outcome of pregnancies is successful in terms of maternal and infant survival and well being and couple are able to have sexual relations free of fear of pregnancy and of contracting diseases".

During the 9th plan, the RCH Programme, accordingly, integrates all the related programmes of the 8th Plan. The concept of RCH is to provide need based, client centred, demand driven, high quality and integrated RCH services to the beneficiaries. The RCH programme aims to bring all RCH services within the easy reach of the community. The RCH programme incorporates the components relating to Child Survival and Safe Motherhood and includes two additional components, one relating into sexually transmitted diseases (STD) and the other relating to reproductive tract infections (RTI).

The RCH programme will make the services under it available at lower level of hospitals like Specialist facilities for obstetric care at sub divisional level hospital, medical termination of pregnancy will be available at PHCs and general obstetric care facilities will be strengthened in PHCs. Specialist facility for Sexually Transmitted Diseases and Reproductive Tract Infections will be available in all district hospitals and in a fair number at Sub Divisional hospitals. At another plane the programme seeks to broaden the ownership of the community in the programme, so that it does not remain a purely Government programme which unfortunately has been the situation so far*1. The Non-Government medical system will be involved in providing RCH facilities and Indian System of Medicine which are known to be efficacious will be utilised in a substantial manner. Certain prominent segment of the population whose RCH needs have not been adequately addressed in the past like the tribal and urban population and the adolescent will be addressed through specially designed programmes. The programme also envisages using the Panchayati Raj functionaries to determine the need of the local population for RCH services generally and for contraceptives particularly under the Target Free Approach. The Panchayat will also be the agency for implementing the programme and extending financial and transport support to women from indigent families.

The 73rd Constitutional Amendment, by the Parliament has provided an unique opportunity to make the paradigm shift of moving the Family Planning Programme from a centralised government approach, to decentralised communities oriented approach through the mechanisms of the local Panchayats.

Also, there has been a paradigm shift in the approach towards family planning and the concept of "population", which has been de-constructed and a new meaning, particularly after the International Conference on Population and Development, held in Cairo in 1995.

To understand the importance and need for community initiatives on reproductive health services, which is the new construct for family planning programmes, it is also important to understand the deconstruction of the term population.

- Population means numbers of people. By itself these "numbers" have no meaning. It may seem more to some and less to others, like tribal groups in remote areas, which may be facing the problem of shrinking numbers.

- These "numbers" are then related to the environment in which people live. In this context, it takes on a totally new meaning - land, water, fuel, fodder, common property, forests- which are needed by people. When "numbers" are seen in this way, the organic link between people and their environment comes alive.

- Are these "numbers" the cause or effect of poverty and deprivation? In concrete terms - people's access to livelihood and income for survival is the issue. Equitable distribution of assets like land and traditional rights to common property resources like forests and grazing land could ease the situation.
- Population is invariably linked to family size - the number of children within a family, factors which influence this decision, the whole issue of whether a child is an additional mouth to feed or another hand to work, along with complex factors which influence that decision, value of children and security of old age, and the impact of education, religion and cultural practices.

"Population" therefore encompasses people's access to livelihood, health care, clean drinking water, sanitation, food, education, and natural resources. It encompasses the social context within which people, and particularly women, function. These social and developmental factors and the overall well being of a populace has a direct and powerful bearing on numbers. Population policies and programmes should therefore logically involve and incorporate this holistic understanding of the basic concept, and not merely focus on the control of numbers.

And, when seen through this perspective, the central role of the Panchayats is clear, since the holistic approach encompasses the totality of their responsibilities at the field level.

1.3 The Panchayati Raj System

The Panchayats have existed in India for a long time and that, with the spread of British colonial rule and subsequently after 1947, these "village republics" gradually lost their teeth. The Constitutional 73rd Act, popularly known as the Panchayat Act, has rekindled interest in local self-government. The Act prescribes a uniform three tier system below the state level (with the exception of states with a population of less than 2 million), comprising of the Village Panchayat at the village level, the Panchayat Samiti at the block level, and the Zilla Parishad at the district level. Furthermore, the Act provides for nominated members alongside elected representatives of the people. The 73rd Amendment of the Act in 1992 provided for certain far reaching steps. However, it is most significant for compulsory reservation for women, Scheduled Castes and Scheduled Tribes.

These provisions may be recaptured as under:

Not less than one-third of the seats will be reserved for women (including that of SCs and STs). These may be allotted by rotation to different constituencies of a Panchayat.

Seats will be reserved for SCs and STs, in proportion to the total population of the area. There would be reservation for women in seats that have been allotted to Scheduled castes and Scheduled tribes. Not less than one third of the SC and ST seats may be reserved for women.

Not less than one-third of the total seats for the offices of the chairpersons at each level, would be reserved for women. This would be rotated among different Panchayats at each level.

In addition, there are certain general features which could be taken advantage of by women, such as direct elections for membership and Sarpanch posts, at the local as well as at the intermediary block level*2.

Panchayat elections have released a lot of creative political energy. People from disadvantaged communities have finally found a forum to be heard, to speak out and, hopefully, to act. A large number of women have been elected as Sarpanches. Elected women representatives have been drawn from a wide cross section - many rural animators who had an opportunity to work with NGOs, women's empowerment programmes and in campaigns (like Total Literacy campaign, anti-alcohol movement, environment protection etc) have been elected. There is also renewed optimism in many areas - especially on greater transparency of development administration.

The electoral process has been an effective political education campaign, and it is envisaged that the Panchayats can be potentially capable and effective vehicles for decentralisation.

The present study was undertaken by Child In Need Institute – CINI, West Bengal with support from World Bank with following objectives :

1. To review the experience in the selective districts in which Community Involvement initiatives are being tested.
2. To formulate operationally useful recommendations and guidance about family health education and training in communication (IEC) for Panchayat members in order to suitably equip them to contribute effectively in implementation of the Family Welfare Programme in the country.

Chapter-II

Study Design

2.1 Selection of Districts

On geographical consideration, basic unit of the study has been five districts selected from the states of Gujarat, Karnataka, Orissa, Tamilnadu and West Bengal. The districts were selected from A, B and C category as identified by Government of India basing on the level of institutional deliveries.

- Tamilnadu – Category A having more than 70 percent institutional deliveries
- West Bengal, Karnataka and Gujarat – Category B having almost 50 Percent institutional deliveries
- Orissa – Category C having less than 50 percent institutional deliveries

2.2 Selection of Blocks

The study blocks were selected by the District Family Welfare Department based on the Family Welfare Programme performance. Two blocks were identified from each district for the study.

