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Abstract

The geographical area of this study is West Bengal - a constituent state (province) of India. The state government policy aims at administrative decentralization through Panchayats (or Village Councils) in rural areas. It is a 3-tier system, comprising a Gram Panchayat in every village, Panchayat Samity (block level), and Zilla Parishad (district level). Focusing mainly on Panchayat Samity members, the study explores the knowledge, attitudes, participation, and involvement of the Panchayat Samity members in National Health and Family Welfare Programs. The categories of respondents are the Health Committee members of Panchayat Samity, and health personnel of Block Primary Health Center and Rural Hospital. With a positive frame of mind, they are found to be involved in promoting awareness about health and family planning, and in providing child immunization and other health measures to predominantly agrarian communities.

Keywords

Panchayat Samity, Health Committee, Child Immunization, Family Planning, Pulse Polio, and Maternal-child Health

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The geographical area of this study is West Bengal - a constituent state (province) of India. The state government policy aims at administrative decentralization through Panchayats (or Village Councils) in rural areas. It is a 3-tier system, comprising a Gram Panchayat in every village, Panchayat Samity[1] (block[2] level), and Zilla Parishad (district level). Focusing mainly on Panchayat Samity members, the study explores the knowledge, attitudes, participation, and involvement of the Panchayat Samity members in National Health and Family Welfare Programs. The categories of respondents are the Health Committee members of Panchayat Samity, and health personnel of Block Primary Health Center and Rural Hospital. With a positive frame of mind, they are found to be involved in promoting awareness about health and family planning, and in providing child immunization and other health measures to predominantly agrarian communities. Key Words: Panchayat Samity, Health Committee, Child Immunization, Family Planning, Pulse Polio, and Maternal-child Health

Introduction

The experiment in economic and political decentralization was introduced in the late seventies in the Indian state of West Bengal. West Bengal is predominantly rural with 72 percent of its population living in villages. Being the most populous state in India, its population size was 82 million in 2001, accounting for about 2.7 percent of the country's area (88,752 square km), but about 7.8 percent of the national population. The state ranks first in terms of density of 904 persons per sq. km. Previously, the provision and maintenance of local public goods and implementation of major public projects was discharged by the bureaucrats of central and state governments. Later, the responsibilities of these functions were handed over to formally elected village councils (*Gram* Panchayats). There is ample evidence that poor performance of local public services in India relates to the centralized and non-participatory nature of their management. Besides, there is little scope for people to voice their demands and criticism in the formal institutional structure (Dreze & Sen, 1995).

To continue the development process of the country, the government of India initiated several measures to organize people locally by self-government or self-administration. The objective was to create an atmosphere, so that the rural people could take proper initiatives to institute social change themselves. Efforts in this direction were

[1] Second tier of the rural self-government organization
[2] Administrative division of a district

the 73rd and 74th amendment of the Constitution in 1992, which made it compulsory to form Gram Panchayats in the rural areas and municipalities in the urban areas in each state of the country (Directorate of Panchayat and Rural Development, 1999). The state legislature provides all opportunities to make the Panchayats complete self-government organizations. They are given legal power to formulate plan proposals for economic development and social justice (Article 243 G of the Constitution).

A study by Srivastava, Ram, Paswan, and Nagdeve (2004), studied the linkages between activities of the health and family welfare programs and Panchayati Raj Institutions (PRI). The specific objectives were to study the functions and roles of the members of the PRI with regard to health and family welfare activities. The involvement of the PRI members in health and family welfare programs is certainly a good endeavor for the multi-dimensional rural development, and this novel approach may yield better results at the grassroots level. The study advocates better understanding and co-ordination between the PRI members, and health and family welfare personnel, which they believe would result in improved health and family welfare services addressing the needs of the masses in the country. The involvement and participation of the rural people in health and family welfare programs has led to a dramatic improvement as compared to the earlier state, where all the developmental projects were discharged by the bureaucrats of the government (Ghatak & Ghatak, 2002).

Child morbidity and mortality is higher in developing countries. The major causes of child death are lack of safe drinking water and proper sanitation as well as poor hygiene. They are generally responsible for the transmission of many communicable diseases like diarrhea, malaria, cholera, polio, and many other parasitic infections. The diseases related to water and sanitation remains the biggest killers in developing countries like India. In the developing countries, around 90 percent of all avoidable mortality in almost all age/sex groups is from communicable diseases, most notably malaria, TB, cholera, and to a lesser extent HIV/AIDS (Mills & Shillcut, 2004).

A major portion of the Indian rural population lack basic sanitation and safe drinking water. In rural areas, pond and river water were the prime sources of drinking water. The people belonging to comparatively better financial conditions have installed hand pumps, tube wells, and wells for their sources of drinking water and household use. Furthermore, since the poor rural people have no toilet facilities at home, they would rather use open fields for that purpose. Even some “better off” people would also prefer the same, thereby creating their own transmission of infections.

In the process of examining the functions of the Panchayati Raj Institution at Panchayat Samity (block) level and evaluating their knowledge, attitudes, participation, and involvement towards national health and family welfare programs in the state of West Bengal, it was essential to explore the performance of the Panchayat Samity members. The Panchayati Raj Institutions are responsible for overseeing and monitoring the functions of the health department. Keeping in view the functioning of the health department, a parallel study was also conducted among the health personnel in the same blocks of the Hooghli district in order to understand the performance of the Panchayati Raj Institutions, the grassroots level rural self government organizations, and their knowledge, attitudes, participation, and involvement in the national health and family welfare programs.

Health Policy of the Country and the State

Under the existing national health policy (NHP) of the country, adopted in 1983, the main focus has been the formulation of an integrated and comprehensive approach towards future development of health services. The Eighth Five Year Plan (1992-97), (World Health Organization, 2004) identified human development as its main focus, with health and population control as the top priority objectives. It was emphasized that health facilities must reach the entire population by the end of the Eighth Plan. During this plan, emphasis was also given for peoples' initiative and participation as a key element.

