

**Evaluation of RCH – IEC Activities Through *Zilla Saksharata Samitis* in
Maharashtra**

District Nagpur

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Background

India would become the most populous country by the year 2050, if the same growth prevails. Though growth rates are declining, population is still increasing enormously – 1.6 crores more people every year. The replacement level fertility of Total Fertility Rate (TFR) of 2.1 would be reached by 2026 in India. However, state-wise variations in TFR show that Kerala and Tamil Nadu have already reached the replacement level whereas Uttar Pradesh would not reach it even by 2051. In the National Development Council a strong opinion was expressed at the time of discussion of the 9th plan that population control is the biggest problem the country is facing today. Unless this problem is tackled, results of development in other sectors will prove inadequate.

Population stabilization being considered as the most important issue, Department of Family Welfare is taking efforts to help couples to limit their families. A well-knit infrastructure of health functionaries all over the country is working as per the schedule to provide necessary support. Thus slowly but certainly the message is reaching. Most of the Information, Education and Communication (IEC) efforts are through the electronic media and the newspapers. Though this is a successful effort, still 20 to 30 per cent families have no access to these media (Communication from MOHFW). Their participation in RCH / population stabilization is crucial for the success of the programme. Particularly to reach this group some additional work need to be taken up.

Department of family welfare has started communicating the message of RCH through schemes like *Mahila Swasthya Sangh* (MSS) and *Zilla Saksharata Samiti* (ZSS) in each and every village, apart from the routine services provided by Government health functionaries. MSS is a platform for women to come together,

where Auxiliary Nurse Midwife (ANM) provides RCH information to group of village women followed by some other programme and / or a tea party. The thought behind this is, when women will come together they will discuss their problems and then somebody may come forward to help them solve.

Role of IEC

IEC is known to play a major role in introducing Reproductive and Child Health (RCH) services to the people and encouraging their utilization. RCH approach to family planning is more client-oriented. Hence, to take the services to the concerned target group. IEC activities assume a lot of importance, Operationalizing this approach to implement family welfare programme in the country poses an enormous challenge to the programme planners and implementers.

During past two decades the activities of the IEC in the field of family planning and health have undergone a change from creating general awareness by providing information to focus on specific services and behaviour change. According to the World Bank, IEC today is defined as “the process of formulating and disseminating messages that make individuals and communities aware of health and reproductive issues and of the strategies and behaviour which would enable them to attain related goals” (World Bank, 1995).

IEC activities have been a part of India’s family welfare programme for past 30 to 40 years now. It certainly has helped in generating awareness about spacing methods, Ante Natal Care (ANC) and immunization. However, the contribution of these activities in bringing out the change in behaviour has been limited, which is evident from findings of National Family Health Survey (NFHS), 1992-93. In Maharashtra though 98 per cent currently married women know about at least one modern contraceptive method, only 53 per cent of them were using any modern method (NFHS, 92-93).

Kapadia - Kundu et. al. (1997) in their study highlight five areas of IEC.

1. Knowledge – behaviour gap
2. Group influence
3. Discussions with households and communities

4. Audience: focus on decision makers

5. Micro and district level planning for IEC for all components of RCH

In general, IEC messages are much more effective if they are need specific and situation specific. It implies a much larger role for inter-personal contact at grass-root level.

About Zilla Saksharata Samiti

ZSS works for literacy campaign. It is a part of the education department and comes under District Collector and District Education Officer. They have proved themselves by working hard to eradicate illiteracy. ZSSs have their volunteers in each and every village. They conduct the classes and teach everyone in the village to read and write. In Maharashtra, now post-literacy programme is going on. Under this programme, these newly literate people are supposed to gather and read the books by themselves, in the presence of a volunteer. Thus this activity brings together those who have passed the age school going age and are illiterate or newly literate. It is then easier to spread the information in this group.

Role of ZSS

Department of Family Welfare in coordination with Department of Education, Ministry of Human Resource Development have attempted to spread RCH messages through ZSS. At present the scheme is in operation in 216 districts and they are at various phases of implementation. Since ZSS have achieved sizeable amount of success in mobilizing the community for literacy, it was thought to be helpful even for the purpose of RCH. Compared to the health workers the Literacy workers cover a larger area and hence, it was rightly assumed that RCH messages spread through ZSS will cover a large population.

It is seen from various fertility studies that there is a direct relation in educational level of women and their fertility. Therefore, if education and RCH information is given together, goal of population stabilisation would be attained in shorter time. ZSSs have achieved a notable success in the field of literacy. Recognizing their efforts in elevating the level of literacy, it was then decided to give them additional

responsibility of RCH. ZSSs have asked to prepare project proposals using local media, folk forms, local talent, display of posters, wall writings, rallies, mass campaigns etc.; keeping in view RCH and population stabilization. Individual projects are scrutinized and sanctioned in collaboration with National Literacy Mission. An amount of Rs. 3 to 6 lakhs was decided to spend annually per project.

In this scheme, one *Swayamsevak*, who is appointed as a volunteer to conduct the literacy classes in the village, is to be trained for various features of RCH and related activities. He is asked to spread this information in the literacy class in the village. He is supposed to be an educated person in the village and being a local person and teacher in the literacy class, is known to everybody. It is seen from various earlier Government schemes that if local person is appointed for certain work in the village, people tend to believe in him / her more; rapport building is easier in such case and they feel that whatever he / she advises is for their benefit. *Anganwadi* worker (AWW) is one such good example. Apart from spreading message just in literacy class everyday, it has to be spread through a local folk medium in the form of *kala jaththa*, which is a very effective medium, posters and rallies in towns and villages and organizing workshops for orienting and sensitizing opinion leaders, literacy workers, social activists etc. The intention behind choosing different media is that when something is to reach the people, it has to be hammered constantly so that its importance is conveyed.

Guidelines for IEC activities through ZSS for RCH

The main objective of family welfare programme in the country on one hand is stabilization of population in the country and on the other hand to seek improvement in reproductive and child health status. To make this nationally important programme successful, both government and non-government agencies have to work hard. All the citizens have a right to get informed, educated and counseled on all related issues to improve on their level of well being and reproductive health. The RCH programme has the following important components to be reached.

1. Awareness about an already large population, in view of education, nutrition, economic share, employment and quality of life for individual family members and also environment and employment etc. in the community.
2. Knowledge about various methods of contraception and consequences of using and not using each of it. It also includes the knowledge about when to use spacing methods and when the terminal.
3. Information regarding nutritional status of children, adolescents and women and effect of nutrition on mental development and on pregnant women.
4. Knowledge of Anaemia – its prevalence and consequences for children, adolescents and women.
5. Information on Diarrhoea control and role of Oral Rehydration Solution (ORS).
6. Awareness about the vaccine preventable diseases and immunization and importance of taking all doses.
7. Vitamin A and Iron and Folic acid supplementation and their importance.
8. Knowledge of Acute respiratory infection, its prevalence and consequences.
9. Awareness about right age at marriage.
10. Information on birth weight of children and consequences of low birth weight.
11. Knowledge about pregnancies and complicated pregnancies, importance of ANC, Tetanus toxoid injections, treatment of Anaemia and post-natal check-ups.
12. Information on maternal mortality situation and importance of institutional deliveries in view of life of both mother and the baby.

In this context, a comprehensive programme of IEC is proposed to undertake through electronic, print and outdoor media at national, state and district levels. At district level, the electronic or print media is unable to reach average families, where both these media are unavailable. However, there is a strong need for reaching them. ZSS can reach this segment of population through effective programme of environment building and mass motivation and mobilization. They can tap the community talent, resources and can use appropriate media to reach this underprivileged population. The

of designing of the project, considering his extensive experience in the field of health and family planning.

Role of District Media Officer in RCH through ZSS

District Media Officer is responsible for the publicity of RCH through ZSS before and after the programme on radio, television and newspapers. He is to look after both the advertisement of the programme as well as the news of the programme. He also has to arrange the interviews and look after related management required for various media.

Profile of Nagpur district

According to 1991 Census of India, population of the district is 32,79,687. Population density per square Kilometer is 159 in Nagpur district and sex ratio is 923. This is the most urban district preceded only by Greater Mumbai. About 62 per cent of the population was urban. Urban population resides in 12 towns in the district. In all there are 1591 villages comprising remaining 38 per cent of the population. In Nagpur district number of *gram panchayats* is 771. Among the males, about three fourths are literate whereas just about half of the females are literate in the district as a whole. There are 1402 primary schools in the district and 139 adult education centres. Number of *Mahila mandals* in the district is 304.

Evaluation of ZSS activities

After initiating the activities, at a later date, it was decided to evaluate the ZSS scheme on the basis of the objectives laid down as per the requirement of the project proposed and their fulfillment. Population Research Centre (PRC) in Gokhale Institute of Politics and Economics, Pune has been assigned the work to evaluate the functioning of ZSS in Maharashtra in all the districts where the schemes are running currently. In the pilot visit to five districts in which the scheme is sanctioned, it was found that it is running only in Nagpur, Akola and Bhandara. This report evaluates the RCH work of ZSS in Nagpur district.

Objectives of the study

Prime objective of this evaluation study is to assess the effectiveness of the implementation of RCH through ZSS scheme and its impact on target group. As per the guidelines drawn by the Department of Family Welfare, the study includes evaluation of

1. Time gap between sanction of funds at the central level (ministry of Health and Family Welfare) and receipt of the same by the ZSS and launch of the project.
2. The modalities of funds use and the manner in which accounts of expenditure have been maintained and financial experiences of the ZSS within the scheme.
3. Actual activities and schemes undertaken by the ZSS.
4. Periodicity of ZSS units meetings for this purpose and monitoring of the scheme.
5. The degree to which this scheme has been able to complement and co-ordinate with efforts by the IEC units within the Department of Family Welfare in each state.
6. The extent to which the targeted population, particularly, population research institutions and other village level bodies have become aware of the new scheme and RCH issues.
7. How far the scheme has been able to influence the health-seeking behaviour of the community in terms of knowledge and practice.
8. Shortcomings of the functioning of the scheme and suggested corrective measures to improve the same.

Methodology

The evaluation of RCH through ZSS is carried out with the help of

1. In-depth interviews with key officials at district level like Collector, ZSS secretary, DHO and District media officer.
2. Review of records to establish process measures.
3. Focus group discussions at community level.

4. Structured questionnaires for opinion leaders like *sarpanch*, *gram panchayat* members, school headmaster and religious leaders; functionaries and at village level and 10 community members in the age group of 15 to 35.

Coverage of the study

As per the guidelines by Department of Family Welfare 10 villages are to be selected for this evaluation study. To get a better spread, two villages each are selected from seven selected *tehsils* of Nagpur district. While selecting the villages criteria of distance from the nearest town is applied. Out of the two, one village is distance-wise very near from the town and the other is distant village. It is done so to see whether the scheme is running all over the *tehsil* or is functional only at the villages near urban area. Thereafter, 6 to 7 opinion leaders and 6 to 7 community members are contacted from each village to make them 100 each. In this evaluation study in all 93 opinion leaders and 112 community members are interviewed.

Out of 14 *tehsils* in the district, selected 7 *tehsils* are Savner, Ramtek, Kamptee, Bhiwapur, Nagpur (rural), Katol and Kalameshwar. From these 7 *tehsils* 14 villages are selected purposively keeping in view distance criteria. Waghoda and Nanda gomukh are selected from Savner, Patgowari and Deolapar are selected from Ramtek, Gada and Lonkhair from Kamptee, Tas and Besur from Bhiwapur, Godhani (Bk.) and Shiwa from Nagpur (rural), Khandala (Kh.) and Dorli (Bk.) from Katol and Sawangi and Lohgad from Kalameshwar. In his list the first village from each *tehsil* is the nearby village and the second is a far away village from the town.

Table 1: Distribution of number of opinion leaders and community members interviewed by *tehsils* and villages

Name of <i>Tehsil</i> / Village	Number of opinion leaders interviewed	Number of community members interviewed
Savner	13	16
Waghoda	7	8
Nanda Gomukh	6	8
Ramtek	16	16
Patgowari	8	8
Deolapar	8	8
Kamptee	17	15
Gada	8	8
Lonkhair	9	7
Bhiwapur	13	16
Tas	6	8
Besur	7	8
Nagpur (rural)	13	16
Godhani (Bk.)	6	8
Shiwa	7	8
Katol	10	17
Khandala (Kh.)	6	8
Dorli (Bk.)	4	9
Kalameshwar	11	16
Sawangi	6	8
Lohgad	5	8
Total	93	112

Duration of field-work

Visit prior to survey of opinion leaders and community members was made to get the overall idea about the project being run in the district and collect some information required for this evaluation from the office of ZSS in Nagpur in November 2000. Then after the translation of questionnaires and printing, actual fieldwork is carried out in December 2000 and January 2001.