2.3 Selection of Gram Panchayat

The Gram Panchayats were selected from among the Panchayats performing well randomly.

2.4 Selected area of the study

State	District	Block/Taluka	Gram Panchayat
Gujarat	Kheda	Matar, Nadiad	Limbasi, Alindra, Matar
Karnataka	Bijapur	Badami,Sindagi	Muthalegai, Patadakal, Layaaguidi, Devara-hippargi, Yeragal B.KMalaghara
Orissa	Koraput	Semliguda, Jaypur	Kundulil, Lungri, Renga, Jayantgiri, Umuri, Randapalli
Tamilnadu	Madurai	Madurai East,	Usilampatti, Mela Senapatti
West Bengal	North 24 Pgs.	Haroa, Gaighata	Chandpara, Dharampur, Duma, Salipur, Haroa, Khasbalanda

2.5 Study tools

For the collection of relevant information interviewing Key personels in health and Panchayat pre-tested detailed questionnaire was used for obtaining information on the status of Panchayat involvement in FW/RCH activities, their perception, knowledge and attitude regarding future role of Panchayat in FW/RCH activities and training needs. The instruments include

1. Questionnaire for the District Family Welfare Officer
2. Questionnaire for Karmadhakhya health, Zilla Parishad
3. Questionnaire for Block Medical Officer(BMOH)
4. Questionnaire for Karmadhakhya health (Panchayat Samity)
5. Questionnaire for Gram Panchayat Pradhan and member
6. Questionnaire for ANM
7. Guidelines for discussion with Women's group
8. Guidelines for discussion with Men's group
9. Guidelines for discussion with Anganwadi Workers
10. Guidelines for discussion with Girl's group
11. Guidelines for discussion with NGO

Other methods used

12. Observation to PHC and subcentre

General information on the districts, blocks and PHCs was collected from secondary sources.

2.6 Time Frame

Total duration: one year

2.7 Constraints of the study

There was an unusual delay in receiving the permission of the concerned state governments for conducting the study in their respective states.

Certain information on health and non health sectors could not be collected in spite of several reminders to the concerned authorities.

Chapter-III

Study findings

3.1 Gujarat

3.1.1 Profile of Kheda District

Kheda district is one of the 19 districts of Gujarat state. The district has 10 rural development blocks and the same number of municipalities. It has a total area of 7194 sq. Km. It has a Nagar Panchayat, 820 Gram Panchayat and 77 Group Panchayat. It has a population density of 478 per sq. Km. and has a total population of 34, 40, 897. The sex ratio is 919 women per 1000 men .

The literacy rate among men and women is 80.49 and 49.93 percent respectively. There are 2696 primary schools 389 middle schools and 167 higher secondary schools.

Kheda, with good agricultural land is one of the better developed districts of the state. The area, also called "Charotar" is known for it's produce of rice, cotton, tobacco and wheat. Out of 6,89,139 hectares of land 5,14,007 hectares of land is cultivated. I,27,328 hectares of land is cultivated more than once a year.

There are 1147 public distribution centres for distribution of food commodities at low cost.

There are 772 centres where milk is being collected. Milk Co-operative sector is very well developed in Kheda.

There are 3287 registered Co-operative societies in the district.

Working persons number 1154106 out of which 408597 are farmers, 339581 are agricultural labourers, 19212 are engaged in home industries and 386716 are engaged in other works.

The district has 111 Family Welfare centres, 17 hospitals and 123 dispensaries.

Out of 970 villages, 918 villages have state transport service through out the year. The entire district is very well connected by state transport services. All the 970 villages are provided with electricity.

3.1.2 Panchayati Raj System

A three-tier structure of Panchayati Raj (PR) with district panchayat at the top, taluk panchayat at the middle and Gram panchayat at the bottom was introduced in 1963. Gujarat is the only state where PR elections were conducted in time during the last 3 decades. PR in Gujarat is also described as a 4-tier system since a State Panchayat Council is statutorily provided at the state level to link and advise the PR bodies at all the 3 levels. The Gujarat Panchayat Parishad a state level body is formed by the District Panchayat President to stimulate and guide the Panchayat.

3.1.3 The District Panchayat

It is the most powerful body to carry out the development functions, it has both supervisory and executive powers. It frames annual budget and enjoys high degree of autonomy in planning. The District Panchayat consists of 31 members. Two of the seats, intended for directly elected members are reserved for women, one each for SCs/STs according to the population. Presidents of Taluk are ex-officio members, co-opted members two persons having experience of matters pertaining to education and residing in the district and associate members consisting of MPs/MLAs, Collector, Co-operative bank representatives, representatives of District Sales and Purchase Union and President of Municipalities in the districts. The President and Vice- President of the district panchayat are elected by the members from among themselves.

There are mandatory standing committees in the district panchayat. They are: Executive Committee, Social Justice Committee, Education, Public health, Production and Co-operation Committee, Public Works Committee, Appeal Committee and Finance Review Committee.

At the district level, the District Development Officer is the Secretary to the Panchayat. Under him there are branch heads of each Department who act as Secretaries to the various committees of the District Panchayat.

3.1.4 The Taluk Panchayat

It is responsible for supervisory and linking functions at the middle tier. Most of the developmental functions are entrusted to it for execution. The Taluk Panchayat consists of the following members: elected members, ex-officio members, Sarpanches (Gram Pradhan)/ Chairman, Nagar Panchayats as co-opted members. Two Women interested in welfare activities of women and children, two representatives each of scheduled castes and scheduled tribes and two social workers possessing experience in rural development and associate members like MLAs and President of Municipalities, local member of district panchayats and mamlatdar. The President and Vice-President are elected by the ex-officio, elected and co-opted members of taluk panchayats from among themselves. The taluk Panchayat in Gujarat is entrusted with planning and execution of agricultural programmes and works, the timely land equitable distribution of inputs and full use of water under irrigation schemes. Its obligatory functions range from subjects relating to health, education, culture, Community Development works, public works, agriculture, livestock, forest, rural industries, rural housing, co-operation, harijan welfare etc.. It also performs a number of discretionary functions. An officer of the state civil service is posted to work as ex-officio secretary of the Taluk Panchayat. He is known as Taluk Development Officer. The other officers working under Taluk Panchayat include staff of former local bodies and extension officers and village level workers of various departments of the Government for activities to be carried out at the taluk level. The President of Taluk Panchayat is the Chairman of the Executive Committee and members of other committees elect their own Chairman.