The vertically structured family welfare program needed to be replaced by a more democratic decentralized alternative. In 1996, the government adopted a multi-dimensional approach towards population stabilization, with a goal of achieving a replacement level of fertility or a total fertility rate (TFR) of 2.1 by the year 2010, but with no targets for specific contraceptive methods use (World Health Organization, 2004).

Panchayati Raj Institutions

The Department of Panchayats & Rural Development of the Government of West Bengal is the nodal agency for implementation, supervision, and monitoring of the major poverty alleviation programs in the rural areas of the State and at the District level, Zila Parishad is the implementing agency for the same. Under the three-tier Panchayati Raj system of democratic decentralization, Zilla Parishad is the highest body at the district level followed by Panchayat Samity at the block level as second-tier, and Gram Panchayats as the third-tier. Of the various measures adopted to make people aware and to increase the acceptance of the facilities provided under health and family welfare programs, one of the important efforts is the involvement of peoples' elected representatives in rural areas for implementation of the programs, as these persons generally command much confidence and respect from the community.

Zilla Parishad

The Zila Parishad consists of the Chairman, Vice-Chairman, and the general members. Besides, the Chairmen of Panchayat Samities at the block level and all the members of Parliament and Legislative Assembly from the district are the Ex-Officio members of Zila Parishad.

Panchayat Samity

Each Panchayat Samity consists of elected members, a Block Development Officer, and other Officials ordinarily stationed at the block. Savapati (Chairman) is the head of the body and is elected directly by the Panchayat Samity members. The Block Development Officer of the respective block is the Executive Officer of the Panchayat Samity.

The main functions of the Panchayat Samity are planning, execution, and supervision of all developmental programs in the Block. The Panchayat Samity also supervises the works of Gram Panchayats within its jurisdiction.

Gram Panchayat

The Gram Panchayat is the primary unit of Panchayati Raj Institutions. Its main function is to implement different developmental work within its jurisdiction.

Accordingly, the Government of West Bengal issued an order for promotion of health and family welfare services as an obligatory part of their duties. Panchayat members are responsible for carrying out the following:

1. Creating awareness among the local people about the main aspects of public health and helping in different aspects of curative and preventive care.
2. Overseeing and helping in implementing the schemes of maternal-child health care facilities.
3. Controlling infectious diseases such as diarrhea, malaria, HIV-AIDS, and other diseases and conditions such as leprosy, blindness, etc.
4. Maintaining the birth-death register.
5. Creating awareness among people about small family norms and identifying whether means for family planning are available to every eligible couple of their locality.
6. Overseeing the nutrition level of local and school children including the ICDS (Integrated Child Development Scheme) program and mid-day meal scheme. (Directorate of Panchayat and Rural Development, 1999)

Socio-Economic and Demographic Characteristics of the Country and the State

Table 1

Socio-Economic and Demographic Characteristics of the Country and the State

	Total			**Rural**			**Urban**		
	Person	Male	Female	Person	Male	Female	Person	Male	Female
India									
Population (in million)[3]	1020.6	532.2	496.4	742.5	381.6	360.9	286.1	150.5	135.6
Percent literate[4]	54.5	63.2	45.2	48.7	58.6	38.3	69.5	75.0	63.3
Crude birth rate (per thousand)[5]	25.4	-	-	27.1	-	-	20.2	-	-
Crude death rate (per thousand)[6]	8.4	-	-	9.0	-	-	6.3	-	-
Natural growth rate(per thousand)[7]	17.0	-	-	18.0	-	-	13.9	-	-
Infant mortality rate (per thousand)[8]	66.0	-	-	72.0	-	-	42.0	-	-

[3] source : Registrar General, India, 2001
[4] source : Registrar General, India, 2001
[5] source : Registrar General, India, 2001
[6] source : Registrar General, India, 2001
[7] source : Registrar General, India, 2001

	Total			Rural			Urban		
	Person	Male	Female	Person	Male	Female	Person	Male	Female
West Bengal									
Population (in million)[9]	80.2	41.5	38.7	57.7	29.6	28.1	22.4	11.8	10.6
Percent literate[10]	58.9	66.2	51.0	53.4	61.7	44.7	72.9	77.6	67.7
Crude Birth rate (per thousand)[11]	20.5	-	-	22.8	-	-	13.8	-	-
Crude Death rate (per thousand)[12]	6.8	-	-	7.0	-	-	6.4	-	-
Natural growth rate (per thousand)[13]	13.7	-	-	15.8	-	-	7.4	-	-
Infant mortality rate (per thousand)[14]	51.0	-	-	53.0	-	-	38.0	-	-

India is a developing country with the second largest population in the world. Some socio-economic and demographic characteristics of the country and the state are given in Table 1.

Main Focus of the Study

The study on the role of the elected Panchayat Samity members in national health and family welfare programs was conducted in Hooghly district of West Bengal, India. The health committee members of Panchayat Samity at block level and the health personnel attached to concerned block were the participants of this study. Considering the importance and depth of the issues, an in-depth research project to study the subjective meanings, knowledge, attitudes, participation, and involvement of the Panchayat Samity members in the national health and family welfare programs was undertaken.

In order to understand these meanings, knowledge, attitudes, and beliefs, the study focused on the following specific areas of interest about availability, access to, and involvement in the provision of family health care services and programs:

1. How to improve the quality of health care facilities and family welfare programs in the rural areas with the involvement of Panchayat Samity members.
2. How to increase the acceptance of the health care facilities and family welfare programs and building of awareness for the same.
3. How to increase the utilization of services among those who do not avail of them and who are unwilling to accept different health care services.

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[8] source : Registrar General, India, 2001
[9] source : Registrar General, India, 2001
[10] source : Registrar General, India, 2001
[11] source : Registrar General, India, 2001
[12] source : Registrar General, India, 2001
[13] source : Registrar General, India, 2001
[14] source : Registrar General, India, 2001

In a developing country like India, expenditure on health and family welfare programs is negligible (around 4 per cent of the Union Budget) (Ministry of Finance, 2008-09) and hence keeping in view the limitation in the budget, it is necessary to improve the quality of these services.