Objectives of the proposed ZSS work

The major objective is to implement the IEC activities in Nagpur district in view of RCH and population control. The specific objectives include, imparting the

knowledge about RCH to selected *Swayamsevaks*, making use of local talent to spread the message of RCH. The project is mostly to stress the points like, literacy of women, age at marriage, small family size, spacing between two children, consequences of population growth, services to mother and child to improve their health status and reduce Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR), and lastly community participation and local involvement in RCH programme.

These objectives laid down in the proposal can serve as indicators while examining whether or not the project is succeeded.

ZSS activities in Nagpur District

In May 2000, a rally was arranged in all *tehsils* of the district. District Collector and Member of Legislative Assembly (MLA) in that area participated in the rally. In this rally, the message of importance of post-literacy programme along with RCH is stressed. Presence of Collector and MLA in rallies, create enthusiasm in the workers. Literacy Volunteer or *Swayamsevak*, as they are commonly called in the literacy programme is a teacher in the literacy class. At the time of the RCH project post-literacy programme was also being carried out in the district. Thus *Swayamsevaks* needed training for both, the post-literacy programme and RCH. For all 3560 *Swayamsevaks* training programme was arranged for two days.

Considering the importance of *Dai* in a village, under this programme one *Dais* training programme was also arranged. Eighty-nine untrained *Dais* are trained to provide natal help to village women.

Recognizing the importance of October 2, *Gandhi Jayanti*, 300 women rallies were organized in the district. Out of these 300 rallies, 283 were organized in the bigger villages or Primary Health Centre (PHC) or Sub-Centre (SC) villages. Seventeen rallies are conducted at the place of *tehsil*. In each of the rallies about 100 to 150 women participated. In Nagpur city and other urban areas a grand rally is arranged for women in slums. These are the women who are deprived of the advantages of staying both in the village and in a city.

Organization of *Kala Jathhas* is another important feature. It was organized in all 7 *tehsils* of the district. These performances were organized again either in bigger villages or PHC or SC villages. This activity was not completed till the time of evaluation.

Under RCH through ZSS, awareness programmes for adolescent girls and boys was arranged. It was run in 525 high schools and 212 junior colleges. It was completed in December 2000.

Training of volunteers

In ZSS, literacy volunteer or *Swayamsevak* is the key person of the scheme. He / she is supposed to spread the RCH information at the time of conducting literacy classes in the village. In Nagpur ZSS now runs the post-literacy programme. Two days training of volunteers was conducted in Nagpur for all 3560 volunteers. The training for such a large number of workers was arranged in 58 batches. In the two days training time slot for the RCH information is allotted on the second day after-lunch session, 2:30 p.m. to 5:30 p.m. RCH training consists of 3 smaller sessions. In one opinion, the time allotted for the RCH training was not adequate. The sessions were as follows:

1. Reproductive and Child Health Programme – Concept and Age at marriage and Disadvantages of Population Growth
Time - 2:30 p.m. to 3:30 p.m.
Resource persons- District Health Officer or Assistant District Health Officer
Form – Lecture, Discussion and Cassette show
2. Importance of Small Family and Methods of Contraception
Time – 3:30 p.m. to 4:30 p.m.
Resource persons- District Health Officer or Medical Officer
Form – Group discussion and presentation
3. Contraceptive Devices and Information on AIDS
Time – 4:30 p.m. to 5:30 p.m.
Resource persons- District Health Officer or Medical Officer

Form – Lecture using overhead projector

This makes clear that the training given to them is mainly on RCH and Maternal and Child Health (MCH), which includes knowledge about contraception for limiting the family size and immunization programme for children. It also gives information about AIDS; but it does not give any information about Reproductive Tract Infections (RTIs) and Sexually Transmitted Diseases (STDs). The message of family planning has already reached even to all interior places in Maharashtra now. What is more important now, is to spread information about RTIs and STDs, which is a chronic complaint of many women in varying severity. This is also important in view of rising threats of AIDS. This important content was missing in this training.

Test of volunteers

To know the awareness of volunteers regarding overall RCH issues, ZSS officials decided to test them. The same questionnaire (as given below) is administered to them before and after the training. They were asked 26 objective type of questions, - in the form of yes / no or true / false - which they had to write in 40 minutes. The questionnaire includes detailed questions on:

- ANC
- Care taken during pregnancy
- Institutional delivery
- Attendance of health personnel at the time delivery
- Birth weight
- Immunization of children especially the time table of various doses
- Information about child health, especially Diarrhoea and Acute Respiratory infection (ARI)
- Desire for more children
- Spacing between the children
- Use of contraception
- Age at marriage and its legal aspects

- Effects of population growth on literacy, IMR, MMR, unemployment, crimes, overall law and order situation in the country, per capita income, standard of living, industrialization and urbanization
- Male and female sterilization
- Spread of Human Immuno-Deficiency Virus (HIV) and modes of transmission
- Treatment on AIDS

This is an exhaustive list of RCH aspects. This is a task in itself to conduct the test of over 3500 volunteers twice. But unfortunately we could not get the results of these pre and post training tests, which could have been very useful to assess the training of volunteers.

Booklets prepared for volunteers

ZSS, Nagpur has prepared a booklet for their volunteers, to be circulated during the training, certainly with the help of Health department. This booklet includes the views of the officials of ZSS involved in the programme RCH through ZSS along with the time-table of the programme. It covers almost all RCH issues to be communicated by volunteers to villagers. If this booklet is read and understood well, volunteers can spread the message very effectively. The -Booklet covers following RCH issues.

- National family planning programme
- Safe motherhood
- Child survival
- RCH concepts and implementation
- Adolescent health
- Age at marriage
- Male involvement
- Ill-effects of population growth
- Advantages of small family
- Information on various family planning methods
- HIV / AIDS

Schedule of *Kala Jaththa*

Kala Jaththa is a major activity under the programme of RCH through ZSS. When asked about their performances, it was told that the programmes are going to take place in various parts of the district during the period November 2000 to February 2001. The schedule of *Kala Jaththa* in all the *tehsils* of the district was arranged as presented in Table 2.

Table 2: Time table of *Kala Jaththas* in various *tehsils* and number of performances in each *tehsil*

<i>Tehsil</i>	Duration	Number of performances
Hingana	29 November 2000 to 20 February 2001	22
Nagpur	28 November 2000 to 15 February 2001	19
Parshiwani	28 November 2000 to 18 January 2001	22
Narkhed	27 November 2000 to 29 January 2001	25
Kuhee	5 December 2000 to 23 February 2001	27
Kamptee	28 November 2000 to 31 January 2001	20
Bhiwapur	27 November 2000 to 27 January 2001	18
Katol	6 December 2000 to 27 February 2001	28
Savner	28 November 2000 to 4 January 2001	29
Mauda	20 November 2000 to 31 January 2001	22
Umred	24 November 2000 to 9 February 2001	22
Ramtek	28 November 2000 to 28 February 2001	27
Kalameshwar	29 November 2000 to 22 February 2001	19
Total		300

Only drawback of this activity lies in the selection of the places for these performances. The programmes are not arranged in the interior or smaller villages. They are organized only in the bigger, roadside villages or PHC or SC villages. Such villages always are benefited because of their position and size, while the interior villages remain deprived. Though such programmes are run keeping in view remote and smaller villages, they never get the benefits of the scheme. It is observed during the fieldwork that in the selected 7 *tehsils* the *Kala Jaththa* programmes were started according to the schedule.

4. Budget for RCH programme through ZSS

ZSS in Nagpur has prepared a budget for the RCH programme for the year 1999-2000. The details of the proposed budget are presented below.

Table 3: Proposed budget RCH through ZSS for the period 1999-2000

Sr. No.	Items / particulars	Proposed budget for 1999-2000
1	One day workshop of <i>swayamsevaks</i>	Rs. 1,78,400 /-
2	Local song groups, <i>kalapathak</i> , <i>natak</i> / dramas (with management charges)	Rs. 2,55,000 /-
3	Workshops for women	Rs. 31,200 /-
4	Workshops for adolescent girls / boys	Rs. 13,600 /-
5	District level supervision	Rs. 47,820 /-
	Grand total	Rs. 5,26,020 /-

For RCH through ZSS, Nagpur district received the grant of Rs. 5,13,000 /-, which is almost the same asked for. The details of the amounts spent are presented in the Table4.

Table 4: Expenditure of RCH programme in Nagpur District

Sr. No.	Item / Particulars	Expenditure
1	One day workshops	Expenditure through PLC
2	Booklets and questionnaire printing	Rs. 61,808 /-
3	Workshops for women	Rs. 27,300 /-
4	<i>Dai</i> training	Rs. 57,316 /-
5	Meetings	Rs. 1,244 /-
6	<i>Kala Jathha</i>	To be paid
7	Tehsil level programmes	Expenditure through PLC
8	Adolescent workshops	From respective schools
9	Local artists honorarium	To be paid
10	T.A. for <i>swayamsevaks</i>	To be paid

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Case 1

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(A review of the report on a follow-up study of IUCD by the Planning Research and Action Institute of Lucknow, May 1969).

A number of research centres in the country are working in the field of demography and quite a few reports are coming out either in print or in mimeographed form.¹ It is difficult to review all such reports. But there seems a need for reviewing at least the work of some of the important research centres since it is likely to be imitated by other centres. The present article thus reviews the report on 1174 IUCD acceptors in Lucknow district by the Planning Research and Action Institute (PRAI) in Lucknow in Uttar Pradesh.

The Director of PRAI mentions in the foreword that the conclusions of the report will be useful in planning and implementation of any IUCD programme. It therefore seems essential to review the report carefully as it may be used as a guide in analyzing the work of similar programmes elsewhere. Occasionally an attempt is also made by us to set out comparable figures for another such study on IUCD in non-city area of Poona district in Maharashtra which helps to assess the responses and findings of the PRAI project.

The PRAI project includes a study of 1174 IUCD acceptors and because of the large size of sample observed especially in rural areas, the findings are no doubt interesting. A number of aspects of the IUCD programme described in the report provide a fund of information on loop-insertions,² removal or expulsion rates, reasons for termination of loop-practice, contraception after termination and so on. The methods of presentation however need a careful examina-

¹ When in the mimeographed form, the findings are used by many taking them to be reliable. Or, they are used or not taken cognizance of, as is convenient. Since there is little that is coming in print, and a lot that is mimeographed and used, there seems a need for reviewing even the mimeographed material.

² In this article IUCD and loop are regarded as identical.

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tion. The present article being a review of methodology suggests alternative ways of presentation of the findings which perhaps may be more acceptable to a scientific approach to the study of loop-programmes.

Every sample survey requires a sampling frame and for a proper presentation of its study it is necessary to inform the reader about the sampling methods. For instance, the methods of selection of the sample, the extent of non-contacted units, extent of non-response, and the representative character of the contacted units—all these have to be described to judge the general applicability and the scientific basis of the enquiry. The report on the PRAI project does not seem to do this. A number of villages in the project could not be interviewed at all and still the question of representative character of the contacted sample is not discussed in the report. The villages that were left out could have an experience altogether different from that described in the report. Moreover the number of such villages is unknown. Thus, methodologically the report seems weak in this aspect of presentation.

A clear description of the administration of the loop-programme was essential to assess the responses of loop-acceptors. A brief description with regard to this on page 3 of the report does not clear a number of points such as the present programme being a part of the Family Planning Action Research Project that was taken up by the PRAI since 1963. If it was so, special sustaining efforts might have been made to motivate the women to loop-acceptance. Can the findings obtained here be compared to those of loop-acceptors in mass programmes conducted through loop-camps in certain other regions of the country? Such questions crop up off and on as one goes through the report but the reader remains in the dark on all such points after reading the complete report. As one goes through the details of data, one carries conflicting impressions of women in the PRAI project being motivated and not motivated to accept the loop. Some of the details are discussed in the following paragraphs.

In chapter two of the report, data regarding the ages of women and their number of born and living children indicate that women were motivated to get the loop inserted at an advanced age. The average age for loop-acceptance was 34.25 years. More than 50 per

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cent women were in the age-group 30-39 years and about 21 per cent were above forty years of age. Even women in advanced ages seemed to accept the loop. Was it due to the efforts made by PRAI? A similar study of loop cases conducted by the Gokhale Institute in the non-city area of Poona district in Maharashtra revealed an average age of loop-acceptance to be 30 years. Only 12 per cent loop-acceptors were above the age of 40 years. The data on age in the two projects show a difference which can be explained perhaps by higher motivation or better propaganda work in the PRAI project.