3.1.5 The Gram Panchayat

It is established for a local area having a population of 500-10,000 and is directly an elected body. Membership of the gram panchayat is based on population criteria and varies from 9-15 members. The Sarpanch and Upa-Sarpanch are elected by the members of the Panchayat and can be removed if a majority of two third members pass a vote of no confidence against them.

The Gram Panchayat are entrusted with collection of land revenue, irrigation dues, education cess and other dues for which collector issues certificates, recovery is done by Gram Panchayat over and above their functions. The Gram Panchayat has control for giving permission for construction, disposal of lands, removal of encroachment, levying taxes, and assistance to weaker sections. The Gram Panchayat are given grant from collection of land revenue. They collect house taxes and other taxes imposed by them. At the Gram Panchayat level, the formation of committee is discretionary.

3.2 Karnataka

3.2.1 Profile of Bijapur district

Bijapur has an area of 17100 sq. km. There are 1247 villages, 363 Gram Panchayat, 11 Taluk Panchayat, 18 Municipalities, 1 Zilla Panchayat and 1 Corporation. Total population is 29,28,000. The sex ratio is 964 per 1000 male.

The total literacy rate is 40.06 percent. There are 444 primary schools, 128 middle schools, 52 secondary schools. The total agricultural land is 1258241 hectares. The total irrigated land is 19 hectares. Of the total workers of 11100 marginal workers comprise 10900. There are 236 large industrial units ranging from textiles to engineering goods. There are 231 medium scale and 6505 medium scale industries. Electricity is available in 148 hamlets. Total motorable road is 6068 Km. and has 208 Km. of railway track.. There is a district hospital, 3 sub-divisional hospital, 11 community health centres, 100 Primary Health Centres and 504 sub-centres.

3.2.2 Panchayati Raj System

The Karnataka Panchayati Raj Act, 1993 was passed to establish a three tier-Panchayati Raj system in the state with elected bodies at the district, taluk and village level, in keeping with the 73rd Constitution Amendment relating to Panchayat for greater participation of the people and more effective implementation of rural development programmes.

Elections were held in the state to elect members to 20 Zilla Panchayat at the district level, 175 taluk panchayat at taluk level and 5640 Gram Panchayat at the village level. Out of 919 Zilla Panchayat seats 325 (one third) were reserved for women members, 165 scheduled caste seats out of which 63 for women, 47 scheduled tribes seats out of which 23 were for women.

The total number of seats under taluk panchayat is 3340, out of which 678 are reserved for scheduled castes, 248 for scheduled tribes and 1117 for backward classes. One third of the seats in all the categories are reserved for women. There are 5640 Gram Panchayats with a total of 80631 seats, out of which 17912 are reserved for scheduled castes, 7571 for scheduled tribes and 26827 for backward classes and for others 28321.

3.2.3 Zilla Panchayat

The new Panchayat Raj Act – Karnataka 1993 has given more powers to the block panchayats compared to the Zilla Panchayats. The role of the Chief Executive Officer has been strengthened by bestowing limited veto power over the resolutions of elected bodies with a power to refer them to the government for confirmation.

Zilla Panchayats are the implementing agency at the district level through which development programmes are executed.

3.2.4 Taluk Panchayat

Taluk Panchayats are the second tier of Panchayati Raj Institution. About 55 percent of the scheme-wise allocations go to the taluk panchayats against 45 percent of zilla panchayat , planning and financing mechanism at taluk level has been strengthened by creating a post of assistant planning officer and assistant accounts officer.

Taluk panchayats are the implementing agencies for government programmes at the taluk and gram panchayat level. Funds for taluk panchayats are routed through zilla panchayats. The executive officer does not have any implementing staff at his disposal.

3.2.5 Gram Panchayat

The chief function of the gram panchayat is identification and selection of beneficiaries under the poverty alleviation schemes. In addition to this, the main resource is the grant-in-aid of Rs.1.25 lakhs. Final powers are restricted to Rs.5,000/- being spent on any work.The administrative aspects are looked after by the secretaries.

The Panchayat members have undergone a one-day orientation in health. The orientation was on antenatal care, immunisation, Family Planning, ORT, personal hygiene, environmental sanitation, breast feeding, etc. The orientation did not deal with common reproductive health problems.

The Panchayat's involvement in health matters is restricted to providing drinking water facilities, providing infrastructure facilities to the sub-centre and PHC and mobilising people for programmes like Pulse polio and P.P. The Panchayat members have not been trained in communication skill nor are they equipped with IEC materials for effective communication. They felt that health staff alone could not be in a position to cover the population effectively and, therefore, women's group members traditional birth attendants, CHG/CHV and school teacher needed to be involved.

They felt IEC on health issues was directive as there was no element of participation. Many Panchayat members felt the Panchayat must restrict itself to policy and administrative role .

Panchayat members felt that there was a lot to improve the health situation of the people. They could, in the meanwhile play the role of watch-dogs to see that the health personnel play their role effectively. Most members expressed their lack of training in health matters.

3.2.6 District Health Department

The matter relating to health is dealt by the district health department. The district has one hospital at the district providing specialist services, three subdivision hospitals, 11 community health centres and 100 primary health centres and 504 subcentres. The District Family Welfare Officer is aware of the term of RCH. The common health problems of women in the reproductive age group identified by him were anaemia, white discharge, heavy menstrual bleeding, under-nutrition and sexually transmitted diseases.

The district receives supplies of IEC materials from the state health department. The IEC materials received are posters, flip books, booklets and video cassettes. Some times they receive 16 mm. films. The visual materials are for immunisation, antenatal care, Family Planning, ORT, nutrition during pregnancy, child nutrition including breast feeding. The visual IEC materials are distributed to the PHCs and NGOs. The video cassettes are played at the PHC level. Often the visual materials like flip books and booklets fall far short of the demands.

3.3 Orissa

3.3.1 Profile of Koraput District

The district of Koraput is situated about 500 Km. from Bhubaneswar the capital of Orissa. It has an area comprising of 8534.1 Sq.Km. There are 14 Community Development Blocks and 1 Municipality. There are 14 Panchayat samitis and 197 Gram Panchayats.

The total population is 10,29,986 (1991 census) with 5,17,274 males and 5,12,712 females. The Scheduled Caste and Scheduled Tribes comprise 1,38,169 and 5,21,849 respectively. The total rural population is 8,57,582.

The adult literacy rate is 24.64 percent. Male literacy is 29.42 percent and female literacy is 15.15 percent. There are 1177 pre-schools run by ICDS, 1524 primary schools, 179 junior high schools and 45 high schools. There are 13 technical and non-technical colleges of which 3 are run by the State Government.