Levels of acceptance of health care services in extremely remote and undeveloped communities and among some Muslim groups on the grounds of their religious beliefs and customs were a particular focus. Refusal to accept health care services and programs like child immunization, maternal-child health care, and family planning methods is based, in part, on preexisting attitudes and values and religious beliefs. Non-utilization of basic health care services and programs results in continuing high rates of childhood and maternal disease and mortality, in particular.

Method

The role of the elected Panchayat Samity members in national health and family welfare programs is a complex and sensitive subject. A descriptive case study approach was adopted since the aim of this study was to explore subjective meanings of knowledge, attitudes, participation, and involvement of the Panchayat Samity members in national health and family welfare programs. Case study research methods can be used to describe a unit of analysis (e.g., a case study of a particular organization). According to Yin (2002) the scope of a case study lies in the fact that a case study is an empirical investigation that investigates a contemporary phenomenon within its real life context, specifically when the boundaries between phenomenon and context are not clearly evident. Gall, Gall, and Borg (2003) suggest that the purpose of case study research is to describe, explain, or evaluate the issues. Yin (1993) has also identified some specific types of case studies, namely, exploratory, explanatory, and descriptive. This case study sought to describe and explore the sensitive issues like knowledge, attitudes, participation, and involvement of the Panchayat Samity members towards the national health and family welfare programs in the state of West Bengal, India.

Participants

The study was conducted in the Hooghly district of West Bengal. There are 18 blocks in the district. Six blocks were selected purposively (Merriam, 1988; Patton, 1990) for this study. Each Panchayat Samity at block level has a health committee consisting of about five to seven members. The functions of this health-committee are to oversee the health care facilities and other aspects of public health of their block area. The Chairman and Vice-Chairman by virtue of port folio are the members of each committee. The Convener of the committee is selected from the general members. In the selected Panchayat Samity, the Chairman, Convener, and three other members were selected and interviewed. In the Panchayat Samities where the number of health committee members totaled five, all the members were interviewed, but in other Panchayat Samities where the total number of members was more than five, three general members other than Chairman and Convener were randomly selected.

The research proposal for this study was submitted to the Technical Advisory Committee of the Indian Statistical Institute as a project proposal. The project proposal

was approved on the basis of the recommendations of the experts. The funding for this study was provided by the Government of India. The author of this paper was the project leader of this study. Professor B. N. Bhattacharya and Professor. P. K. Majumdar were the collaborating scientists of the study. Written applications from the head of the Population Studies Unit, Indian Statistical Institute, for seeking permission for conducting the study, were forwarded to the Savadhipati (Chairman) of Zilla Parishad and to the Chief Medical Officer of Health of Hooghly district. The Savadhipati of Zilla Parishad and Chief Medical Officer of Health approved our applications and cooperated with us from their level by encouraging the concerned Panchayat Samity, Block Primary Health Center (BPHC), and Rural Hospital to provide assistance in order to help us conduct our study smoothly.

From the Block Primary Health Center or Rural Hospital, Block Medical Officer of Health (BMOH), and either one, Block Sanitary Inspector, Social welfare Officer, Health Supervisor, or Health Inspector were also interviewed. The medical officers and health personnel were interviewed in order to explore the subjective meanings, knowledge, attitudes, performance, and involvement of the Panchayat Samity members towards the national health and family welfare programs.

Table 2

Distribution of the Respondents

Respondents		**Number**
Panchayat Samity	**Chairman of the *Panchayat Samity***	**6**
	Convener of the health committee	**6**
	Member of the health committee	**18**
Total 30		
Health Personnel	**Block Medical Officer of Health**	**6**
	Medical Officer	**1**
	Block Sanitary Inspector	**2**
	Social Welfare officer	**3**
	Health Supervisor	**1**
	Health Inspector	**1**
Total 14		

Data Collection

In-depth interviews were employed as the method of data collection. Qualitative research (Wolcott, 1990) is defined as a research design that generally advocates open–ended interviewing to explore and understand the attitudes, opinions, feelings, and value judgments of the respondents or a group of respondents. Keeping in view the complexities and sensitiveness of the study, it was felt necessary to undertake the qualitative survey to obtain in-depth information on these issues. The procedures for data collection were a combination of a standard open-ended interview guide and a few fixed response questions. The fixed response questions had been administered to obtain socio-economic and demographic information about the respondents, and to collect information about health care facilities available in their block area. The socio-economic and demographic questions included the respondents' age, marital status, level of education, ethnicity, and occupation. Generally, this information was gathered at the beginning of the interview in a conversational way in order to help make the respondents feel at ease about the interview.

In order to facilitate this process, an interview guide was also developed in the local language. The following standardized questions were administered.

1. How many Primary Health Centers (PHCs) are there in your locality?
2. In how many of the Primary Health Centers (PHCs) are an adequate number of doctors unavailable?
3. Are there any government directives for involvement of the Panchayat Samity members in the public health care system?
4. What are the objectives of the health committee?
5. Do the health committee members oversee the matter of treatment of the patients in the Block Primary Health Centers (BPHCs), Primary Health Centers (PHCs) and Sub Centers (SCs)?
6. Do the health committee members oversee the matter of supply of medicines in the Block Primary Health Centers (BPHC), Primary Health Centers (PHCs) and Sub Centers (SCs)?
7. How do the health committee members take the initiative to improve the health care facilities of their locality?
8. What is, from the point of view of Panchayat Samity members, the role of Panchayat in facilitating the family welfare programs in the locality?

Six field investigators, having at least a bachelor's degree and efficient in this area were appointed for the purpose of collecting data and were accompanied by the author. Accessibility to some eminent persons and professionals (respondents) was somewhat difficult since they were busy with their occupations. They were given information by official letters, seeking permission for an interview. Later they were contacted over the telephone for fixing the date and time for the interview.

The interviews were primarily conducted in the Panchayat Samity office, Block Primary Health Center, and sometimes at the residence of the respondents. Each interview lasted for about 40-50 minutes and the duration of data collection continued for

about one and a half months. The interview was recorded in the local language. It was then transcribed into English. Apart from the interview guide, there were field notes and observations, which were also recorded and used for analysis of data.