The average numbers of born and living children to a woman accepting loop in the PRAI project are 6.5 and 4.02 respectively. The proportion of living children among the total born was relatively small and still large numbers of women accepted the loop. It indicated that the loop-programme was a success in spite of a high death rate among the children born. Probably the efforts by PRAI motivated the women to accept the loop. The non-city experience with loop, in Poona district, showed that average numbers of born and living children to a woman accepting loop were 5.5 and 4.5.

The socio-economic characteristic of loop-acceptors discussed in the report included their caste and educational level. The sub-groups of Hindus as high, medium, low and 'others' in Table 4 of the report do not seem satisfactory. The category 'others' includes 21 per cent of the total loop-acceptors and 30 per cent of the Hindus who cannot be classified in the hierarchy of caste. Why should one use a vague classification like high, medium and low and still leave out 30 per cent as unclassifiable in the three categories? Further the caste-composition of the loop-acceptors is compared with that of the 'population'. One does not know what this 'population' is. Is it the parent population of females in the two blocks of the PRAI project? Or of married females of child-bearing ages in the area? Or, is it the total number of loop-acceptors including contacted and non-contacted cases? The total number in the 'population' with which the caste distribution of loop-acceptors is compared is 2928 as against 1174 loop-acceptors. If the 'population' means the total number of women, there were 190 women of child-bearing ages, among high caste Hindus, of whom 181 accepted the loop. Is it possible that almost all the women from the 'high' caste Hindus got

the loop fitted irrespective of their age or the number of children? On the other hand, if the 2928 is the total number of loop-acceptors, a host of problems arise regarding their representation through only 1174 cases. But apparently this does not seem to be the meaning of 'population' in Table 4 of the report. Again in the same table the last column indicates the significance or otherwise of the response to loop. How is this significance determined? Why is the response from the Muslims considered 'significant' and that from the medium Hindus called 'not significant'? It is difficult to guess the basis of such judgement without any explanation in the report.

Similarly the comment on Tables 6, 7 and 8 of the report either does not necessarily follow from the tables or could be made without the tables. For example, Table 6 gives the distribution of loop-acceptors according to the number of children born and living among them. This table could be used fruitfully to examine the proportion of living children among women of different parities accepting the loop and to compare similar proportions for the general female population. Instead of this the conclusion is, "From the distribution of women by number of living children, it is apparent that the device can prove very effective if it could be retained over a period of time." (Page 8 of the report). The author probably means that if the loop is retained long enough by women with smaller number of children it will have significant effect on reducing the number of births. But such interpretation needed no table.

As for the comment on Table 7, the author apparently considers the average for each group-interval to refer to the upper end of the interval and not the mid point of the interval as should usually be done. In Table 9 the distances of the residences of loop-acceptors from the clinic are given. These will be more relevant if the methods of administration of the programme are known. For instance, if the village women were attending the clinics on their own voluntarily, the distances from which they were coming indicated their level of motivation too. But in the present case, there is no way of knowing about this.

The distribution of loop-acceptors according to the age of the youngest living child is set out in Table 10 of the report. It is found that 75 per cent loop-acceptors had the youngest child below five

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years of age presumably at the time of loop-insertion.³ This, however, does not prove that the loop-acceptors were more fertile as concluded by the author of the report. A comparison with similar distribution for all the women including non-acceptors of loop alone could reveal whether the loop-acceptors were more fertile. Moreover, one is surprised to see that 24 per cent loop-acceptors had their youngest child more than five years old and still they adopted the loop. About five per cent had their youngest child aged nine or more years and they also adopted the loop. One is amazed to see such response to loop even in rural areas. Was it for incentives? Or, do the ages refer to the time of enquiry and not the time of loop-insertion? In the programme of loop-insertion conducted in the non-city area of Poona district, only nine per cent women had their last child more than three years old.

Table 11 again is an instance where the point regarding joint-family being less common among loop-acceptors cannot be proved without relevant data for the total number of households.

Thus the defective presentation of the data is quite common throughout the report and we do not collect more instances of it. However, certain errors in estimating the removal rates deserve attention especially in the analysis of IUCD cases. In revealing such errors, data for 889 loop-cases for non-city area in Poona district are also presented so that the responses in the two experiences can be compared and their importance evaluated.

The methods of administration of the loop-programme in the two projects differed. In non-city area of Poona district, with some spade-work by the field workers, women were gathered from the nearby areas to a 'loop-camp' by providing them transport. Instructions to examine the fitness of women for loop-insertion could not be strictly followed in this large scale programme⁴ either because of misreporting on the part of loop-acceptors or because of neglect of instructions on the part of workers in the programme. This probably is

³ But from the questionnaire one is not certain whether the ages or the number of children of loop-acceptors given in the analysis are at the time of loop-insertion or at the time of enquiry.

⁴ Records for about 3300 loop-insertions in this programme were available at the Institute. The Gokhale Institute planned to follow about two thousand of these. In the present study we analyzed only 889 cases investigation regarding which was completed while writing the present article.

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different from the loop-programme in the PRAI project where IUCD clinics were held regularly once a week at the primary health centre and fitness of cases for loop-insertion was carefully checked. With this brief background it is proposed to present the findings of the two projects both of which comprised an experience with loop programme of about 40 months.

In the PRAI project out of 1174 cases observed during 41 months there were about 42 per cent women with loop in position, 20 per cent with loop expelled, and 38 per cent with loop removed at the time of enquiry. In the Poona project the corresponding percentages were 29, 18 and 53 respectively. The higher percentage of women with loop in place in the PRAI is probably due to careful watching of the cases. Then why was it that the removal of loop was done by the women themselves in 68 per cent cases? Especially in 1967, women were not generally instructed to take the loop out themselves. Moreover about 24 per cent of the removals were done during the first month which percentage was much higher than that in the other loop programme of Poona district which had only 3 per cent removals during this period. One could therefore suspect the strength of motivation of women in the PRAI project which was conducting the loop-insertion-programme so carefully. Either for incentives or for something unknown, a sizable percentage of women accepted the loop and probably removed it. Thus the response in the PRAI project seems conflicting in the sense, sometimes women seem favourable and sometimes unfavourable in the same loop-programme. This is so in spite of the presumed careful regular watch on the loop cases in the PRAI project.

Reasons for removal of the loops are presented in Table 14 of the PRAI report, in the form of a frequency distribution. The distribution covers 858 reasons for removal without reference to 445 women who got the loop removed. The reader is more interested in the number of suffering women and the reasons for their suffering than in the reasons themselves.

The low motivation of women in the PRAI was obvious from the low level of contraceptive practice after removing the loop. The percentage of contraceptors did not rise even after adopting the loop for sometime and then removing it for some understandable reasons.

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Only eight per cent women practised contraception before loop-insertion and after the removal or expulsion only 8.5 per cent started the contraceptive practice. In the Poona project the percentage of contraceptors was only 11 before the acceptance of loop while 36 per cent took to contraceptive practice (including sterilization) after the termination of loop. These included 22 per cent who got sterilized. Among the 64 per cent not practising contraception 16 per cent intended to get sterilized in future. Sterilizations were mostly tubectomies. Comparing these results with those of PRAI one wonders how women could accept the loop in such large numbers with apparent low motivation.

A serious methodological point arises in respect of cumulative 'drop-out' rates presented in Table 24 on page 20 of the report. The procedures of calculation of these rates are more or less those of Dr. Tietze.⁵ The cumulative drop-out rates given here are obtained by adding the cumulative removal and expulsion rates at each month as obtained in Appendices B₁ and B₂ of the report. These are gross rates of removal and expulsion and are not additive. These are called gross because they are calculated by applying the life-table techniques on the assumption that removal/no removal or expulsion/no expulsion are the only two alternatives in the case of loop-insertions. In actuality the loop is either in place or removed or expelled and the life-table technique can be reasonably applied by considering the two alternatives of loop being in place or its termination. This latter will include both removal and expulsion of the loop. To get the removal or expulsion rates the terminations have to be divided into removals and expulsions in proportions which can be justified. The drop-out rates are given to be respectively 52 and 73 at the end of the first and second twelve months per 100 initial insertions in the PRAI project (Table 24 on page 20-21 of the report). The corresponding rates calculated by the present authors in the manner which is justified above are 46 and 61 only. At the end of three years the termination rate is given in the PRAI report (Table 24 on pages 20-21) to be 88 while the modified rate estimated by the present authors is 71. (See Table A). In the adjoining graph the two sets of

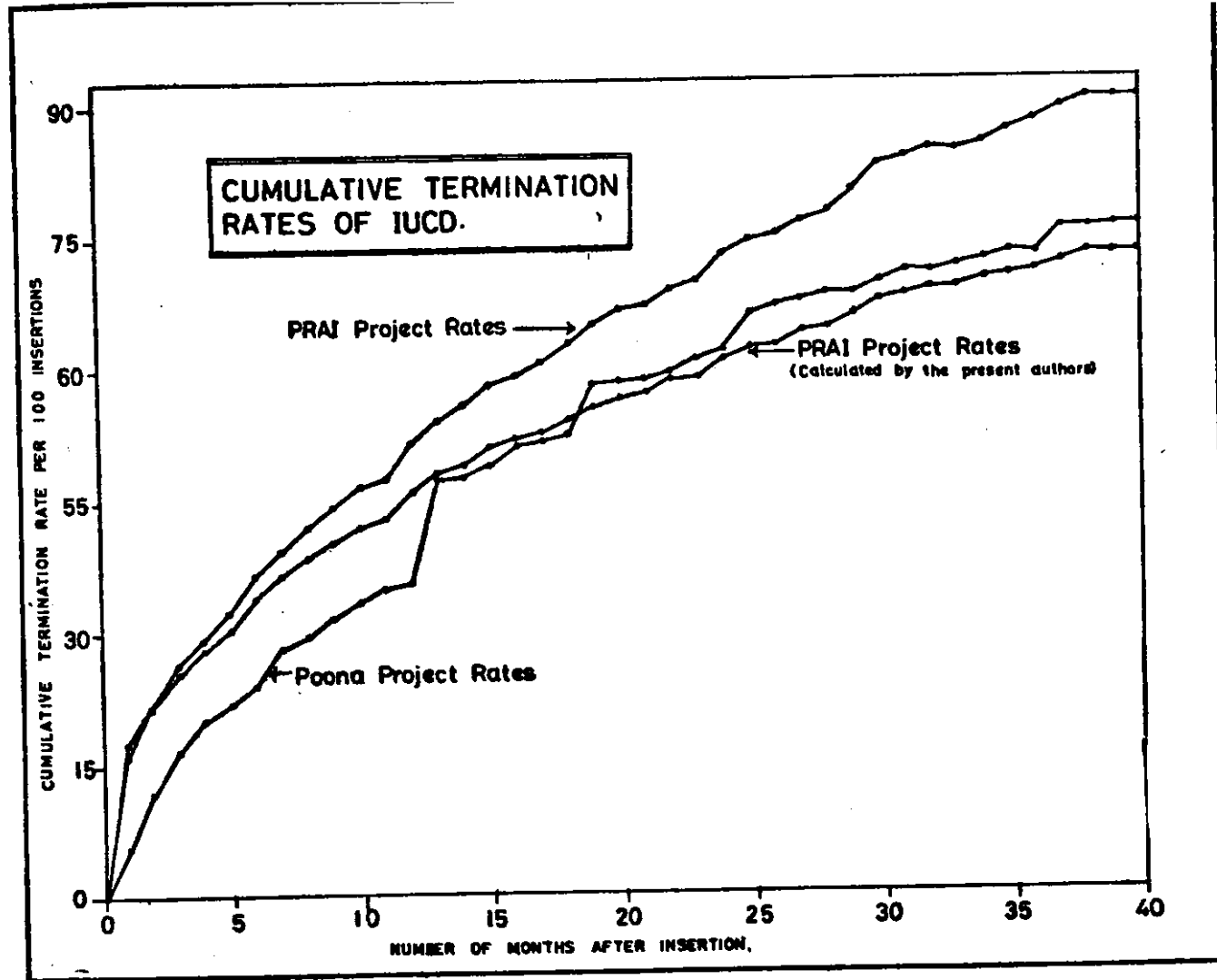
⁵ 'Intra-Uterine Contraception : Recommended procedures for data analysis' by Dr. Tietze, 'Studies in Family Planning' No. 18 (supplement), published in April 1967, by the Population Council, U.S.A.

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termination rates are given. The corresponding rates for the non-city area in Poona district are also shown in the same graph. The difference in the two sets of values for PRAI project is not negligible besides of course the serious methodological defect in the method of estimation by the PRAI.