The total land under agriculture is 3,51,000 hectares. Crops grown are paddy, maize, ragi, jowar, bajra, millets, arhar, horse gram, ground nuts, til, castor oil, vegetables, chilli, ginger and turmeric. Forest produces include tamarind, sal seeds, hill brooms, timber and firewood.

Medium and large scale industries comprise of production of aluminium, paper, oil, machine tools, cement and granite slabs. Small industries include food processing units, chemical, electrical and electronic goods, ceramic and leather goods, paper and paper products, rubber and plastics, textiles etc.

3.3.2 Zilla Parishad

The Panchayat elections in Orissa was held in January 1997. One third of the Zilla Parishad members are women. The members have undergone an orientation at the state capital Bhubaneswar on the concepts of Panchayati Raj, the various poverty alleviation programmes of the Government and health issues like immunisation, Family Planning, diarrhoea, personal hygiene, water and sanitation programme and the responsibilities of the Panchayat in the successful implementation of the programmes. Till the time of the study they were not directly involved with health issues.

3.3.3 Panchayat Samiti

This is the Block level Panchayat. The Panchayat members a third of whom are women were provided orientation, training at the Block level for a duration of 5 days. A day was entirely spent to orient members on health issues – like antenatal check-ups, immunisation

of pregnant women and children, safe home delivery, breast feeding, immunisation, Family Planning, personal hygiene and environmental sanitation. No orientation was received by them on communicating health messages.

There are 6 committees in the samiti. Health is included in the committee for education and ground water supply.

The various health activities carried out in the two blocks under study were construction of drains, installation of tube wells. In Semliguda Panchayat Samiti bi-monthly review meetings are held with the Block Medical Officer.

The Panchayat members often accompany the health staff for community meetings during diarrhoea epidemics and malaria. They accompany the health staff to individual houses to motivate families to immunise women and children.

Staff of ICDS, Block Development Officials, health and members of Panchayats worked together during Pulse Polio immunisation and during outbreaks of diarrhoea. Anganwadi workers are the usual source of health awareness for the women. Sometimes the ANM from the PHC provides information on immunisation, Family Planning and Oral Rehydration Therapy.

The Panchayat members have not been oriented to the common Reproductive Health problems of women.

Future role of Panchayat in health envisaged were to provide transport facilities to critically ill patients and awareness generation on health issues relevant to the community besides the present activities.

3.3.4 Gram Panchayat

The Gram Panchayats have female members comprising one third of the total members. The Panchayat is responsible for planning and implementation of development programmes in villages under its jurisdiction.

The members had orientation training on health for a day.

It provides assistance for setting up sub-centres, accompanying the ANM during motivational meetings for immunisation and Family Planning in the villages. Future roles included providing transport services to critically ill patients, paving of village roads connecting the main roads for better transportation.

The Pradhan had also undergone orientation training on Target Free Approach along with the Panchayat Samiti members.

3.3.5 District Health Department

The District Health Department is responsible for provision of health facilities to the people in the district. At the district level there is a hospital with 107 beds providing specialised care. There are 4 Community Health Centres(CHC) each with 16 beds, 9 Primary Health

Centres each with 6 beds and 1 up-graded Primary Health Centre with 13 beds provides specially services in Paediatrics, Gynaecology and Obstetrics, Medicine and Surgery. There are 253 sub-centre manned by ANM. Each PHC caters to a population of above 20000 and a CHC to 80000. There are 4 additional PHCs for 20000 population each. There are 2 Post Partum Centres and 14 Rural Family Welfare Centre and 1 STD clinic. The Assistant District Medical Officer has undergone a 2-day orientation on the Target Free Approach at the state headquarters in Bhubaneswar. He is aware of the components of RCH. He complained of a dearth of materials on reproductive health problems of women. They also face problems to replenish health education materials as they are in short supply.

The different IEC materials used for awareness generation were posters, flip books, flash cards, 16 mm. film on Family Planning and video cassettes on immunisations F P methods, diarrhoea and malaria. The Assistant District Medical Officer District Medical Officer(ADMO) Family Welfare felt that the visual do not depict the life style and hence may not be accepted by majority of the tribal population. It receives IEC materials from the State health department.

The district health authorities sought the help of community leaders for motivation of community members for immunisation, use of oral rehydration solution and early referral of dehydrated patients.

Case Study

In 1995 there was an outbreak of acute diarrhoea in the village of Koraput District. The district authority came to know of a child's death due to diarrhoea on further investigation. They were told that infact more death had taken place and they were prevented from reporting in time by the dishari (local medicine man) as it was regarded to be caused by spirits.

On the advice of a representative from the State UNICEF the district health officials decided to invite the disharis for a video show on prevention of dehydration following diarrhoea. This was followed by a question answer session and demonstration on preparation of Oral Rehydration Solution. This resulted in controlling diarrhoeal deaths subsequently.

The health department has conducted orientation training on Target Free Approach to all members of the Zilla Parishad for 3 days. Orientation has also been provided to all panchayat samiti members, Pradhan of Gram Panchayat, NGO staff and Anganwadi Workers.

There is under reporting of births and death in the district and hence a clear picture on the birth and death rates are not available.

3.3.5 Primary Health Centre (PHC)

The PHCs provides both curative and preventive services. These services are provided at the PHC itself and also through its sub-centres. The PHC undertakes training programmes for traditional birth attendants, ANMs. Panchayat Samiti members. Gram Pradhan, NGO staff involved in health and ANMs have been oriented in Target Free Approach.

The Block Medical Officer and staff feel that Panchayat members , women's group members and other opinion leader participation is needed for the success of the Target Free Approach. Target for relevant health activities will be discussed and fixed after completion of the training programmes. The BMOH felt that Panchayat members. Youth club leaders and women's group members can play an effective role in communicating health messages. The PHC on its part can train them and provide them with IEC materials.

Focus Group Interview with men and women revealed men's ignorance of the common reproductive health problems of women. The women often suffered from leucorrhoea, excess menstrual bleeding, itching in the private parts. Most of the time they suffered in silence, sometimes they sought the help of the local medicine man and if it was unbearable they went to the PHC. Regular antenatal check-up was not seen as a necessity. The perception of antenatal check-up was restricted to receiving Tetanus Toxoid injections. They never thought of discussing common reproductive health problems with the ANM as she never asked them to. The health education provided was most of the time directed. IEC materials was occasionally used was restricted to ANC, immunisation, breast feeding, weaning ORT and Family Planning.