Mode of Analysis

Case study research is not based on a statistically representative sample. Keeping in view the nature of information gathered through qualitative study, focused on the purpose of the research is of critical importance. A large number of respondents or groups may not always assure more meaningful and pertinent information; it is rather more important that key respondents have been selected. Information collected by interviewing 44 respondents was satisfactory since most of the information converged as described in the findings. Data analysis consisted of examining, categorizing, tabulating, or otherwise recombining the evidence to address the initial propositions of the study (Yin, 1994). The transcribed data (from regional language to English), the field notes, and field observations were organized and analyzed based on a "case study approach." After the completion of data collection, the researcher engaged himself in the preparation of transcript, field notes, and field observations. The first step of analysis was the scrutiny of data, followed by their coding (Weber, 1985). The data were subjected to micro analysis, that is, detailed line by line analysis, as a result of which each individual case was coded in line. The process led to the construction of initial categories of responses and to the determination of the relationships among categories and then transcribed into key words (Datta, 2004). Using Miles and Huberman's (1984) tools such as charts, event lists, casual networks, and memos, the responses were then arranged in a pattern on the basis of similarity by putting tally marks. Moreover, the responses were arranged under major themes and categories and their relationship within and across the respondents that held together in a meaningful but distinct way. The present study discusses the nature of themes and patterns relating to the subjective meanings, knowledge, attitudes, participation, and involvement of the Panchayat Samity members. They were also seen highlighting the dynamic issues involved in how the role of the elected Panchayat Samity members were organized in national health and family welfare programs in West Bengal.

Trustworthiness

The case study research can be judged from the point of view of ensuring validity, credibility, reliability, and dependability of the study. Credibility is dependent upon the validity and reliability of the instruments used and internal validity of the study. In this study, the researcher (as the instrument) was intimately involved in preparing the questionnaire, in the entire process of data collection, in scrutinizing, and in analyzing the data. Credibility is also ensured by persistent observation, appropriate selection of respondents, and thick description of the study. Right selection of the respondents, thorough observation, in-depth interview, and appropriateness of the data contextual with the subject ensures dependability of the results. However, this study may not provide a generalization of results. It has aimed to achieve the holistic and in-depth understanding relating to the subjective meanings, knowledge, attitudes, participation, and involvement of the Panchayat Samity members in the national health and family welfare programs.

Triangulation

The observations, in-depth interviews, document review, and conversations with the participants reflected in the pattern of findings obtained from multiple data sources ensure the confirmability of the triangulation method. For example, the information obtained from the interviews of health committee members highlighted the perspectives and understandings, which were also evident from the interviews of the health personnel. Moreover, multiple transcriptions of the data have been done to ensure the validity of the results. Besides, most of the results of this study converge with the information in the existing literature. Furthermore, the research design has been selected according to the relevance of the subject being studied.

Findings

The organization of data that gave rise to the themes relating to the role of the elected Panchayat Samity members in national health and family welfare programs in West Bengal, India are discussed below.

Health Committee Members at Panchayat Samity (Block) Level

Table 3 is prepared with 60 percent male members and 40 percent female members of the health committee at Panchayat Samity level. 83 percent of members were Hindus and 17 percent were Muslims. 87 percent members were ever married (that is, currently married, widowed, divorced or separated). Little more than one-third of the members completed Madhyamik (10th standard) or Higher Secondary (12th standard) examination.

Thirty percent of the members had completed a graduate degree and 17 percent had completed a post-graduate examination. Among the males, 11 percent were post-graduates while among the females, 25 percent had completed post-graduate degrees. Among male members 28 percent each were in agriculture and fishing and in business, while only 17 percent were in service. Among females two-thirds of the members were house wives and 25 percent were in service. The percent of service holder females was higher than that of service holder males.

Involvement in Public Health Measures

Out of a total number of respondents of 30, only little more than half (n=16) responded regarding their involvement in public health system. The responses are presented below:

Knowledge of the Health Committee Members Regarding their Statutory Involvement in Public Health

The Panchayat health-committee members conducted monthly meetings along with the health workers. They also actively participated in the public health system and cooperated the activities of the health department. A few respondents reported that the

provision of articles 31, 32, 33, and 124 of the Panchayati Raj Institution made it obligatory to form health committees at three-tier Panchayats. Moreover, it is obligatory for the Panchayat members to get involved in the public health affairs of the rural people.

Table 3

Background Characteristics of the Panchayat Samity Members

Respondents and Characteristics	**Percent of members**		
	Male	**Female**	**Total**
Designation			
Chairman	**27.8**	**8.3**	**20.0**
Convener	**22.2**	**16.7**	**20.0**
Member	**50.0**	**75.0**	**60.0**
Total	**100.0**	**100.0**	**100.0**
Age (in years)			
26-40	**22.2**	**33.3**	**26.7**
41-55	**66.7**	**56.4**	**63.3**
56+	**11.1**	**8.3**	**10.0**
Total	**100.0**	**100.0**	**100.0**
Religion			
Hindu	**88.9**	**75.0**	**83.3**
Muslim	**11.1**	**25.0**	**16.7**
Total	**100.0**	**100.0**	**100.0**
Marital Status			
Never Married	**11.1**	**16.7**	**13.3**
Married	**88.9**	**83.3**	**86.7**
Total	**100.0**	**100.0**	**100.0**
Education			
Post Graduate	**11.1**	**25.0**	**16.7**
Graduate	**33.3**	**25.0**	**30.0**
Madhyamik or H.S complete	**44.5**	**25.0**	**36.6**
Middle complete	**11.1**	**25.0**	**16.7**
Total	**100.0**	**100.0**	**100.0**
Work Status			
Agriculture & Fishing	**27.8**	**-**	**16.7**
Laborer	**5.5**	**-**	**3.3**
Self Employed	**11.1**	**-**	**6.7**
Business	**27.8**	**-**	**16.7**
Service	**16.8**	**25.0**	**20.0**
Retired / Pensioner	**5.5**	**8.3**	**6.7**
Unemployed	**5.5**	**-**	**3.3**
House Wife	**-**	**66.7**	**26.6**
Total	**100.0**	**100.0**	**100.0**
Number of Members	**18**	**12**	**30**

The health committee members held their views that they were involved in the building of awareness about public health and also motivating people regarding child immunization with special emphasis on Pulse Polio, safe drinking water, sanitation, and State and National Health Programs. Further, they cooperated in the treatment of infectious diseases like malaria, diarrhea, Tuberculosis, etc.