The termination rates for the non-city area of Poona district are similar to those of PRAI project at the end of one, two or three years as shown in table A and the graph. But the patterns of termination or loop in the Poona and PRAI project are different. The rates are rather high in the PRAI project in the first year and especially in the first month of insertion. The effect of the high rate in the first month is to inflate all the cumulated figures for the later months.

A few more remarks on methodology of presentation of the PRAI findings are made in the subsequent paragraphs. In Tables 30 to 32 of the report associations between the experience with loop and its period of use or contraceptive practice etc. are considered. While testing the association between any two factors, it is essential to have a hypothesis regarding the possible relationship the author expects to exist between the two factors. Without such a hypothesis, use of statistical techniques such as the X^2 tests may not be meaningful. For example what kind of relation does the author expect between the period of use of loop and contraceptive method practised after the termination of loop? Similar remarks can be made about the Tables 30 and 32.



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Table A: CUMULATIVE TERMINATION RATES PER 100 LOOP-INSERTIONS FOR THE PRAI PROJECT AND THE POONA PROJECT

<i>No of months after loop-insertion</i>	<i>Cumulative termination rates per 100 loop insertions</i>		
	<i>PRAI project rates</i>	<i>PRAI project rates (as calculated by the present authors)</i>	<i>Poona project rates (non-city area)</i>
1	17.4	17.4	5.3
2	21.8	21.4	11.9
3	26.4	25.5	15.6
4	29.2	27.9	19.9
5	32.0	30.3	22.1
6	36.4	34.0	23.9
7	39.4	36.5	28.2
8	42.0	38.6	29.4
9	44.2	40.3	31.5
10	46.5	42.1	33.4
11	47.4	42.8	35.0
12	51.5	45.9	35.8
13	54.3	48.0	47.4
14	55.8	49.2	47.7
15	58.1	50.8	48.8
16	59.1	51.6	50.9
17	60.5	52.5	51.9
18	62.9	54.2	52.5
19	65.0	55.6	57.8
20	66.6	56.8	58.3
21	67.3	57.3	58.5
22	69.2	58.6	59.7
23	69.8	59.0	61.0
24	73.0	61.1	62.0
25	74.5	62.3	66.2
26	75.1	62.6	66.9
27	76.8	63.7	67.8
28	78.1	64.5	68.6
29	80.6	66.1	68.9
30	83.1	67.7	69.9
31	84.0	68.3	70.8
32	85.0	69.0	70.8
33	85.0	69.0	71.7
34	86.4	69.9	72.5
35	87.2	70.5	73.3
36	88.3	71.2	73.3
37	89.4	72.0	75.8
38	90.7	72.9	75.8
39	90.7	72.9	76.4
40	90.7	72.9	76.4
41	90.7	72.9	—

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Generally, a number of minor but important methodological points with regard to the presentation of the tables, draw attention of the reader while reading the report. As far as possible the table should be self-explanatory describing the data in the table. A few such points are mentioned below:

(1) In Table 5 pregnancies and children are used as synonyms. This should be avoided at least in presenting demographic data.

(2) In titles of Tables 6, 7, 8 the word cross-tabulation is used to denote the association. To make the matter understandable to most readers such purely technical terms can be avoided.

(3) In Table 9, the unit of distance (whether a mile or a kilometre) is not mentioned.

(4) Use of the word 'response' with yes and no in Tables 15, 16, 18, 22, 25, 27, 29 is improper.

(5) Presentation of Table 26 is loose. There is a reference to three kinds of percentages in the table without proper indications to know them.

(6) Use of the word 'correlation' in Tables 30 and 31 is not fit. That word has a specific meaning in statistics.

In spite of the above discussion, the information collected in the PRAI project is of great use as a study of loop-programme. The information collected in the project provides a rich fund of rare data especially about rural experiences. With a careful presentation, their value can be multiplied and one can trust them more. The director of PRAI mentions that the conclusions of the report will be useful in planning and implementation of the IUCD programme but we would like to add that the methods of presentation of data used here illustrate what should not be done.

Widow Remarriage in six Rural Communities in Western India

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1 The purpose of the present paper is to put forward certain data relating to the incidence of widowhood and the practice of remarriage available from a demographic study of six rural communities earlier conducted by the author. * The study was conducted during 1954-55 and covered five districts of the then Bombay State and one district of the then Hyderabad State. It was extended to a total population of 37,292. This included 11,716 women of ages 13 years and above. The following paper is based on the data relating to the marital status of these women.

2 In Table No. 1, the women are shown classified into quinquennial age-groups and by marital status. It will be seen that there were very few unmarried women in the age group 23-27 and fewer still in the later age-groups, so that apparently everyone married before the age 23 and practically no one remained permanently unmarried - only 3 out of 3291 women in the age group 43 and over were unmarried. On the other hand, widowhood begins to make its appearance even in the youngest age-group and quite considerably in the age group 23-27. In this age group over 6 per cent of the women were widowed and this percentage steadily rose in the older age groups; in the age group 38-42, over 25 per cent were widowed and in the age group above 42 years, nearly 60 per cent of the women were widows. Finally, nearly 3 per cent of all the women were divorced or otherwise separated and this proportion was more or less the same in all the age groups from 18 to 42 years. In the following, we shall concentrate attention on the married and the widowed women.

3 Not all the women shown as married in Table No.1 were married without interruption. Some of them had been widowed and later remarried. Among the 7836 women shown as married there were 547 women thus remarried so that

* Publication No.37 of the Gokhale Institute of Politics and Economics, Poona 4 (India) "Demographic Survey of Six Rural Communities" by Kumudini Dandekar.

Table No. 1 : The marital status composition of women of ages 13 & above.

Present age	Unmarried		Married		Widowed		Divorced & separated		Total
	Number	Per- cent- age	Number	Per- Cent- age.	Number	Per- cent- age	Number	Per- cent- age	
13-17	782	46.0	875	51.4	12	0.7	32	1.9	1701
18-22	141	7.8	1570	87.4	27	1.5	59	3.3	1797
23-27	17	1.1	1330	89.2	91	6.1	53	3.6	1491
28-32	4	0.3	1219	86.2	131	9.3	60	4.2	1414
33-37	2	0.2	794	79.3	167	16.7	38	3.8	1001
38-42	5	0.5	723	70.8	258	25.3	35	3.4	1021
43-	3	0.1	1325	40.3	1898	57.6	65	2.0	3291
All ages	954	8.1	7836	66.9	2584	22.1	342	2.9	11716

the remaining 7289 women were married only once. On the other hand, there were also women who having been widowed and remarried, became widows a second time. There were 256 such women and they were naturally included among the 2584 widows shown in Table No.1. We might thus distinguish four categories of women as under :

Married only once	7289
Widowed only once	2328
Remarried.	547
Widowed a second time.	256

If we add these four categories together, we get what we might call women who were ever-married. In the same way, the last three categories added together give us women who were ever-widowed and the last two categories added together give us women who were ever-remarried. We might set out these categories as under:

Ever married.	10,420
Ever widowed	3,131
Ever remarried	803
Widowed a second time	256

In the above, if we relate the ever-widowed to ever-married we get an index of the incidence of widowhood. Similarly, if we relate the ever remarried to ever-widowed, we get an index of the practice of remarriage. Finally, by relating those who were widowed a second time to the ever-remarried, we get an index of the incidence of a second widowhood. The indexes are as under:

Ever/widowed/Ever married	30.06
Ever remarried/Ever widowed	25.65
Widowed a second time/Ever-remarried.	31.88

In Table No.2 we give such indexes for women in different age groups. It should be noted that the age-groups are based on the present age of women and that therefore the indexes shown in Table No.2 are not related to the age of the women at their first or second marriages or their first or second widowhoods. The incidence of widowhood is naturally higher in the higher age groups. Besides, the practice of remarriage is also more frequent in the younger age groups. These two put

Table No. 2 : Values of the indexes ever-widowed/ever-married, ever-re-married/ever-widowed, widowed second time/ever-remarried for various age groups.

Age group	Ever-married (E.M.)	Ever-widowed (E.W.)	Ever remarried (E.Rem.)	Widowed twice (W.T.)	$\frac{E.W.}{E.M.}$	$\frac{E.Rem.}{E. W.}$	$\frac{W. T.}{E.Rem.}$
13-17	887	27	15	-	3.04	55.55	-
18-22	1597	61	35	1	3.82	57.38	2.86
23-27	1421	167	83	7	11.75	49.70	8.43
28-32	1350	221	100	10	16.37	45.25	10.00
33-37	961	238	78	7	24.77	32.77	8.97
38-42	981	333	106	31	33.94	31.83	29.24
43 -	3223	2084	386	200	64.66	18.52	51.81
All ages	10420	3131	803	256	30.06	25.65	31.88

together make the resulting proportion of the existing widows much smaller in the younger age groups than in the older age groups. Of course, to this we must also add the women who after remarrying became widows a second time. The incidence of second widowhood in most of the age groups is close to the incidence of the first widowhood but is naturally lower than the latter; this is because the age at remarriage would be later to the age at first marriage.

4 The incidence of widowhood is governed by rates of mortality and the age at marriage. We have no direct information on the rates of mortality affecting the women under consideration or their husbands. Rates of mortality are however known to have declined considerably in recent years, and we would expect that this would reduce the incidence of widowhood particularly in the younger age groups. Another development favourable from this point of view is the advancement of the age at marriage. We might furnish direct evidence on this point by examining the ages at marriage of the women under consideration. In Table No.3, we give the distributions of the women in each age group according to their ages at first marriage. In order to facilitate comparison between different age groups, the Table shows, for each group of women, the proportion which had married on or before each specified age. It is evident that the age at marriage is advancing. Thus of the women of age 43 years and above, 71.2 per cent were married before age 13, while in the age group 13-17 only 34.0 per cent were married before age 13.

5 The combined effect of the advancing age at marriage and the decline in mortality on the incidence of widowhood may be seen from the Table No.4, where we give a classification of the women in each age group according to the age of the first widowhood of those who thus suffered. Again, to facilitate comparison between the different age groups, the Table shows for the women in each age group, the proportion of those who were widowed for the first time at or before the given age. A small but a steady advance in the age at widowhood is evident. Thus, of the women in the age group 43 and over, 4.56 per cent were widowed before age 13 and 14.43 were widowed before age 23. The same percentages for the women in the age group 23-32 are 1.59 and 9.96 respectively.

6 We might next turn attention to the other phenomenon, namely, the remarriages of widows. In Table No.2 we have shown what proportion of the ever-widowed women

Table No. 3 : Age at first marriage of evermarried women

Age at marriage Present Age.	Years								Total percent- age of ever- married women	Per- centage of un- married women	Total No. of ever- married women	Total No. of women including unmarried
	8 and below	10 and below	11 & below	12 & below	13 & below	14 & below	15 & below	16 & below				
13 - 17	11.4	20.5	25.3	34.0	41.5	-	-	-	52.1	46.9	887	1669
18 - 22	13.5	28.1	34.8	46.8	56.3	63.8	70.9	78.7	91.9	8.1	1597	1738
23 - 27	17.1	30.7	37.6	49.2	57.8	64.8	74.3	84.3	98.8	1.2	1421	1438
28 - 32	21.5	39.4	45.8	59.9	66.5	73.2	79.5	88.1	99.6	0.4	13 50	1354
33 - 37	24.1	40.9	48.5	60.5	65.4	72.7	79.8	88.4	99.8	0.2	961	963
38 - 42	26.2	43.5	50.5	66.4	72.6	77.7	82.0	90.0	99.6	0.4	98 1	986
43 -	28.5	50.0	56.6	71.2	76.4	82.4	88.0	93.4	99.9	0.1	3223	3226
All ages	20.8	37.2	43.6	56.4	63.2	69.6	75.7	82.5	91.6	8.4	10420	11374

Table No. 4 : Percentage of women widowed up to a given age from among the ever-married women in the 4 age-cohorts.

Age at widowhood	Upto 12 :		Upto 22 :		Upto 32 :		Upto 42 :		43 and over		Total No. of ever-widowed women		Total No. of ever-married women
Present age	No. of widows	Per cent widowed	No. of widows	Per cent widowed	No. of widows	Per cent widowed	No. of widows	Per cent widowed	No. of widows	Per cent widowed	No. of widows	Per cent widowed	
13 - 22	31	1.25	88	3.54*	-	-	-	-	-	-	88	3.54	2484
23 - 32	44	1.59	276	9.96	386	13.93*	-	-	-	-	386	13.93	2771
33 - 42	53	2.73	206	10.61	451	23.22	576	29.66*	-	-	576	29.66	1942
43 -	147	4.56	465	14.43	824	25.57	1376	42.70	2081	64.57*	2081	64.57	3223
All ages	275	2.64	1035	9.93	1749	16.78	2426	23.28	2081		3131	30.05	10420

* These percentage figures cannot be compared because women of the given age-cohort are not fully exposed to widowhood up to the given age.

in each age group had already remarried. The proportions were seen to be higher in the younger age groups than in the older age groups. This is because, the widows in the younger age groups would more often have been widowed at an earlier age leaving a greater desire and a larger possibility of remarriage. To appreciate this point fully, it is necessary to examine the data on remarriage tabulated by both the present age of the women concerned and the age at their first widowhood for in order to remarry the woman should have been widowed early enough and sufficient time should have passed for her to have already remarried. This is done in Table No. 5. Here, the ever-widowed women are classified according to their present age and also their age at widowhood. The Table then shows, for each such group of women, what proportion of women had already remarried. The Table is analytically important and we should examine it more closely.