Focus group discussion with adolescent girls revealed that they suffered from irregular menstruation, painful periods and white discharge. Most often they never resorted to any treatment. Home remedies were sought if they were severe. In acute cases they went to the PHC.

3.4 Tamilnadu

3.4.1 Profile of Madurai district

Madurai is also known as the temple district of Tamilnadu. It has an area of 7057.3 sq.km. The total population in the district is 34,49,662.There are 668 villages and 7 municipalities. There is a Zilla Panchayat, 37 Taluk Panchayat and 560 Gram Panchayat, 1 Corporation and 24 Town Panchayats.

The adult literacy rate is 57.55 percent. There are 1421 pre-primary schools, 363 primary schools, 127 middle schools, 108 secondary schools, 26 higher secondary schools, 28 colleges, 11 technical schools and colleges and 1 University. Of the total workers 43.99 percent are male and 55.78 percent are female.

All the villages have been electrified. The total land under agriculture is 394637 hectares. The total irrigated land is 169767 hectares.

3.4.2 Panchayati Raj

The elections to the Panchayats took place in October 1996. One third of the members of the Panchayat at the district, taluk and Gram Panchayat level are women. The Zilla Parishad members, taluka and Gram Panchayat members have undergone orientation training on the Panchayati raj system and role of Panchayat. They have been oriented to the national health programmes viz. Immunization, Family Planning, ORT etc.

3.4.3 District Health

All health issues in the district are dealt by the District Health and Family Welfare Department. Services are rendered through the district hospital, seven Taluk hospitals, 41 PHCs, 314 Sub-centres and 7 Municipality hospitals. All awareness generation activities on health are planned at the district level.

3.5 West Bengal

3.5.1 Profile of North 24 Parganas District

North 24 Paragons District is one of the most populous district of West Bengal. The district headquarter Barasat is situated about 25 kilo meters from Calcutta the state capital .It has a total area of 4094square kilo meters. The total population is 72,81,881 . It has 17 Community Development Blocks Scheduled caste and scheduled tribe population comprise 21 and 2 percent respectively. The sex ratio is 907 female per thousand male. . There are 22 Panchayat samitis and 27 municipalities . About 51 percent of the population reside in municipal area.

The adult literacy rate is about 56 percent .There are 3733 primary schools,331 junior high schools,462 high schools and 159 higher secondary schools. There are 29 colleges and 816 institutions (schools and colleges) which impart technical training .

The male and female worker number 18,97,198 and 1,56,114 respectively . There are 3,45,478 and 5,666 male and female cultivators . Male and female agriculture labourers number 3,26,395 and 26,586 respectively. Marginal farmers number 173679,while small farmers are 1,51517. The total land under agriculture is 1,56,878 hectares . The main agricultural produces are paddy, jute sugarcane and green vegetables.

There are several large, medium and small scale industries. All blocks are accessible by roads. Train and boats are also important means of transport. The international airport is situated at Dum Dum in the district.

During the year 1995-96 the immunisation achievements for BCG, Polio and DPT was above 90 percent for measles it was 64 percent. The achievements for sterilisation , IUD and Oral Pills were 46, 31and 99 percent respectively.

The Deputy CMOH III is overall in charge of the Family Welfare Programme in the District. The targets for the districts were set by the State Family Welfare Department which in turn were provided a target by the Ministry of Health and Family Welfare .The district in turn set targets for the blocks under them.

3.5.2 Panchayati Raj System

Elections to panchayati bodies on party lines were first held during 1978. The Panchayati Raj body provides for 664 seats in Zilla Parishad, 9516 for Panchayat Samiti and 61395 seats for Gram Panchayat.

Staffing pattern of different tiers of Panchayati Raj bodies :

To implement programs, requires the assistance of technical and administrative personnel which is provided by the staff of the State Government belonging to different departments and functioning at the district, block and gram panchayats.

3.5.2 Zilla Parishad

The staffing pattern at the Zilla Parishad is as follows :

i. Executive Officer- District Magistrate, Ex-officio Executive Officer.
ii. Additional Executive Officer – One IAS officer in the rank of Additional District Magistrate posted as full time Additional Executive Officer.
iii. Secretary – A senior State Civil Service Officer looks after administration and accounts matters.
iv. District Engineer – with supporting staff deals with preparation of plans, estimates and implementation of programmes.
v. Executive Officer, Assistant Engineer and other staff of Rural Development Department are placed on deputation to Zilla Parishad.
vi. Other supporting staff.

The District Magistrate is the Executive Officer of Zilla Parishad assisted by an Additional Executive Officer in the rank of Additional District Magistrate. The Executive Officer is responsible for all matters relating to execution of schemes approved by the Zilla Parishad through its standing committees. There are ten different standing committees each headed by Karmadhyakha elected from among the members of the Zilla Parishad.

The Executive Officer issues necessary direction for execution of schemes to the respective state level officers as per the order of the Zilla Parishad and it's standing committees. He receives progress report of different sectoral development schemes. Sectoral heads are members of different standing committees. Besides the Chief Executive Officer a senior officer of the state civil service has been appointed as Secretary to run the regular organization of the Zilla Parishad and co-ordinate implementation of schemes undertaken by Zilla Parishad. The Sabhadipati (Head of Zilla Parishad) is a key functionary in the Zilla Parishad. He chairs the District Planning Board meeting as head of District Panchayat administration. At the district level there are two Co-ordination bodies viz. " District Planning Committee" and the other "District Planning and Co-ordination Council". It can approve scheme up to Rs. 5,00,000/-.

The District Planning and Co-ordination Council is composed of Sabhadipati of Zilla Parishad, Sabhapatis of Panchayat Samitis, Chairmen of municipalities in the districts. Besides MLAs/MPs (not holding the office of minister) from the district are also made members. Besides district level officers of the development departments and Commissioners in-charge of the division are also invited to the meeting of the council.

The District Planning Committee is chaired by Sabhadipati of Zilla Parishad. Ten Karmadhyakshas of Sthayee Samitis of Zilla Parishad, Sabhapatis of all Panchayat Samitis, Chairman of municipalities in the district and one representative of each state body in the district have been drafted as members.

The District Magistrate is the Member-Secretary of both the District Planning and Co-ordinating Council and District Planning Committee.