Knowledge of the Health Committee Members Regarding the Objectives for Formation of Health Committees

Out of 30, 29 respondents (n=29) offered their views regarding the objectives for formation of the health committee at Panchayat Samity level. The health committee members were knowledgeable about the objective of building awareness among people on public health issues, the related practice of keeping the surrounding areas clean and preventing environmental pollution. Most of the respondents felt the need to arrange for safe drinking water. The Panchayat health committee members realized that water supply and sanitation are very important in the overall program of rural development. The respondents were aware of their responsibility, which was to inspect and improvise the health care facilities in their locality. Most of the respondents reported that one of the main tasks was to campaign, motivate, and participate in the Pulse Polio Immunization Program. They also knew that another important objective was to keep a watch on the functioning of Rural Hospital, Block Primary Health Center (BPHC) Primary Health Center (PHC), and Sub Center (SC). According to them, active participation in different National Health Programs and looking after the maternal-child health care were major activities. The health committee members reported that some other objectives for formation of health committee are to build awareness; to arrange for preventive care; to help identify the patients suffering from communicable diseases such as diarrhea, malaria, T.B., and HIV-AIDS; and to get involved and take initiative in birth control and family planning measures.

Necessary Actions Taken by the Health Committee Members Regarding Implementation of Decisions

Out of 30, 16 respondents (n=16) advanced their views regarding necessary actions for the implementation of the decisions taken at their last meeting.

Necessary actions were taken to implement the decision of the last meeting on Pulse Polio for all children (0-5 years) and on other immunizations. Special care was also taken for the defaulter cases of Pulse Polio.

The health committee members responded that actions were taken on mass campaigning for the Integrated Sanitation Program and installation of sanitary toilets at cheaper cost, inspecting whether everybody was being provided with adequate safe drinking water, re-sinking and repairing of tube-wells, spraying bleaching powder, distribution of halogen tablets in post flood situation, and the eradication of environmental pollution.

Only a few respondents informed that actions were taken on: construction of houses for Sub Center, repairing the old houses of health centers, and arranging for electricity and ambulances in the health center.

A considerable number of respondents told that necessary steps were taken to oversee ante-natal care of mothers. Further, it was also decided to oversee and monitor the services of health workers in this regard.

Follow-up Actions Envisaged by the Health Committee Members on the Decision Taken in the Last One Year's Meeting (preceding the date of survey)

According to all the respondents, cooperation and campaigning for Pulse Polio got top priority among other activities of the Panchayat health committee. Campaigning was proposed to be done for the Integrated Sanitation Program, construction of sanitary toilets for those below poverty line (BPL) households, and assigning responsibilities to the non-governmental organizations (NGOs). The majority of the respondents answered that actions were taken for identification and building of awareness about the diseases such as T.B., leprosy, diarrhea, malaria, cholera, and HIV-AIDS, and arrangement of treatment and increasing motivation for maintenance of cleanliness and hygiene, including advice for giving boiled water for drinking to the children. Actions were also taken for repairing and re-sinking of old and defective tube-wells, and installing the new ones. The respondents told that emphasis was given on a priority basis in improving maternal-child health care and providing pregnancy allowance to below poverty line (BPL) mothers. A few of the respondents noted that campaigning was also organized for family planning. Furthermore, action was taken for recruiting permanent doctors at the Primary Health Center (PHC). The Zila Parishad was requested to arrange for necessary funding for the construction of houses of Sub Centers.

Responses of the Health Committee Members Regarding Whether they Would Oversee the Supply of Medicine at Primary Health Centers and Sub Centers in their Block Area

The health committee members were specifically asked whether they would oversee the supply of medicine at Primary Health Centers (PHCs) and Sub Centers (SCs). The respondents answered that during a crisis of medicine, they requested the Chief Medical Officer of Health (CMOH) through the Block Medical Officer of Health (BMOH) to arrange the supply of medicine at Primary Health Centers (PHCs) and Sub Centers (SCs), but reported that supply could not often meet the needs and demands. The respondents said that information was received from Primary Health Centers (PHCs) and Sub Centers (SCs) about health care services during different health programs. Information was also taken from health staff about whether the patients were provided with adequate medicine. Further, enquiry was made whether the pregnant mothers were given proper care and medicine.

Responses of the Health Committee Members Regarding the Aspects of Health Care Services they Would Oversee at the Health Centers in their Block Area

We know whether the health committee members were involved in overseeing various aspects of health care services of the heath centers. For Block Primary Health Centers (BPHC)/ Rural Hospital and Primary Health Centers (PHC), most of the

respondents stated that they supervised the aspects of treatment provided by the doctors' services, as well as status of family planning, medical test, antenatal care, and medical check up of pregnant mothers, immunizations of children, birth, and death registration, implementation of National Health Programs, supply of medicines, supply of safe drinking water, electricity, cleaning the surrounding areas, and maintenance of the houses of health centers etc.

The health committee members informed us that they took care of the services of health workers for maternal-child health, housing problem of Sub Centers, electricity, and drinking water. Moreover, they oversee and monitor the immunizations of the children including Pulse Polio and treatment of the patients at the Sub Centers and activities of health workers for family planning.

Responses of the Health Committee Members Regarding how they had Cooperated with the Health Department in Order to Improve the Health Care Facilities in their Block Area

Out of 30, 28 health committee members (n=28) reported that they had cooperated with the health department in order to improve the health care facilities in their block area. The respondents had cooperated in campaigning for different national health and Pulse Polio programs. They had arranged for treatment of the serious patients and the patients suffering from communicable diseases like T.B., malaria, diarrhea, etc. The health committee members said that they participated in the family planning camp and motivated the Muslim (minority community) couples to accept family planning methods. Besides, they had discussed with the Block Medical Officer of Health (BMOH) regarding the adequate supply of medicine, resources for treatment, infrastructure of the health centers, and problems of the health workers and patients. Initiative was also taken for improvement of the health care facilities and recruitment of doctors, arrangement of maternal-child health care for those who were not under treatment, and arrangements were also made for a mothers' meeting. Furthermore, a medical team led by the BMOH was sent at the time of an epidemic. Cooperation was also enhanced for improvement of birth and death registration.