7 It is obvious that the age at widowhood is greatly relevant as far as the remarriage is concerned. Thus among the women who were widowed before the age 13, as many as 87.4 per cent had remarried. On the other hand, among those who had been widowed after age 42, none had remarried. It is possible of course that some of those who were widowed after 42 would still remarry. Some of these had been widowed now over ten years and had not yet remarried. But some others had been widowed only recently and might still remarry. But we have no concrete evidence.

8 The effect of the passage of time on the possibility of remarriage is naturally better seen among women who were widowed at an early age, say, before 13. Let us examine this group more closely. In the following is a relevant extract from the Table :

<u>Present age</u>	<u>Per cent remarried</u>
13-22	83.3
23-32	93.0
33-42	90.2
43-	86.1

Thus the percentage of remarried rises from 83.3 in the initial age group 13-22 to 93.0 in the next age group 23-32. This may be the effect of the passage of time. What is meant is that some of the widows in the first age group have not been widowed long enough to yet remarry and that some of them would remarry in due course. If the remarriage habits do not change with time and the mortality rates do not change with marital

Table No. 5 : Percentages of the remarried among the ever-widowed in the 4 age cohorts, widowed at various ages.

Age at widowhood	Below 13		13 - 22		23-32		33-42		43-		Total	
	No. of widows	% re-married	No. of widows	% re-married	No. of widows	% re-married	No. of widows	% re-married	No. of widows	% re-married	No. of widows	% re-married
13 - 22	31	83.3	57	47.3	-	-	-	-	-	-	88	56.8
23 - 32	44	93.0	232	57.3	110	8.4	-	-	-	-	386	47.4
33 - 42	53	90.2	153	69.2	245	15.0	125	2.5	-	-	576	31.9
43 -	147	86.1	318	61.8	359	16.1	552	2.0	705	-	2081	18.5
All ages	275	87.4	760	60.5	714	14.2	677	1.4	705	-	3131	25.6

status the percentage of remarried may either increase from one age group to the next (due to remarriages at later ages) or may remain the same after an age. But in the present case the percentage of remarried does not go beyond 93.0 and in fact in the next two age groups it comes down systematically to 90.2 in the age group 33-42 and to 86.1 in the age group 43 and above. It may connote a possibility that the widows in the higher age groups were widowed in an earlier era and that in those days the practice of remarriage was not quite so common as it seems to be at present.

9 There seems a similar possibility in the next group of widows, namely those who were widowed between ages 13 and 22. In the following is a relevant extract from the Table :

<u>Present age</u>	<u>Per cent remarried</u>
13-22	47.3
23-32	57.3
33-42	69.2
43-	61.8

Obviously many of the widows in the youngest age-group 13-22 had been widowed only recently and not enough time had passed for them to remarry. Only 47.3 per cent in this group therefore appears to have remarried. But undoubtedly some more would remarry in due course. This is evident from the manner in which the remarried percentage increases to 57.3 and 69.2 in the next two age groups respectively. However, the percentage then declines to 61.8 in the last age group of 43 and above. For reasons stated in the earlier paragraph this decline may connote that the remarriage was less common in the earlier era than it is in the recent times.

10 If the argument in the above two paragraphs is acceptable, we might put forward what might be called estimates of the extent to which the widow-remarriage is frequent at present. We might put it down as under:

<u>Age at widowhood</u>	<u>Percent expected to remarry</u>	
	<u>In the era represented by women of age 43 and above</u>	<u>In the era represented by women of 13-22</u>
Below 13	86.1	93.0
13-22	61.8	69.2
23-32	16.1	16.1
33-42	2.0	2.5
43-	-	-

The first column above is of course taken down straight from the second line from the bottom in Table No. 5. The manner in which the second column above is built is also obvious - it is built out of the maximum percentages in the several columns of Table No. 5. The reason for this choice is already explained above. We might add here a further word of explanation. What the second column may represent is not the actual remarriage rates to which the widows among the women of present age group 13-22 will be subject. It may represent the possible remarriage rates in recent years. If the trend continues in future the widows among the women of the present age group 13-22 might be subjected to even higher remarriage rates.

11 It is also evident from the above data that the rates of remarriage depend much upon the age at widowhood. The rates of remarriage are much higher among women widowed at a younger age than among those widowed at an older age. This was expected. The reasons for this appear two-fold. In the first instance, with older age, it just becomes too late to remarry. Secondly, women widowed at an older age more often have children from the first marriage. Therefore psychologically, remarriage is less strongly desired. Also emotionally and because of many practical considerations, the children from the first marriage prove a positive handicap for remarriage. In the following, we shall examine the influence of the children by the first marriage on the rates of remarriage.

12 While considering the influence of the children by the first marriage, we might neglect groups of women who were widowed either at too young an age or at too late an age, the former because few among them would have children by the first marriage and the latter because remarriage is anyhow rather uncommon among them. Thus among the women who were widowed before age 13, only one had reported a child from that marriage. On the other hand, among the women who were widowed after age 42, none had remarried; in fact, even among the women who were widowed after age 32, only a small number had remarried. We might therefore neglect these groups of women, namely, those who were widowed either before the age 13 or after the age 32 and concentrate attention on the middle groups.

13 In Table No. 6, we have classified the two groups of women, namely, those who were widowed between ages 13-22 and those between 23-32, according to the number of children they had from the first marriage. The women

are also classified, as before, according to their present age. For each category of women we then show what proportion of them had remarried. It will be obvious from the Table that the number of children from the first marriage has a very large influence on the rates of remarriage. In particular, the difference between having no child and having some children is very large, the marriage rates being almost double when there are no children from the first marriage.

14 The Table also shows that for any category of women such as those who were widowed between 13-22 and had no child from the first marriage, the rates of remarriage increased upto a point as the present age increased. This is what we had earlier termed the effect of the passage of time. There, we had also suggested that we might take the maximum rate of remarriage to indicate the proportion of women in each category who would remarry in due course. We might bring together such maximum rates from Table No. 6.

Expected rates of remarriage for women with age at widowhood 13-22 and 23-32.

	Age at widowhood	
	13-22	23-32
Number of children from first marriage		
None	80.6	45.0
1	46.5	20.4
2 or more	57.0*	12.1

15 In Table No. 7, we give the distribution of the remarried women according to age at remarriage.

Table No. 7 : Remarried women according to their age at remarriage.

<u>Age at remarriage</u>	<u>No. of women</u>
- 13	4.06
13 - 17	38.27
18 - 22	34.05
23 - 27	12.67
28 - 32	6.52
33 - 37	3.69
38 and above	0.74
Total	100 = 803

* Sample size is too small and hence percentage is not necessarily reliable.

Table No. 6 : Percentages of remarried widows widowed at 13 to 22 years and 23 to 32 years when they had the specified number of children.

No. of children	Age at widowhood 13 - 22						Age at widowhood 23 - 32					
	0	:	1	:	2 +	:	0	:	1	:	2+	
Present age	Per- cent re-married	Total ever-widowed	Per- cent re-married	Total ever-widowed	Per- cent re-married	Total ever-widowed	Per- cent re-married	Total ever-widowed	Per- cent re-married	Total ever-widowed	Per- cent re-married	Total ever-widowed
13 - 22	60.0	35	31.25	16	-	4	-	-	-	-	-	-
23 - 32	69.2	146	38.5	52	29.6	22*	45.0	20	-	23	-	64
33 - 42	80.6	98	38.7	31	58.8	17*	27.6	29	20.4	49	11.0	155
43--	65.2	198	46.5	71	67.0	19*	22.7	66	18.7	75	12.1	190
All ages	69.2	477	41.2	170	49.4	62	27.8	115	16.3	147	9.8	409

* Samples are too small in size and percentages may not be necessarily reliable.

16 We have so far discussed three factors which affect the practice of remarriage. They are: The age at widowhood, the number of children from the first marriage and the present age of the women concerned. The first two factors affect remarriage directly. The third factor merely checks whether sufficient time had been allowed for the widow to remarry if she wanted to. All the three factors are however in a sense personal. They affect decisions regarding remarriage in a personal way. There remains the overriding influence of custom and tradition. As is well known, the Hindu society is divided into a number of castes and the customs and traditions regarding marriage vary greatly between different caste groups. In order to examine to what extent they influence remarriage, we give in Table No.8, certain remarriage rates for a number of caste groups. For such a comparison to be valid, it would be necessary to remove the influence of the three factors mentioned above. However, to do this would be computationally rather complicated. Among the three factors mentioned above, the age at widowhood is the most important. Also as it itself, depends upon the age at

Table No. 8 : Percentage of remarried widows in different caste groups.

<u>Caste Group</u>	<u>Total No. of widows</u>	<u>Percentage remarried.</u>
Advanced caste Hindus	808	10.4
Intermediate Hindus	816	25.9
Scheduled caste Hindus	392	41.1
Backward Hindus	478	32.2
Non-Hindus	281	27.0
Lingayats	354	32.4
Total	<u>3131</u>	<u>25.6</u>
	=====	=====

marriage and as the age at marriage is likely to be different in different castes, the composition of the widows by the age at widowhood is likely to be different in different caste groups. Therefore, we propose to keep separate the categories of the widows according to

the age at widowhood and compare the remarriage rates in different castes. Even here, we might confine attention to only two categories of widows, namely, those who were widowed before age 13 and those who were widowed between 13-22, for, it is in these categories of widows that in the majority of cases, remarriage seems desired on personal grounds. In Table No. 9, we give the remarriage rates for these two categories of widows in different caste groups. The caste groups are broad and

Table No. 9 : Percentage of remarried widows in different castes, widowed at age below 13 and at ages 13-22 years.

Caste Group	Widowed at			
	Below 13		13 - 22	
	No. of widows	Per cent remarried	No. of widows	Per cent remarried
Advanced caste Hindus	44	43.1	165	32.7
Intermediate caste Hindus	88	95.4	174	57.5
Scheduled caste Hindus	41	100.0	111	75.7
Backward Hindus	18	94.4	114	84.2
Non-Hindus	15	100.0	74	71.6
Lingayats	56	94.6	86	59.3
Total	262	87.4	724	60.5

each group includes a number of castes having different marital patterns. Still it will be obvious that except in the group of advanced castes among Hindus, no bar on remarriage as such prevails. Remarriage of women who were widows before age 13, is almost universal in all other caste and religious group. Even among advanced castes of Hindus 43 per cent of such widows were remarried. It is worth examining whether the remarriage

trend among the various advanced castes is changing. It may provide an explanation for the changing trend of remarriage.

17 In conclusion, we might note that in the rural society covered by our investigation, by and large what seems to govern the remarriage of widows are the personal factors such as the age at widowhood and the number of children from the first marriage. Remarriage seemed less common among advanced castes of Hindus and a close scrutiny of the trends of remarriage in this caste group seemed worth following.

SUMMARY

The purpose of the present paper is to assess the extent of widow-remarriage and the factors affecting it in six rural communities of Western India. Total number of women of age 13 and above covered by the sample is 11716. Among them is observed a steady but regular fall in the extent of widowhood at younger ages.

The effect of age at widowhood, number of children born from first marriage, and the present age of women on remarriage is examined. The effect of caste on remarriage is also analysed, though further study is necessary to arrive at useful results.

Widow remarriage depends largely on the age at widowhood. Widows widowed at ages below 13 remarried to the extent of 93 per cent in the recent past. They married to the extent of 86 per cent in the era represented by women of ages 43 and above. When widowed at ages 13 to 22 years, 69 per cent remarried in the recent past and 60 per cent were remarried among women of ages 43 and above. 15 per cent remarried when widowed at ages between 23-32 and only 1.4 per cent were found remarried when widowed at ages 33-42. None remarried if widowed after 42 years of age.

The number of children from the first marriage has also a large influence on the rates of remarriage. In particular the difference between having no child and having some children is very large, the marriage rates being almost double when there are no children from the first marriage.