The Sub-divisional Magistrates of the area and District Officer of lead bank are also invited to these meetings. The District Planning Committee directs different sectoral heads to prepare plan and estimate for schemes for different blocks. The schemes are selected in consultation with District Planning Committee on a priority basis. On completion of selection they prepare plans and estimates and compile and integrate these schemes pertaining to the respective district. The completed plan is considered by the District Planning Committee for approval and permission is given for submission to the department heads at the state headquarters. The concerned District Officer disburse funds to different block in consultation with the District Planning Committee.

The Zilla Parishad monitors the implementation of the work by the Panchayat Samiti and Gram Panchayats. The monitoring sell is headed by the District Planning Officer.

3.5.3 Panchyat Samiti

The Sabhapati is the head at the block. He is elected by the Panchayat Samiti members. Block Development Officer is the Executive Officer and a key functionary of the samiti.

There are ten different Standing Committees each headed by karmadhyakha elected from among members of the Panchayat Samiti. The BDO is assisted by the joint BDO in the implementation of development activities in the block. The Sabhapati acts as the Chairman of the Block Planning Committee. BDO is Member-Secretary of this Committee. The block Planning Committee selects schemes fed by the Karmadhyakshas of the Sthayee Committees. The Block Planning Committee compiles a draft Block Plan and submits the same to District Planning Committee for approval. The implementation of schemes at the Gram Panchayat is monitored by the Panchayat Samiti.

Staffing pattern:

(i) Executive Officer-Block Development Officer (from state civil services Cadre) being the ex-officio Executive Officer;
(ii) Secretary- Extension Officer of Panchayats (posted as ex officio Secretary) dealing with administration and accounts matters;
(iii) Other supporting staff;
(iv) Services of the officials of Rural Development Department and other Departments posted at the block level are placed at the disposal of the Panchayat Samiti

3.5.4 Gram panchayat

The Gram Panchayats have the following category of staff:

(i) Secretary – dealing with administration and accounts matters.
(ii) Job Assistant – dealing with all matters, technical or otherwise in connection with preparation of schemes under various programmes and their implementation.
(iii) Gram Panchayat Karmee (Group D employee)- two or three such employees posted in each Gram Panchayat (depending upon the total number of elected members equal to or above ten).

3.5.5 District Health Department

The health facilities in the district comprises of a district hospital with 306 beds . There are 3 subdivision hospitals at Barasat, Basirhat and Bongaon besides 7 State General Hospitals , 1 ESI hospital ,5 rural hospitals , 17 Block PHC and 690 sub centres .The Chief Medical Officer is the person in charge of the health Department in the district. The Deputy CMOH III is in charge of the Family Welfare Programme.

The District Health Department and the Zilla Parishad meets once a month to share the progress made by the department regarding Family Planning and Immunisation in the district. The department also shares new programmes to be undertaken in the district and assistance needed from the Panchayat to accomplish the task.

3.6 Assessment of Current Practices in Health Activities in Panchayats

In the five states covered, the Panchayat elections had been carried out at different times. The stage of development of the Panchayats, therefore, were at different levels. However, this did not seem to have any effect on their current practices regarding health activities.

The panchayat's involvement in health activities is generally minimal. While in places like Tamilnadu, Karnataka and Gujarat there is no direct involvement, in states like Orissa and West Bengal, there is direct involvement but the quality of that involvement is low. For example, in Tamilnadu and Karnataka, health has not been a subject entrusted to the panchayat, and hence no initiatives have been undertaken directly. The case is similar for Gujarat as well. But in West Bengal there are Health Committees in place who have also undergone orientation training on health related topics.

But in spite of the differences mentioned above, none of the panchayats are actually directly involved in health related activities beyond providing support to awareness generation campaigns on health issues such as diarrhoea, malaria, immunisation, etc., by basically motivating people to attend the health camps on these issues. Even in West Bengal, the role of the Health Committee moves little beyond this, and the additional responsibility undertaken is in accompanying health workers during their visits to the households on request, The other area of involvement of the panchayats is in providing infra-structural support such as meeting places, furniture etc., as is the case in Tamilnadu and Karnataka, or in infrastructural construction of toilets, drainage, tube wells, etc., as in Orissa and West Bengal.

The level of awareness regarding health issues and problems is also very low amongst the panchayat members. The panchayat members interviewed, were not aware of the term RCH but, were familiar with Family Planning and Immunisation Programme. As mentioned above no training has been conducted on health issues or communication. In Tamilnadu and Karnataka, due to the generally higher level of awareness regarding health issues amongst the people, the Gram panchayat members said that they have discussed health problems at their meetings but since health is not a subject on their agenda they are unable to take decisions. Even if suggestions are made, their suggestions are also not implemented and get lost in bureaucratic discussions at higher levels. In Orissa and West Bengal, although the panchayat members had undergone orientation in health, this training however only covered issues regarding immunisation, diarrhoea control, breast feeding, etc. superficially. The training, as such, was for a short duration (3-4 hours) and the input emphasised on

information rather than on explaining the holistic aspect of health, the linkages of the panchayat members with the existing health delivery system, their roles and responsibilities, etc.

3.6.1 Future Roles

While the existing roles being performed vis-à-vis health activities are peripheral, yet most of the people interviewed were clearly of the opinion that the panchayat members do have a potential future role to play primarily as watch dogs for the efficient delivery of existing health services and programmes, and also as being more central to the health system at the field level, in order to play this role more effectively. Another primary role of the panchayat was seen to be as continuing to support the existing health delivery systems by motivating the community to access the services, and creating greater awareness amongst the community members about health problems and issues. The panchayat was accepted as being the vital link between the community members and the health personnel such as the ANMs, the PHCs, the Health Department. But a number of people also felt that this future role can only be adequately performed if there is more direct allocation of funds, and the requisite authority as well as autonomy, to utilise those funds, by the panchayat members.

3.6.2 Concerns and Gaps

There are two main areas of concern regarding the present functioning of the panchayat. One is the lack of adequate training and capacity building of the panchayat members with the objective of facilitating their understanding of their present and future roles, not only as panchayat members but also in the delivery of general health services, as well as specific components of programmes such as the RCH. And the other is the complete lack of co-ordination between the panchayat and the existing health delivery mechanisms as well as personnel. While the former concern can be addressed by no-state players such as NGOs and other civil society institutions, the latter can only be addressed by policy changes and commitment to empowering panchayats, not only on paper but also in practice. The mechanisms of devolution and decentralisation of power and authority to the panchayats has to be more systematic and integrated within the system as well for the panchayats to be truly effective.