Out of 30, 26 health committee members (n=26) took initiative for improvement of health care facilities in their block area. The respondents tried to increase public awareness about health care through motivation and campaigning for Pulse Polio and other immunization programs. Further, they took the initiative to implement the Integrated Sanitation Program. As evidenced from the field enquiry, the health committee members resorted to the development of the infrastructure. They had arranged to repair and construct the houses of Sub-Centers, arranged for a rented house and ambulance, appointed specialist doctors, extended the outdoor facilities, and increased the number of beds. They participated in the maternal-child health program and arranged for a mothers' meeting, arranged to provide preventive care for malaria and diarrhea, and disinfected the wells and tube wells in a post flood situation. Initiatives were also taken by the health committee members to implement the national health programs and family planning programs. Furthermore, they had arranged for treatment of the patients in their block area.

Initiatives Taken by the Health Committee Members to Improve the Drainage and Sanitation System in their Block Area

We find the nature of actions taken for improvement of the drainage system in their block area. Out of 30, 27 health committee members (n =27), a significant majority, took initiative in this regard. As a part of this initiative the under-prepared drains were cleaned and concrete drains were constructed before rain with the financial aid from Gram Panchayat. They were aware that water is so essential for daily life, could also be a source of communicable diseases like malaria, diarrhea, and jaundice, and a cause of ill-health if contaminated or improperly used and stored. It is a positive achievement that they understood the importance of safe drinking water and improved sanitation, which play an important role in the overall well being of the people with a significant bearing on the infant mortality rate, general death rate, and longevity. They further reported that the poor rural people bear a disproportionate burden of non-availability of water. Accordingly, the health committee members took measures to provide sufficient safe drinking water to the rural people of their area. The respondents also said that emphasis was given on Integrated Sanitation Program to facilitate the improvement of drainage systems. Furthermore, a few concrete drains were also constructed by the Panchayat Samity.

Responsibilities and Duties of the Health Committee Members Towards Following Serious and Communicable Diseases and Family Welfare Programs

Almost all the respondents took necessary actions towards the following serious and communicable diseases.

After identification of T.B. patients, the respondents referred them to hospital for treatment under direct observation (DOT). The patients were advised to examine their coughing and blood in the hospital. Actions were taken to provide adequate medicine to the poor patients. Above all, emphasis was also given for building up awareness about the harmfulness of the disease.

The health committee members advised the patients to test their blood and coughing, if malaria parasites were found, they were referred to the hospital for treatment. The Panchayat Samity arranged to spray DDT and bleaching powder in the Malaria affected area. People were also advised to take preventive measures even though they were not infected from the Malaria parasite.

The health committee members were actively involved in the treatment of patients in the eye camps organized by the non-governmental organizations (NGOs). They were also involved in identifying the patients suffering from eye sight problems and they (patients) were referred to the hospital for treatment. Further, cataract operation camps were also organized by the Panchayat Samity to facilitate the treatment of poor patients.

The health committee members reported that a medical team led by BMOH was sent to the diarrhea affected area. They had arranged to supply ORS, saline, halogen tablets to the patients suffering from diarrhea with advice to maintain cleanliness and hygiene. If serious, the patients were referred to hospital. Campaigning was also done to advise people to drink boiled water and fresh food during a flood.

The health committee members took initiative to identify the patients suffering from leprosy, and after identification the patients were referred for regular treatment in the hospital. Leprosy being a noteworthy social disease, attempts were made to build awareness and motivation to treat with utmost care while maintaining patients' privacy.

The respondents took initiative to bring women belonging to general strata of society to the family planning camp. It is generally known that the minority Muslim communities are opposed to family planning on religious grounds. The respondents and the ICDS workers took on the difficult task of motivating them. The health committee members participated in awareness campaigning to limit family size to two children, and those who had more than two children were advised to accept a ligation method. Furthermore, they took initiative for adequate supply of oral contraceptive pills, condoms, and temporary methods of family planning.

The respondents advised the pregnant mothers to go to the Sub Center for ante-natal care where they were given iron folic acid and vitamin tablets. The health committee members arranged for a mothers' meeting and made them aware of family planning methods. Further, the mothers belonging to below poverty line (BPL) households were given pregnancy allowances and also advised to consume balanced diets during pregnancy.

The majority of respondents had referred children to a Sub Center for Polio, Pulse Polio, and other immunizations. The health committee members arranged for baby shows in their block area along with the Block Primary Health Center (BPHC). Efforts were made to help children overcome malnutrition and developmental impairments. Moreover, the parents were advised to give boiled water for drinking to their children.

Opinion of the Health Committee Members Regarding Whether They had Made any Complaints About the Health Care Services and a Remedial Measures Taken in this Regard

Out of 30, 24 health committee members (n = 24) reported that they had made complaints about the following health care services and accordingly, the authority concerned taken remedial measures.

The health committee members complained to the Chief Medical Officer of Health (CMOH) and Zila Parishad through the Block Medical Officer of Health (BMOH) for remediation of workers negligent in their duties. Accordingly, the concerned workers had been transferred by Block Medical Officer of Health (BMOH). The health committee members further reported that the doctors on night duty who neglected their work were also referred for remediation.

The respondents reported that complaints for insufficiency in the distribution of medicine were sent to the Chief Medical Officer of Health (CMOH) through Block Medical Officer of Health (BMOH). Participants reported that after a complaint the supply of medicine was better than before.

The health committee members reported that for deficiency in the supply of resources of treatment, an appeal was made to the Chief Medical Officer of Health (CMOH) and Zila Parishad through Block Medical Officer of Health (BMOH) to take necessary action. As a result, the supply of resources became more satisfactory.