The other factors like custom and tradition prevalent in the various castes of the Hindu society are also expected to be important. In order to examine the effect of 'caste' on remarriage it is necessary to remove the influence of the three factors mentioned above. In this procedure the size of the sample in each category dwindles down to a large extent. Hence the effect of caste on remarriage is considered by eliminating only one important factor, namely, the age at widowhood. It is found that widow-remarriage is less common in the advanced castes of Hindus.

REMARIAGE DES VEUVES DANS SIX COMMUNAUTÉS RURALES
DE L'INDE OCCIDENTALE

(R é s u m é)

L'auteur a cherché à mesurer l'ampleur du remariage des veuves et l'influence des facteurs en cause dans six communautés rurales situées dans la partie occidentale de l'Inde. Le sondage a porté sur 11,716 femmes de plus de 13 ans. On note, dans ce groupe, une diminution nette et régulière du veuvage aux jeunes âges.

L'auteur étudie l'effet de l'âge au moment du veuvage, du nombre des enfants nés du premier mariage et de l'âge des femmes lors de leur remariage. Il analyse aussi l'effet de la caste dans ce domaine, mais de nouveaux travaux sont ici nécessaires avant d'arriver à des résultats utilisables.

Le remariage des veuves dépend beaucoup de leur âge au veuvage. Au cours des dernières années, les veuves dont le mari est mort avant qu'elles aient 13 ans se sont remariées 93 fois sur 100 (ce nombre tombe à 86 pour les femmes ayant 43 ans et plus lors de l'enquête). Les femmes devenues veuves entre 13 et 22 ans se sont remariées 69 fois sur 100 au cours des dernières années (60 fois sur 100 pour les femmes ayant 43 ans et plus). Les femmes, devenues veuves entre 23 et 32 ans, ne se remarient que dans 15 pour 100 des cas; ce chiffre tombe à 1,4 pour 100 quand elles deviennent veuves entre 33 et 42 ans. Aucun remariage de veuve de plus de 42 ans n'a été observé.

Le nombre des enfants du premier mariage a aussi une grande influence sur les taux de remariage. Il y a, en particulier, une grande différence entre le fait d'avoir quelques enfants ou de ne pas en avoir du tout : dans ce dernier cas, les taux de remariage sont presque deux fois plus forts.

D'autres facteurs comme les coutumes, la tradition des diverses castes de la société hindoue peuvent jouer un rôle important. Pour pouvoir analyser l'effet de la caste sur le remariage, il faut écarter l'influence des trois facteurs ci-dessus. La taille de chaque sous-échantillon diminue alors dans une grande proportion. On doit donc procéder en n'éliminant qu'un seul facteur, à savoir l'âge lors du veuvage. On constate que le remariage des veuves est moins répandu dans les castes supérieures des Hindous.

Une enquête en France sur le choix du conjoint

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Les objectifs

Parmi tous les rites de passage qui jalonnent le déroulement d'une vie, le mariage revêt une importance particulière, non seulement pour l'individu, mais pour la société. Pour autant que de l'union des couples dépendent l'avenir du groupe, et son existence même, toutes les sociétés connaissent des règles très strictes en ce qui concerne le mariage. Une immense littérature sociologique et ethnologique étudie l'ensemble de ces règles ou interdits dans les communautés les plus diverses.

Les sociétés modernes n'échappent pas à cette loi générale. Mais elles sont beaucoup plus peuplées, et ouvertes à de larges courants de mobilité géographique et sociale, et l'on peut se demander si l'emprise du groupe ne s'est pas desserrée, au point que les individus disposent d'une liberté beaucoup plus grande et presque totale pour choisir un conjoint.

La question est importante à plus d'un titre. On se rapprocherait en quelque sorte de l'hypothèse, faite par la génétique de population, de l'existence de la panmixie, où les mariages se font au hasard dans l'ensemble de la population. Mais cette hypothèse n'est pas en concordance avec les faits réels, notamment à cause du choix du conjoint, correspondant à "l'assortative mating" étudié par les Anglo-saxons, qui ne se fait pas au hasard. Les conjoints peuvent choisir leur partenaire, parmi les personnes qui leur ressemblent, ou bien éviter d'épouser des personnes qui ont des caractères communs avec eux, physiques ou psychologiques. Dans un cas comme dans l'autre, choix "positif" ou choix "négatif", la distribution des gènes dans la population se trouve affectée, et l'étude de ces phénomènes requiert un examen approfondi.

Le sociologue et le démographe ne sont pas moins concernés. Les contraintes extérieures, conscientes ou inconscientes, qui agissent sur les individus, font partie de l'ensemble des déterminismes sociaux qui régissent l'organisation et l'évolution de la société. Si le choix du conjoint s'opère à l'intérieur de groupes plus ou moins étendus, les valeurs propres et les idéaux de ces groupes se perpétuent de manière plus ou moins étroite et durable au cours des générations, et la constitution de la famille, comme le mouvement naturel de la population s'en trouvent affectés.

PLC: Post literacy campaign

PLC is an activity carried out solely by ZSS. Thus ZSSs have that money handy with them actually to spend for the literacy purposes. Since the same committee is working on two issues, the expenditure on certain activities is also shared. For creating the awareness on this issue, many meetings and programmes are conducted. The expenditure for these also is taken out from PLC funds. Till the monthly meeting of January 2001, from RCH funds, ZSS has spent only Rs. 1,47,668 /-. It was decided to pay the honorarium for the local artists as per Rs. 100 /- and similarly for the group as a whole, Rs. 300 /-. After the schedule of *Kala Jaththa* is over, they will be paid Rs. 2,25,000/-. For the activities for the adolescents, respective schools and junior colleges spent the money.

There is a small discrepancy in the amount spent on the workshops for women, submitted to the ministry and the details collected by the field investigators of PRC. The statement states that the amount spent is Rs. 1,01,974 /- which is Rs. 74,674 /- more than the amount told to investigators.

It is thus seen that, in all, ZSS will spend Rs. 3,72,668 /- for the activities of RCH through ZSS, till the end of the project. It can be suggested that they can use the remaining Rs. 1,40,332 /- or (Rs. 65,658 /-) - depending on the expenditure for workshop for women for the RCH purposes - especially in remote and smaller villages.

Findings of the survey of opinion leaders and community members in the village

As mentioned in the previous section, number of opinion leaders contacted is 93 from selected 14 villages. Table 5 gives the distribution of opinion leaders by the posts they hold in the village.

Table 5: Distribution of opinion leaders by the posts

Post	Number
<i>Sarpanch</i> or deputy <i>sarpanch</i>	14
<i>Gram panchayat</i> member	12
<i>Gram shikshan</i> committee president, member, teacher	29
<i>Police patil</i>	5
<i>Mahila mandal</i> president	7
<i>Anganwadi</i> worker	13
Literacy worker	10
<i>Yuvak mandal</i> president, member	2
Post not mentioned	1
Total	93

In running any project in the village, local leaders there play a vital role. Their level of perception and understanding of the issue are the deciding factors of successful implementation of the scheme. Without their support, it is very difficult to work there, though the work is for the benefit of the villagers. Therefore it was thought important to collect some information from these leaders about the knowledge of the scheme as well as of RCH in general. In the selected 14 villages 14 leaders were either *sarpanch* or deputy *sarpanch* and 12 were the members of *gram panchayat*. Among these leaders the highest proportion is from education and related areas. Twenty-nine were from *gram shikshan mandal* or teachers and 10 are literacy workers. Another important class includes AWW and *mahila mandal* members. This group is important, keeping in view the RCH work to be conducted in the village. All these opinion leaders are expected to know beforehand about the schemes run in the village and their positive opinion about the scheme makes difference in case of successful implementation of any scheme. The knowledge of the background of these leaders is essential to know more about the scheme. This information is presented in Table 6 along with the community members contacted in each village.

Table 6: Background characteristics of the opinion leaders and community members

Background characteristics	Opinion leaders	Community members
Religion		
Hindu	83	98
Muslim	2	2
Buddhist	8	12
Caste		
Scheduled caste / Scheduled tribe	31	51
Other	60	60
Not given	2	1
Sex		
Male	44	55
Female	49	57
Age		
15-19	2	2
20-24	6	22
25-29	11	32
30-34	27	37
35-39	6	7
40-44	15	3
45 and more	11	-
Age not given	15	9
Marital status		
Never married	9	14
Currently married	80	94
Widowed	2	-
Divorced	1	-
Not given	1	4
Educational level		
Illiterate	1	5
1 – 4 standard	8	23
5 – 7 standard	10	19
8 – 9 standard	13	8
S.S.C.	28	31
H.S.C.	18	19
Below graduation	4	3
Graduate and above	6	4
Attendance at literacy class		
Yes	9	27
No	78	78
Not given	6	7
Total	93	112

As expected more Hindu leaders (80) are included in the sample, whereas only 2 of them are Muslim. Eight are Buddhist leaders and 31 are either from scheduled caste or scheduled caste - giving reasonable representation for the backward communities - and 60 are from the other communities of the society.

Male – female distribution of the leaders is about fifty - fifty. It is seen that a little more female than male leaders are interviewed. RCH being the issue under consideration more female leaders might have been selected. Looking at the age distribution of these leaders it is seen that 19 are less than 30 years of age, 33 are between 30 and 40 years and 26 are 40 years or above. Being the leaders in the community they happen to be older. Almost all of them are married currently (80) though 9 are unmarried. Two are widowed and 1 is a divorcee. Seventy-eight opinion leaders have not attended the literacy classes held in the village and only 9 had been there. Only one of them is still illiterate whereas 56 have passed at least S.S.C. Among them 6 are graduates.

Looking at the background characteristics of community members, it is found that most of them are Hindu (98), only 2 are Muslim and 12 are Buddhists. Fifty-one members belong to either scheduled caste or scheduled tribe and 60 belong to other castes. This shows a fair representation for backward class population in the sample. Sex-wise composition of respondents is balanced for this sample. Except those who have not stated their age, all other are in reproductive ages, comprising 93, below 35 years of age. This is the most important group as far as reproductive health is concerned. Similarly most of them (94) are currently married and 14 are never married. Educational level of the respondent community members indicates that 57 are educated above S.S.C level and 5 are illiterate. In all 50 members are educated between 1 and 9 standard. Though 78 members have not attended any literacy class in the village, 27 have been there and 7 have not mentioned about the attendance in literacy classes conducted by education department. This is an important observation, since these classes are supposed to be the media for communicating the RCH messages.

Exposure and participation of opinion leaders and community members in various RCH activities

Let us now get some information about the various RCH activities conducted in the village and participation of the respondents in such activities. This can shed some light on whether something is done in the village about RCH, may be through ZSS or through health department. Table 7 gives information about such RCH activity conducted in the village and participation of both community members and opinion leaders.

Table 7: Distribution of opinion leaders and community members by participation any RCH activity *

RCH activity in the village	Opinion leaders	Community members
Participation in RCH activity		
Yes	49	36
No	41	76
Not given	3	-
Number of activities		
1	5	9
2	17	15
3 or more	26	12
Not given	1	-
Attendance at orientation workshop		
Yes	22	3
No	68	108
Not given	3	1
Number of workshops		
1	17	-
2	4	3
3	1	-
Organizers of workshops		
Health department	2	-
Education department	17	1
Other	3	2
Place of workshops		
Taluka place	13	1
Village	7	2
PHC	2	-

Contd...

RCH activity in the village	Opinion leaders	Community members
Duration of workshop		
1 day	1	-
2 days	18	3
3 or more days	3	-
Method of training in workshop		
Lecture	20	3
Question – answer	18	3
Demonstration	4	1
Exhibition	1	-
Posters / Pamphlets	5	1
Resource persons		
Doctor	18	3
ANM / MPW / Health worker	2	-
Literacy personnel	1	-
Other	1	-
Subjects of workshop		
Family planning	10	3
RCH	18	1
Child care and immunization	11	1
Health in general	12	-
AIDS	9	2
Literacy	4	1

* Total may not tally to 93 in case of opinion leaders and 112 in case of community members

Table 7 shows that 49 of 93 opinion leaders and 36 of 112 community members report that some RCH activity is conducted in the village. Though about half of the opinion leaders are aware of the RCH activities, very few community members even know about it. Similarly opinion leaders report more about the number of occurrences of these activities compared to community members reporting. Only 2 community members have ever attended any RCH workshop whereas 22 opinion leaders have reported their attendance. This clearly shows that opinion leaders have much more exposure than common people in the village to various activities carried out in the village. Among these workshops reported, 17 by opinion leaders and 1 by community member are conducted by education department. This thus seems to be the work of ZSS in regard to RCH. It should be mentioned here that among the 93 opinion leaders and 10 are *Swayamsevaks*. Therefore may be two days workshop is reported by

maximum, 18 opinion leaders and 3 community members. The training is carried out mostly by Doctors and ANM, in the form of lectures and question – answers sessions. The topics covered in the workshop include family planning, RCH, childcare, immunization and AIDS. Among 3 community members attended, all 3 reported family planning and 2 have reported AIDS. Opinion leaders give a more all over picture of the subjects, where RCH is the most common (18) along with Family planning (10), childcare and immunization (11) and health in general (12). Information on AIDS is reported by 9 of them. According to community members the message received in these workshops is mainly on RCH and literacy. Opinion came out with a much more comprehensive list of the messages, which includes, along with RCH and literacy, age at marriage, adolescent health, awareness about AIDS, ill-effects of population growth and importance of small family.