In contextual terms, the major area of concern is the total inadequacy and inefficiency of existing health delivery systems at the community level. The study revealed that most of the Primary Health Centres (PHCs) were not functioning adequately, with lack of attendance of doctors, rude personnel, lack of available medicines, lack of adequate beds, inaccessibility of the PHCs,etc. In most of the districts covered in the different states, it was found that private practitioners and traditional health systems were more widely used because of the above reasons. The government health system was only accessed in extreme cases, and that too not successfully.

Another area of concern is the complete lack of understanding regarding the linkages between good health and socio-environmental factors such as adequate clean drinking water facilities, sanitation, illiteracy, and lack of awareness leading to poor personal hygiene. While some of the understanding regarding the importance of these inter-linkages are seen in the composition of responsibilities of the committees - for instance in West Bengal where the Health Committee is responsible for Education, Health and Ground Water Supply - but the gap between the intent and the practice on the ground is very sharp.

3.6.3 Communications Needs

The study clearly revealed the gaps between the actual communications needs at the community level and the existing communication materials and approaches being used at present. Most of the materials being used at present are perceived as being unattractive and reflecting the components of the programmes, rather than being based on the actual health needs of the community. The methodology of usage of the existing materials is also not conducive to community involvement and participation and is more mass based rather than interpersonal or interactive. In Tamilnadu, for example, most of the IEC programmes have been through the use of mass based media posters and film shows, which allow for very little interactions and discussions. In Gujarat, the primary materials available were also posters and flip charts, and even these were found to be unattractive and uninteresting. In places where slightly more interactive communications materials were available or being used, such as flash cards, it was found that the pictures on the flash cards did not reflect the life styles of the people, and were therefore not effective in transmitting the requisite information.

The content of most of the IEC materials was also unrelated to the health needs and concerns of the community, particularly the women. While the available materials focussed on diarrhoea, ORS, size of family, immunisation, etc., there are no available materials reflecting the concerns of the women, as revealed from the focus group discussions and interviews. The reproductive and sexual health problems affecting the women were severe menstrual pains, excessive menstrual bleeding, white discharge, sexually transmitted diseases, etc. Even in Tamilnadu and Karnataka, where the general level of awareness regarding health problems was very high, yet the existing IEC materials did not reflect this. They still presupposed that all that is needed is basic information.

Another issue which emerged from the study was that most of the existing materials focus only on women and do not target the men at all, thus ignoring in many cases the partial cause of some of the health problems, such as sexually transmitted diseases, and ignoring as well the role of men in RCH programmes. While it can be understood that women need to be the primary beneficiaries of IEC materials, because it is their health and well being that is more imperative, yet the role which men play in women's health, particularly in reproductive health, has to be also targeted for successful implementation.

Finally, the main users of IEC materials at present are the health functionaries and not the members of the panchayats at all. While some of he panchayats have undergone training in health, none of them have been trained in IEC strategies and use of the materials. If the panchayats are to be the main vehicle for involving the community, the members have to undergo training in use as well as production of IEC materials.

Chapter-IV

Recommendations

The recommendations being put forward have to be understood in the context of the following issues:

4.1 It has to be understood that the panchayats do not operate in isolation of the existing health delivery structures. Any training/IEC strategy would have to develop this interrelationship, and build up a support team for RCH activities. No amount of training in IEC approaches and strategies would be effective if the referral linkages and effective health services are not available at the community level. Linkages also have to be built with existing institutions and organisations such as NGOs, etc., at the field level which have expertise in some of these areas, as well as traditional imparters of health information within the family such as elder women, the traditional dais, etc.

4.2. It also has to be understood that the panchayat members themselves are very new to their roles and responsibilities, and therefore need to be first oriented in more explicit ways of what these roles and responsibilities are and how they can be carried out. Any training intervention therefore has to focus not only on the RCH component but also on a totality of capacity building for the panchayat members.

4.3. While the panchayats are elected people's representatives at the field level, training interventions and IEC strategies have to move beyond panchayats and also focus on the community members, especially the women. Any strategy therefore has to put the individual woman at the centre and then incorporate the family, the community, the panchayat, the other health workers, the related departments such as water and sanitation, etc.

In the context of the above, it is therefore recommended that

- The approach to responding to the health needs at the community level must be focused to the needs and problems of the women and adolescent girls. This is particularly crucial in the RCH programme, where the needs of the women and the girls are central to the issue.
- Women panchayat members need to be trained not only in skills to identify health needs of the local women, but also in understanding the roles and status of women in general since it cannot be assumed that all women are gender sensitive, as such. The panchayat women also need to undergo gender sensitisation so that they are able to understand their own as well as other women’s condition and situation. They also need to undergo decision making and assertiveness training such that they are able to identify and demand services for women from the health sector.

- Similarly, male panchayat members also need to be sensitised to women's condition and situation, particularly their reproductive roles and health problems, such that they can also support the women panchayat members in their demands for effective health services as well as influence other men in the community.

- The existing health functionaries such as medical and paramedical workers need to be further trained and informed about the components and approaches of the RCH

programme in order to supplement their existing knowledge and skills, particularly since there is still inadequate understanding of these at present.

- Efforts have to be made to support all training interventions by strengthening and easing the bottlenecks in the functioning of the present health delivery systems, which must provide all the services identified under RCH. The training should be backed up by adequate supplies and laboratory facilities, which should be suitably de-centralised.

- The health functionaries, particularly those working in the PHCs, also need to be trained and oriented to working in participatory ways with the community, in order to bring about changes in their attitudes and behaviour towards the users of the health services.

- Panchayat members need to be trained in all aspects of a holistic health approach, as envisaged in the RCH programme, and should be aware of all the interventions that are required to be taken up at the community level. They need to be equipped adequately so that they can form an effective link between the community and the providers.

- Panchayat should be strengthened to co-ordinate all the developmental programmes under their jurisdiction, in order to understand the context of the priority to be attached to health and its relation to adequate and clean drinking water, sanitation facilities, and effective drainage and sewerage systems.

- The other medical and paramedical workers and health functionaries, as well as other government functionaries at the field level such as the BDO, etc., should be oriented regarding the potential role and jurisdiction of the panchayat members such that they work in closer co-ordination and joint planning initiatives, particularly in the health components. These personnel must be convinced and influenced to attach greater importance and centrality to the panchayat members than they do at present.

4.2 Information, Education and Communication Strategies

Any strategy planned must be based on a participatory and need based approach. This implies an approach that begins with where the people are, and one which places them at the centre of all interventions, whether it be the individual woman or the panchayat member. All IEC strategies therefore must start by defining the needs of the targeted or focus group. This has two implications for both IEC and training interventions - one at the level of the methodology adopted for the development and usage of IEC materials, and another at the level of the content of the messages.