The health committee members took initiative to appeal to Zila Parishad for the improvement of infrastructure, that is, construction of houses of the health centers, increase in the number of beds therein, and building labor rooms. As a follow up to the appeal, Zila Parishad enquired about the infrastructure and took necessary action for its development.

Attitude of the Health Committee Members Towards the Activities of NGOs and Other Voluntary Organizations

Out of 30, 29 health committee members (n = 29) provided responses. The respondents reported that they were satisfied with the activities of the non-governmental organizations (NGOs). They (NGOs) were sometimes provided with financial aid by the Panchayat Samity but participants felt that there should be more co-ordination between Panchayat and NGOs. They further reported that the NGOs organized eye camps and blood donation camps, provided relief during the occurrence of flood, provided safe drinking water, and literacy programs to the adult and handicapped persons. Besides, the respondents acknowledged that the NGOs worked for the Integrated Sanitation Program and Pulse Polio Program. Also the NGOs provided some emergency services such as cooperation in natural calamities, in epidemics, and rescue operations during the time of flood. But some of the respondents were of the view that the NGOs should not be biased politically, which might cause adverse image towards such a voluntary organization.

Opinion of the Health Personnel

In this section, the Block Medical Officer and one each from Block Sanitary Inspector, Social Welfare Officer, Health Inspector, and Health supervisor from each Block Primary Health Center (BPHC) and Rural Hospital were interviewed.

Opinion of the Doctors and Health Supervisors Regarding the Objectives Behind the Formation of Health Committee

Most of the doctors and health supervisors believed that there should be co-ordination between health department and Panchayat Samity members in order to implement the state and national health programs. They agreed that one of the objectives of the health committee is to determine policy for promotion of health care facilities and family welfare, discuss the health related issues, and generate the possible solutions.

Opinion of the Doctors and Health Supervisors Regarding Whether they Work Together with the Panchayat

Most of the doctors and all health supervisors held their views that the Panchayat Samity members at block level cooperated with the health staff for campaigning and motivation in the immunization programs. The respondents opined that the Panchayat Samity members were involved in the health care services of Primary Health Centers (PHCs), and took information regularly from the health staff regarding the facilities available in the health centers. Further, the Panchayat Samity members cooperated with

the health department in implementing the leprosy, malaria, T.B., and HIV-AIDS control programs as well as family planning programs. The cooperation was also extended to birth and death registration. Besides, they cooperated and got involved in some other health related activities such as natural calamities, baby shows, health fairs, supply of safe drinking water, pollution control, and distribution of oral rehydration salts (ORS) and halogen tablets during flooding.

Perception of the Doctors and Health Supervisors Regarding the Areas of Advantages in the Joint Activities of Panchayat and Health Department

All the doctors and health supervisors believed that the Panchayat members, as the peoples' representatives with popular backing, their cooperation was essential in motivating people for child immunization, health and family welfare programs, and treatment of infectious diseases. The respondents were of the opinion that among Muslims and isolated communities, Panchayat members were successful in motivating people to participate in immunization and family welfare programs. The respondents further observed that in the joint activities, the Panchayat members shielded the health workers from public grievances so that the health workers could work smoothly and comfortably.

Perception of the Doctors and Health Supervisors Regarding the Disadvantages in the Joint Activities of Panchayat and Health Department

The respondents reported that as a result of illiteracy and ignorance, some Panchayat members sometimes crossed their legal boundaries and intervened in the internal administrative affairs of the health department. The participants believed that Panchayat members were not the competent authority to enquire into the attendance register and activities of the health personnel. Some participants complained that the Panchayat members occasionally tried to impose their opinion from a political view point.

Perception of the Doctors and Health Supervisors Regarding the Measures that Can be Adopted to Remove the Disadvantages in the Joint Activities of Panchayat and Health Department

The doctors and health personnel strongly felt that the Panchayat members should not be politically biased while dealing with peoples' problems. According to them, Panchayat members should be paid for their active involvement in the health programs. Needless to say, the respondents wanted the Panchayat members to be aware of their responsibilities, duties, and capabilities. The doctors and health supervisors agreed that to be a member of such a health committee, efficiency and competence should be the criterion. The participants believed that the medical personnel should also be strict without being influenced by petty politics in the villages.

Opinion of the Doctors and Health Supervisors on the Effective Participation of Panchayat Members in Health Programs

Most of the doctors and health supervisors agreed that the Panchayat members should be provided with health training so that they might have better knowledge to get involved in different aspects of the public health system more effectively. The doctors and health supervisors opted for building awareness of the Panchayat members about their duties and responsibilities towards health care services. The participants believed that health committee meetings should take place at regular intervals and that there should be more co-ordination between the health department and Panchayat. Moreover, the participants ranked their perspective very highly that the Panchayat representatives should have goodwill and should be hearty and have a cooperative attitude towards the health programs.

Perception of the Doctors and Health Supervisors Regarding the Involvement of Panchayat Members in the Family Welfare Programs in Their Locality

The doctors and health supervisors felt that the Panchayat members, specifically the female members, should conduct more campaigning for increased motivation for the acceptance of family planning methods. They thought that in order to implement the family planning program successfully, the Panchayat members should be provided with intensive training. Additionally, they urged that intense focus should be given for motivating vulnerable populations such as Muslims and isolated communities in accepting small family norm. The respondents also believed that they (Panchayat) should also increase the number of laproscopy camps and arrange for mothers' meetings and awareness camps.

Perception of the Doctors and Health Supervisors Regarding the Role of Panchayat Members for the Improvement of Health Care Facilities and Family Welfare Programs

The doctors and health supervisors felt that the Panchayat members should be more active in creating health awareness among people and in promoting the health care facilities in their locality. The respondents were in favor of building awareness among people about maternal and child health care. The doctors and health supervisors were strongly of the opinion that public health programs can not be achieved successfully without active involvement of Panchayat. Moreover, they believed that Panchayat members should take active roles in building awareness about the harmfulness of communicable diseases like T.B., malaria, HIV-AIDS, etc.