Thus the workshops seem to be well organized as regards matter of the workshop but not regarding its coverage in terms of participants.

Other activities through which the RCH message is to be sent, is street plays, folk songs, rallies, posters exhibitions, advertisements on television and debate and essay competitions. Table 8 gives the details about the street plays.

Table 8: Distribution of opinion leaders and community members by knowledge and participation in RCH street plays *

Knowledge and participation in RCH street plays	Opinion leaders	Community members
Knowledge and participation in street play		
Yes	25	10
No	64	101
Not given	4	1
Number of street plays		
1	25	9
More than 1	-	1
Place of street plays		
District place	3	-
Taluka place	1	-
Village	20	10
SC	1	-
Other	1	-

Contd...

Knowledge and participation in RCH street plays	Opinion leaders	Community members
Organizers of workshops		
Health department	2	-
Education department	19	8
Other	4	2
Occasion of street play		
To celebrate some day	17	5
Just like that	5	2
Not given	3	3
Duration of street play		
Upto 15 minutes	6	8
1 Hour	4	-
1 and half hour	1	-
2 hours	10	2
3 hours	4	-
Advertisement of street play		
Yes	10	7
No	9	1
Not given	6	2
Subjects of street play		
Family planning	15	6
RCH	15	2
Child care and immunization	6	4
Health in general	12	2
AIDS	13	5
Literacy	10	4
Not given	1	-
Opinion about street play		
Satisfactory	12	6
Neither satisfactory nor unsatisfactory	1	-
Unsatisfactory	-	-
Programme to be organized frequently	11	3
Programme to be organized once a month	-	-
Not given	1	1

* Total may not tally to 93 in case of opinion leaders and 112 in case of community members

According to Table 8, performance of street plays are reported by 25 opinion leaders and just 10 community members. These plays are mostly for the community and only

a few reporting to have watched, does indicate that they are not performed in the way they are thought of. In rest of Table 8 only the distribution of those who have reported positively for street plays, is presented. Almost all of them have watched only one street play while only single person watched more than once. The street plays are performed in their own village, stating all 10 by community members and 20 by opinion leaders. Among the 35, who have responded positively for street plays, 19 opinion leaders and 8 community members reported organizer of these plays is education department. There is no consistency in the responses of duration of street plays, both by opinion leaders and community members. Half of them reported about the prior advertisement of these plays. The subjects covered in the street plays include family planning, RCH, childcare, immunization, AIDS, literacy and health in general. Though half of them reported their satisfaction about these plays, 14 (11 opinion leaders and 3 community members) feel that these programmes should be organized more frequently. Both community members as well as opinion leaders report the important messages from these street plays are : stay away from AIDS, it's not curable; keep the family small; increase age at marriage and don't be superstitious. One important suggestion from community members comes in the form of prior advertisement of these street plays so as to increase the number of spectators; whereas opinion leaders, along with advertisement stress that the participants in the play should get some money. This indicates that message can reached to people through the street plays. So this medium can be useful to spread the message. Only thing is that it should be arranged such that it will reach each and everybody to achieve the goal of 'knowledge to all'.

Folk songs is another effective medium in rural areas. Whether any such activities are conducted in the villages can be seen from the information presented in Table 9.

Table 9: Distribution of opinion leaders and community members by knowledge and participation in RCH folk songs *

Knowledge and participation in RCH folk songs	Opinion leaders	Community members
Knowledge and participation in folk songs		
Yes	24	13
No	65	98
Not given	4	1
Whether folk songs performed separately		
Yes	23	13
No	1	-
Not given	-	1
Number of performances		
One	16	10
More than One	5	1
Not given	3	3
Medium of folk songs		
Stage performance	21	10
Street performance	1	2
Radio	1	-
Television	1	-
Cassette	-	1
Organizers of folk songs		
Village group	6	1
Outside group - Health department	1	5
Professional group	7	5
Other	8	2
Not given	2	-
Place of folk songs		
Taluka place	1	-
Village	21	13
SC	1	-
Occasion for folk songs		
To celebrate some day	12	8
Just like that	9	5
Not given	3	-
Subjects of folk songs		
Family planning	16	9
RCH	3	2
Child care and immunization	4	3
Health in general	8	6
AIDS	10	5
Literacy	15	6
Not given	1	-

* Total may not tally to 93 in case of opinion leaders and 112 in case of community members

Like the street plays, only 24 opinion leaders and 13 community members reported positively for the RCH messages through folk songs. Both these numbers are very small considering the interviews. The songs are separately performed and only once in the form of stage performance in the village only is the response of most of the respondents. Folk songs also are not frequently, as they could have done it more easily than any other form. They are either performed by village group (6 opinion leaders + 1 community members) or by professional group (7 +5) or some other group invited by health department (1 + 5). Among these programmes 20 are performed to celebrate some day and 14 performed just like that. In these songs issues covered are family planning, AIDS, health in general and literacy, according to both opinion leaders as well as community members.

The message according to opinion leaders is about AIDS, cleanliness and disadvantages of population explosion. Apart from these community members report about addiction and immunization. This medium should be used frequently and effectively further because of its simplicity and easy to reach nature.

To know more about the people watching any posters, hoardings or wall writings, some information is collected for past one year. This is an effective visual medium and is accessible to all if presented in the village. Table 10 gives the details of this activity in the selected villages.

Table 10: Distribution of opinion leaders and community members by viewing of posters / wall writings / handbills / hoardings regarding health and family planning in last one year *

Viewing of posters / wall writings / handbills / hoardings about health and family planning in last one year	Opinion leaders	Community members
Whether seen any posters / wall writings / handbills / hoardings in last one year		
Yes	79	76
No	10	35
Not given	4	1
Type of items seen		
Posters	52	58
Wall writings	64	40
Handbills	19	11
Hoardings	4	2
Not given	-	2
Number of items		
1 - 5	20	31
6 - 10	21	22
Ten or more	36	22
Not given	2	-
Place of items seen		
PHC	26	19
SC	-	1
<i>Gram Panchayat</i>	41	23
School	19	6
Other	38	44
Not given	1	-
Subjects of posters / wall writings / handbills / hoardings		
Family planning	48	34
RCH	15	13
Child care and immunization	50	39
Health in general	38	23
AIDS	46	41
Literacy	9	3

* Total may not tally to 93 in case of opinion leaders and 112 in case of community members

Table 10 states that 79 of 93 opinion leaders and 76 out of 112 community members have come across either posters or handbills or wall writings or hoardings related to

RCH in past one year of the survey. The distribution is 52 and 58 posters, 19 and 11 handbills, 64 and 40 wall writings and 4 and 2 hoardings for opinion leaders and community members respectively. Posters and handbills come in large quantities so the possibility that many will see them is also higher. The place is mainly PHC or *Gram panchayat* where generally the posters are displayed. Once again the message of RCH, family planning, childcare and immunization, AIDS, health in general and literacy is spread through this. According to opinion leaders most important message is regarding AIDS and importance of small family; whereas according to community members it is about AIDS, small family and age at marriage.

Spreading the RCH message through these media is a routine activity of health department, so it is difficult to isolate the effect of posters etc. published by ZSS. Nevertheless, many have reported positively for this form of IEC indicating the awareness on RCH issues.

Television also is a very effective medium. It is easier to spread the message through television, as once telecast it is instantaneously received at all remote places too. So viewers of television are at advantage. Therefore to know about whether the advertisements regarding RCH are seen in last one year on television is also important. Table 11 gives the details about it.

Table 11 : Distribution of opinion leaders and community members by viewing of advertisement on television regarding health and family planning in last one year *

Viewing of advertisement on television about health and family planning in last one year	Opinion leaders	Community members
Whether seen any advertisement on television in last one year		
Yes	65	57
No	13	55
Not given	1	-
Frequency of advertisements		
Less than 50	3	3
50 to 100	52	51
More than 100	9	3
Subjects of advertisements		
Family planning	38	30
RCH	8	3
Child care and immunization	26	15
Health in general	22	8
AIDS	52	39
Literacy	5	6
Other	2	-
Not given	11	57

* Total may not tally to 93 in case of opinion leaders and 112 in case of community members

According to Table 11, 65 opinion leaders and 57 community members have watched advertisement carrying RCH message. Among those who have watched, have watched for more than 50 times. Only 3 in each category stated less than 50 times. Subject matter reported most is AIDS (52 opinion leaders and 39 community members) and family planning (38 and 30). These are followed by childcare and immunization (26 and 15) and health in general (22 and 8). This is quite consistent with the proportion of advertisements shown on the television on these subjects.

The most important message that is reached to both opinion leaders and community leaders through these advertisements is certainly about AIDS and small family.

Another most appealing form for spreading the messages, particularly in rural areas is *Kala jathhas*. People watch these programmes and carry the message home, which is not communicated to them by other media. ZSS have particularly chosen this form for

spreading the message, but unfortunately scheduled it at the end of the year so whether they have proved effective could not be tested. As mentioned earlier, the schedule of this important folk form was between November 2000 and February 2001. Whatever information is available through the survey is presented in Table 12.

Table 12 : Distribution of opinion leaders and community members by knowledge and participation in RCH jaththas / rallies *

Knowledge and participation in RCH <i>jaththas</i> / rallies	Opinion leaders	Community members
Knowledge and participation in <i>jaththas</i> / rallies		
Yes	9	5
No	80	104
Not given	4	3
Number of performances		
One	7	5
More than One	1	-
Not given	1	-
Organizers of <i>jaththas</i> / rallies		
Health department	-	-
Education department	8	5
Not given	1	-
Place of <i>jaththas</i> / rallies		
Village	8	5
PHC	-	-
SC	1	-
Occasion of <i>jaththas</i> / rallies		
To celebrate some day	2	1
Just like that	4	-
Not given	3	4
Subjects of street play		
Family planning	4	3
RCH	2	1
Child care and immunization	2	2
Health in general	6	5
AIDS	1	4
Not given	1	-

* Total may not tally to 93 in case of opinion leaders and 112 in case of community members

Only 9 opinion leaders and 5 community members reported positively for *Kala jaththas* according to Table 12. Seven opinion leaders and 5 community members

have watched it once and 1 opinion leader has watched it 2 times in the village. Everybody who watched these programmes mentioned that organizers of the programme are staff of education department. This certainly is a ZSS activity. That may be the reason that the occasion of these shows could not be reported properly. The message sent by these groups is on all the RCH topics they are supposed to cover. The most important message to both opinion leaders and community members reported is about AIDS. Other include family planning, age at marriage and alcohol addiction.

Information in Table 12 indicates that folk medium of *Kala jathhas* is doing well to spread the RCH message. It is reaching to everyone who attends. Only thing to be mentioned here is that these are to be conducted even in remote areas of the district and if possible, frequently, to repeat the message again and again.

One more activity being conducted is essay competition or debate on RCH issues. This gives people to express their opinions about these issues. They can be helpful in a way, as can be used to remove the misconceptions in their minds, if found any. Information collected on this form is presented in Table 13.

Table 13 : Distribution of opinion leaders and community members by knowledge and participation in RCH essay competition or debate *

Knowledge and participation in RCH essay competition or debate	Opinion leaders	Community members
Knowledge and participation in essay competition or debate		
Yes	10	5
No	79	106
Not given	4	1
Number of competitions		
One	9	5
Two	1	-
Organizers of essay competition or debate		
Education department	10	5
Place of essay competition or debate		
Taluka place	2	-
Village	6	5
SC	2	-

Contd...

Knowledge and participation in RCH essay competition or debate	Opinion leaders	Community members
Subjects of essay competition or debate		
Family planning	3	3
RCH	-	1
Child care and immunization	4	-
Health in general	7	2
AIDS	2	5
Literacy	2	4

* Total may not tally to 93 in case of opinion leaders and 112 in case of community members

As expected, very few, that is only 10 opinion leaders and 5 community members have either have knowledge or participated in such debate or essay competition on various RCH issues. Nine opinion leaders and 5 community members have reported the occurrence of this event once. All community members and 6 opinion leaders have reported that the activity is conducted in the village itself by education department. The coverage of the topics was well spread, from family planning to AIDS and health in general. According to the responses of community members the most important message they have received through this form is regarding various illnesses of women, particularly related to reproductive system. Opinion leaders reported the important message as knowledge about AIDS and importance of small family.