(A) Methodology:

The methodology of development of IEC materials so far have been centrally based, where the materials are all developed not from the field level up, but from a central point down. This is why the people find the materials uninteresting and irrelevant. And, also because the preparation of the materials are centrally based, there is no scope for interaction with the community during the process. For future interventions, what is therefore recommended is a process or an approach which decentralises the formulation of the IEC components. It is

recommended that IEC materials should be developed at the panchayat level, using interactive processes such as focus group discussions, folk plays and songs, puppet shows, etc., to elicit the kinds of content areas which need to be covered, to understand the existing levels of awareness of the community and their attitudes to some of the components of the RCH to be able to develop materials or contents which will effectively communicate with the people, and not to the people. It must also be kept in mind that the majority of the people at the village level are illiterate, and therefore the thrust of all IEC interventions must be on visual presentations rather than on content and input, in terms of language, levels of information, etc. To quote an old truism," the medium is more powerful than the message", must be always kept in mind.

Most of the existing materials also seem to be aimed more at the health functionaries at present. And this is also reflective of the approach mentioned above. The focus of materials must shift to the community as the end beneficiaries, and not merely seen as tools for the functionaries. IEC materials must be seen as facilitating interaction, and not an end in themselves. At the community level all IEC materials can only be used effectively if those who use them are trained in doing so to initiate interactive discussions to generate awareness and needs through this process, and then to refer the women to the available health referral services.

It is imperative that this approach and methodology be understood and internalised by all those who will use IEC materials, either directly or indirectly, including the panchayat members as well as the health functionaries at all levels from the district down.

(B) Content:

The primary focus of the contents should be on their relevance to the expressed health needs of the community, particularly the women and not on what the centralised health system perceives as being important in promoting a particular programme such as the RCH. If the women's needs are for information about reproductive health problems, then the messages must first address those needs before imparting additional information regarding RCH or any other programme. Unless the women feel that their needs are being met, they will not be motivated to access any services even if they might require them.

The content of the messages should also be simple and uniform to avoid any confusion in the mind of the people. It should be culturally context specific so that the women can relate their lives and realities to the messages being transmitted. One of the suggested ways of ensuring this is to direct the messages from the individual to the community, so that the totality of relationships and linkages are understood. For example, at the community level, an individual woman cannot take a decision regarding sterilisation or fertility control by herself. Her immediate family members, particularly her husband and mother in law, have to be a part of this decision. Similarly, if the cause of the health problems of her children is unsafe drinking water or polluted drinking water sources, or in-sanitary drains and toilets, then just her change of attitude and behaviour is not sufficient to bring about long lasting improvements in her child's health. The other members of the community also have to be made aware of these causes and their effects. All IEC materials, therefore, must cover content areas which move from the individual women, to her family members, then to the extended community, then to the extended socio-environmental conditions which affect and impact her health as well as the health of her family, then to the providers of health and related services, the decision makers who influence the provision of those services, etc.

The IEC strategies recommended therefore are to primarily provide capacities for implementing and carrying out IEC activities through a participatory, people centred approach which develops materials through a proactive and interactive process, suing traditional innovative methods and including simple and culturally relevant information.

Chapter-V

Suggested Training Modules

While it is recommended that specific training modules be planned with the specific groups, including panchayat members, community members, especially women, other resource persons and organisations, the following are some of the suggested content areas which can be covered in the modules:

- Understanding the roles and responsibilities of panchayats, specifically with regards to the implementation of RCH but also more broadly with regards to implementation of other health interventions and initiatives; their inter-linkages with the existing health delivery infrastructure at the panchayat level.
- Specific components of RCH programme, and their relevance in the local context, including the focus on women as the primary stakeholders.
- Understanding elements of information, education and communications as strategies to involve community members in taking charge of their own health, and not only in the context of imparting messages.
- Understanding of different participatory strategies for IEC starting from one to one individual interaction and interpersonal communication to wider awareness generation methods.
- Developing IEC materials, with the help of available local resources, both financial and human, ranging from basic printed materials such as posters, etc., to developing plays, songs, puppet shows.

The above are examples of the types of content areas to be covered. These can be further sub-divided into modules for training. However, the thrust of the training interventions should not only be on building the capacity of the panchayats to carry out all of the above initiatives by themselves, but also to equip the members with the skills and understanding of accessing and utilising available resources such as other institutions working in the area, the existing expertise of NGOs in the area, the other training programmes being imparted to the ANMS, ICDS workers, etc.

In conclusion, some fundamental issues need to be settled if a meaningful partnership between the existing health systems and the panchayats have to be built. Every small intervention and/or interaction planned in the course of building bridges between people's organisations and the health care system must begin by respecting people's ability to take their own decisions, respect equality, and create room for individual variation and uniqueness. If a poor woman is asked what she really means by development, she is bound to place dignity and self-respect in the centre. While the centrality of this concept is widely accepted in actuality the concept has not permeated across the board. In a sense, therefore, participatory initiatives have the potential to become the platform where the concept and practice of people's empowerment and participation in developmental processes can coalesce and where the holistic approach to population as an issue which covers the totality of the lives of the poor become a realistic component of programmes such as the RCH.

References

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ANNEXURES

(Framework for advocating a participatory community based initiative)

Concept	Family Planning Constituency	People's Perception
Population growth	Explosion theory, need for control, cause of poverty, environmental degradation, affects quality of life. Poor country cannot afford such alarming growth rate.	Symptom and not a cause, population will automatically come down with better quality of life, employment, income, quality health care and education.
Population Policy	Family planning – focus on contraception, quantity important, but no time, given the urgency, therefore no time for quality and finer points even though they are important.	Holistic Primary Health care is necessary. FP should be a significant component. The focus on quality of services, dignity and respect for human life.
Programme on the ground	People need to be motivated, incentives and disincentives necessary, as it is a social goal (as different from individual's felt need) - need to set targets for service providers, women / poor do not know, they need to be told. Focus on women to the exclusion of men especially after 1977.	People-centred approach, respect human rights, dignity of the individual, address constraints, quality service and good follow-up, women / poor know and make rational choices, address factors that influence these choices. Need to focus on men taking responsibility for their sexuality, male involvement.
Concrete inputs	Distribution of contraceptives, search for long acting methods, reliance on terminal methods. No particular emphasis on quality.	Address primary health care and reproductive health, enable the system to focus on factors that encourage or inhibit spacing methods, give women information to make their own choices.