Follow-up Actions Taken by the Panchayat Samity Members for the Proposals Suggested By the Doctors and Health Supervisors

In regard to the proposals given by the doctors and health supervisors, Panchayat members had taken the following actions: conducted campaigning and providing person-power for the Pulse Polio immunization program, Panchayat made contact with the Zila

Parishad, Chief Medical Officer of Health (CMOH) and Member of Parliament regarding the local health problem and financial aid, extended cooperation towards the Integrated Sanitation Program, and provided funds for construction of houses of Sub Centers (SC) and buying materials necessary for health care treatment.

Discussion

Nearly 90 per cent of the health committee members had adequate knowledge about the educational institutions, public and private health facilities, number of health workers in the health centers, delivery of different types of health care services provided by different health workers, and quality of health care services rendered by health centers.

The health committee members at Panchayat Samity level were involved in promoting health awareness among people, especially about child immunization, and motivating people about the acceptance of family planning methods and arranging for treatment of the rural people.

For effective implementation of small family norms, the health committee members were involved in mass campaigning, in raising consciousness of the people and in cooperation and communication with the health workers. They (Panchayat) had also taken initiatives for the improvement of the public health system through initiatives to improve safe drinking water and sanitation.

The health workers who had been interviewed agreed that the involvement of Panchayat members is required in improving the health care facilities in rural areas. The Panchayat members assisted in campaigning for the immunization program, maternal-child health programs, public health and sanitation, work for communicable diseases, and in registration of births and deaths. It was observed that the health committee members at Panchayat Samity level take more interest in and participate in the child immunization efforts, specifically the Pulse Polio program, which was given top priority among other activities.

Furthermore, it was found that there was a gap in knowledge of the health committee members at Panchayat Samity level. Nearly 10 percent of the health committee members were not aware of the educational institutions, public and private health facilities, delivery of different types of health care services provided by different health workers, quality of health care services rendered by health centers, and government orders regarding involvement of Panchayat members in the public health affairs. This gap in knowledge was mainly due to illiteracy and lack of understanding of their responsibilities of the respective health committee members. Special care should be taken to improve the literacy level of the health committee members.

To improve the level of knowledge, performance, involvement, and attitudes of the health committee members towards the national health and family welfare programs of the rural people, discussion of health related issues should include the health committee members in meaningful ways. In this regard, health oriented training may be helpful in order to improve the level of efficiency of the Panchayat members. Building of awareness about their duties and responsibilities regarding health and family welfare programs is needed and the Panchayat members should be provided with a special training module for their duties and responsibilities towards health and family welfare

programs. To insure the smooth functioning of the Panchayati Raj Institution, outside intervention from political parties should be stopped in order to overcome serious delays in decision making. Health committee meetings are not arranged regularly, which creates a communication gap between the health committee members and the health personnel. Special care should be taken in this regard by regularly scheduling health committee meetings.

Apart from the above, Hooghly is a highly developed district in the state of West Bengal where the literacy rate and per capita income is high and birth rate is lower than the state average. Though the performance of Panchayat members in the Hooghly district is better than the state average performance, there is still room for improvement.

References

Datta, P. (2004). Push-pull factors of undocumented migration from Bangladesh to West Bengal: A perception study. *The Qualitative Report 9(2),* 335-358. Retrieved from http://nova.edu/ssss/QR/QR9-2/datta.pdf.

Dreze, J., & Sen, A. (1995). *Economic development and social opportunity*. New Delhi, India: Vedams.

Gall, M. D., Gall, J. P., & Borg, W. R. (2003). *Educational research: An introduction* (7th ed.). Boston: Allyn and Bacon.

Ghatak, M., & Ghatak, M. (2002). Recent reforms in the Panchayat system in West Bengal – toward greater participatory governance. *Economic and Political Weekly of India, 37(1),* 45-58.

Merriam, S. B. (1988). *Case study research in education: A qualitative approach*. San Francisco: Jossey-Bass.

Miles, M. B., & Huberman, A. M. (1984). *Qualitative data analysis: A sourcebook of new methods*. Newbury Park, CA: Sage.

Mukherjee, S. K. (1974). *Local self government in West Bengal*. Kolkata, India: Dasgupta Publishers.

Mills, Anne & Shillcut, S. (2004). *Challenge paper on communicable diseases, Copenhagen consensus challenge paper*. Retrieved (01.09.2007) from http://:wwwcopenhagenconsensus.com/Admin/Public/DWSDownload.aspx?File=Files%2FFiler%2FCC%2FPapers%2FCommunicable_Diseases_160404.pdf.

Ministry of Law and Justice, Government of India. (1950). *Article 243 G, Constitution of India*, New Delhi, India.

Ministry of Finance, Government of India. (2008-09). *Union budget & economic survey*. Retrieved from http://indiabudget.nic.in/ub2008-09/bag/bag4-2.htm.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). London: Sage.

Registrar General, Census of India. (2001). *Table C-8: Education level by age and sex for population age 7 and above, India, 2001,* C Series, New Delhi.

Registrar General, Census of India. (2001). *Table C-14: Population in five year age-group by residence and sex,* C Series, New Delhi.

Registrar General, India. (2001). *Sample registration system: Statistical report,* Vital Statistics Division, New Delhi.

Srivastava, H. C., Ram, F., Paswan, B., & Nagdeve, D. A. (2004). *Involvement of the members of Panchayati Raj Institution in health and family welfare programs: A case study of Bharatpur and Udaipur districts of Rajasthan,* Population, Health and Development in India: Changing Perspectives, Udaipur and New Delhi: Rajat publication.

World Health Organization. (2004). *Country health profile – India: Trends in policy development*. Retrieved from http://w3.whosea.org/EN/Section313/Section1519_6803.htm.

Yin, R. K. (1993). *Applications of case study research*. Newbury Park, CA: Sage.

Yin, R. K. (1994). C*ase study research: Design and methods* (2nd ed.). Thousands Oaks, CA: Sage.

Yin, R. K. (2002). *Case study research: design and methods* (3rd ed.). Newbury Park, CA: Sage.

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