Sharing of information

After the information is collected on various activities conducted in the district to enhance the awareness of people regarding various RCH issues, it was thought important to know about whether they have shared their knowledge with anybody. Have they ever discussed these issues among themselves so as to know more about the problems and consequences on health in general? Out of 112 community members, 64 reported positively for sharing and 19 for not sharing the RCH information. Twenty-nine of them did not provide any information on sharing question. In case of opinion leaders, 79 have shared the RCH information with others and 7 have not. Remaining 7 have not reported anything about sharing. Sharing is

seen to be more common in case of opinion leaders than community members. Increase in discussing these issues would certainly elevate the awareness level of RCH issues in general.

Knowledge on health and family welfare issues

Upto this point knowledge and participation of opinion leaders and community members in various RCH activities is discussed in detail. The messages are seen to be reached on issues like family planning and AIDS to most of them through various media. To know more about their actual knowledge on some of the family welfare related issues, detailed information is collected from each of the opinion leader as well as community member in the sample. Table 14 to Table 17 present the set of information on these issues.

Table 14 : Distribution of opinion leaders and community members by knowledge of legal age at marriage

Knowledge of legal age at marriage	Opinion leaders	Community members
Minimum legal age at marriage for girls		
Less than 18		
18	-	4
19 or more	88	103
Not given	2	4
	3	1
Minimum legal age at marriage for boys		
Less than 21		
21	2	5
22 or more	88	98
	3	9
Total	93	112

Table 14 states that legal age at marriage for girls correctly reported by 88 opinion leaders and 103 community members, which is more in case of legal age at marriage for boys particularly reported by community members (98). Thus more information has to be spread about the legal age at marriage for boys too.

Table 15 presents the knowledge of opinion leaders and community members about various ANC issues. As ANC is directly related to health of the child and also of mother, it assumes a lot of importance under RCH.

Table 15 : Distribution of opinion leaders and community members by knowledge regarding ANC *

Knowledge regarding ANC	Opinion leaders	Community members
Month of first ANC check-up		
1 – 2 months	27	38
3 months	29	28
4 – 6 months	5	5
7 or more months	27	39
Not given	5	2
Minimum number of ANC check-ups		
1	2	8
2	10	8
3	19	29
4	9	13
5 - 7	17	14
8 or more	31	37
Not given	5	3
Number of TT injections in pregnancy		
1	7	4
2	34	43
3	16	23
More than 3	-	1
Don't know	28	37
Not given	8	4
Tests to be done during pregnancy		
Height	34	40
Weight	49	60
Abdominal checkup	55	59
Internal examination	23	43
Blood test	61	63
Urine test	49	45
Blood pressure test	36	37
X-ray	7	9
Sonography	9	6
Amniocentesis	2	1
Other	2	2
Don't know	17	26
Not given	5	4

Contd...

Knowledge regarding ANC	Opinion leaders	Community members
Risk pregnancy		
First pregnancy	42	45
Short stature of mother	24	28
Pregnancy under 20	35	42
Pregnancy after 30	28	28
Third or higher order births	26	27
Short birth interval	25	22
Other	3	2
Don't know	27	38
Not given	6	4
Dangerous health problems during pregnancy		
Swelling on hands and feet	45	46
Paleness	39	36
Weakness or tiredness	35	43
Dizziness	44	42
Visual disturbances	27	21
Bleeding	32	24
Convulsions	5	7
Weak or no movement of foetus	12	8
Abnormal presentation	5	1
Other	1	-
Don't know	30	33
Not given	5	6
Precautions during child birth		
Use of DDK	47	25
Institutional delivery	71	79
Delivery by trained person	45	56
Delivery in a clean place	32	35
Use of sterile blades	25	23
Use of sterile thread	13	6
Don't know	11	18
Not given	5	5
Cleanliness measures during child birth		
Clean place	51	59
Clean hands	43	44
Clean thread	39	47
Clean blade	47	53
Clean umbilical chord	31	22
Don't know	36	45
Not given	5	4

* Total may not tally to 93 in case of opinion leaders and 112 in case of community members

First ANC visit as well as minimum number of ANC visits are considered important. Twenty-seven opinion leaders and 38 community members reported that first ANC visit should be in first or second month of pregnancy and 29 and 28 have reported it to be third month. Five each report it to be 4 to 6 months whereas 39 and 27 respectively report in 7 to 9 months. This indicates that very few know the correct month of first visit. Similar is the case with minimum number of ANC check-ups. Only 16 opinion leaders and 24 community members reported the correct Tetanus Toxoid injections. Most common test to be done during pregnancy is blood test as reported by 61 opinion leaders and 63 community members followed by abdominal check-up (55 and 59) and weight (49 and 60). The other tests include height, blood pressure and urine test. Nine opinion leaders and 6 community leaders also have mentioned about sonography. Incorrect test are X-ray (9 and 6) and of course amniocentesis (2 and 1). Most of the fundamental RCH information has not reached this area but sonography and amniocentesis has already reached there. Among the risk pregnancies, first pregnancy (42 and 45) and pregnancy under 20 (35 and 42) have reported to be the most risky. Similarly dangerous health problems reported are swelling on hands and feet (45 and 46), dizziness (44 and 42), weakness (35 and 43) and paleness (39 and 36). Message about institutional delivery (71 and 79) and delivery by trained personnel (45 and 56) with disposable delivery kit (DDK) (47 and 25) has seen to be reached. Similarly little less than half opinion leaders and community members either don't know about the cleanliness to be observed at the time of delivery or did not mention it. Remaining more than half respondents know about the cleanliness and its importance well.

On the basis of ANC information, it can be said that correct information about the first ANC visit, minimum number of visits and TT injections has to spread properly. Most of them now know about the risk pregnancy and illnesses during pregnancy as well as importance of cleanliness and medical attendance at the time of delivery.

After ANC and childbirth come childcare and immunization. Information on knowledge regarding child health and immunization is presented in Table 16.

Table 16 : Distribution of opinion leaders and community members by knowledge regarding child health and immunization *

Knowledge on health and family welfare issues	Opinion leaders	Community members
Age in months till child should be breastfed		
Upto 6 months	44	35
7 – 9 months	20	23
10 – 12 months	13	21
More than 12 months	3	16
Don't know	9	13
Not given	4	4
Time child should be put to breast first		
Immediately	53	48
After few hours	14	26
Next day or after few days	12	16
Don't know	10	18
Not given	4	4
First breast milk		
Should be given	56	60
Should be discarded	19	21
Don't know	14	27
Not given	4	4
In case of Diarrhoea		
Take to doctor	71	76
Give ORS	74	66
Give more liquids	28	18
Give medicines	4	6
Other	6	3
Don't know	8	24
Not given	4	3
Signs to decide to take the baby to health personnel		
Repeated watery stools	24	23
Any watery stools	49	52
Repeated vomiting	48	44
Any vomiting	37	31
Blood in stools	25	42
Fever	17	42
Marked thirst	21	18
Not eating / drinking well	17	14
Getting sicker / very sick	21	9
Not getting better	5	3
Other	1	3
Don't know	12	23
Not given	6	5

Contd...

Knowledge on health and family welfare issues	Opinion leaders	Community members
Feeding in case of Diarrhoea		
Less to drink	27	22
About same amount to drink	35	43
More to drink	12	13
Don't know	15	29
Not given	4	5
Name of vaccination against Tuberculosis		
BCG	46	34
Other	4	-
Don't know	39	76
Not given	4	2
Name of vaccination against Diphtheria, Whooping cough and Tetanus		
DPT	60	55
Don't know	29	55
Not given	4	2
Number of DPT injections		
1	-	1
2	11	23
3	50	27
More than 3	1	-
Don't know	22	51
Not given	9	10
Name of the vaccination against Polio		
Polio	81	101
Don't know	8	9
Not given	4	2
Number of Doses of Polio		
1	2	1
2	31	58
3	37	21
More than 3	3	4
Don't know	10	22
Not given	10	6
Age of Measles vaccination		
Upto 8 months	10	13
9 months	39	44
More than 10 months	7	12
Don't know	32	40
Not given	5	3

* Total may not tally to 93 in case of opinion leaders and 112 in case of community members

As stated in Table 16, 44 opinion leaders and 35 community members feel that child should be breast-fed upto 6 months only; whereas 20 and 23 report upto 7 to 9 months and 13 and 21 feel upto one year. Only 53 opinion leaders and 48 community members feel that child should be put to breast immediately and rest other (26 and 42) feel that it should be after few hours or days after the birth. Fifty-six and 60 opinion leaders and community members feel that first breast milk should be given to the child and 19 and 21 respectively feel that it should be discarded.

Message of ORS as a treatment for Diarrhoea has reached along with giving more fluids to the child and taking to doctor. Similarly not reducing the feeding quantities has explicitly stated by 35 opinion leaders and 43 community members. In case of signs of Diarrhoea, watery stools (49 and 52) and repeated vomiting (48 and 44) is reported the most.

Coming to immunization of children 46 opinion leaders and 34 community members have correctly reported about vaccination against tuberculosis as BCG, 60 and 55 about DPT and 81 and 101 about Polio. Fifty opinion leaders and 27 community members reported number of DPT injections as 3 and 37 and 21 reported number of Polio doses as 3. Measles vaccination to be given in ninth month is reported by 39 and 44 opinion leaders and community members respectively.

Looking at this information, it can be said that details about the vaccination and its time schedule should be provided to all. Similar is the case with ANC. Very few know about the correct ANC schedule. The information present here is mostly approximate and not based on the knowledge.

Family planning programme is run very efficiently in the state. Importance of small family is stressed through various media. To know more about the correct knowledge of family planning methods to space the children Table 17 is prepared.

Table 17 : Distribution of opinion leaders and community members by knowledge of family planning methods *

Knowledge of family planning methods	Opinion leaders	Community members
Knowledge of family planning methods		
IUD / Loop / Copper – T	79	89
Oral pill	83	98
Condom	43	95
Rhythm / Periodic abstinence	28	21
Withdrawal	27	19
Other	-	2
Don't know	3	8
Not given	6	3

* Total may not tally to 93 in case of opinion leaders and 112 in case of community members

Most commonly known method is oral pills as reported by 83 opinion leaders and 98 community members, followed by IUD (79 and 89). Then comes condom (43 and 95). It is seen that condoms reporting is sizably less in case of opinion leaders. Traditional methods like rhythm or periodic abstinence is reported to have known by 28 opinion leaders and 21 community members and withdrawal is by 27 and 19 respectively. It is thus seen that the knowledge of methods has reached. What is required is the actual use, which will lead to small family, spaced children and population stabilization.

Recently attention of those working in the area of health in general and also in reproductive health has been drawn towards AIDS. It is spreading very fast and since no treatment on AIDS is available, it naturally is considered as very disastrous. To assess knowledge and level of awareness in terms of conceptions and misconceptions, information is collected on AIDS. It is presented in Table 18.

Table 18 : Distribution of opinion leaders and community members by knowledge about AIDS *

Knowledge about AIDS	Opinion leaders	Community members
Heard of AIDS		
Yes	83	107
No	6	5
Not given	4	-
Mode of transmission of AIDS		
Sexual intercourse	80	100
Homosexual intercourse	30	36
Heterosexual intercourse	39	47
Needles / Blades / Skin puncture	71	89
Mother to child	64	62
Transfusion of infected blood	58	41
Don't know	1	1
Not given	10	10
Get AIDS due to hand shaking		
Yes	1	1
No	83	103
Don't know	1	3
Not given	8	5
Get AIDS due to hugging		
Yes	4	2
No	80	102
Don't know	1	3
Not given	4	5
Get AIDS due to kissing		
Yes	6	12
No	78	90
Don't know	1	4
Not given	8	6
Get AIDS due to sharing clothes		
Yes	2	14
No	82	89
Don't know	1	4
Not given	8	5
Get AIDS due to sharing eating utensils		
Yes	2	19
No	81	86
Don't know	2	2
Not given	8	5

Contd...

Knowledge about AIDS	Opinion leaders	Community members
Get AIDS due to stepping on urine / stool		
Yes	5	17
No	78	84
Don't know	2	5
Not given	8	6
Get AIDS due to mosquito / flea / bedbug bites		
Yes	6	19
No	77	82
Don't know	2	5
Not given	8	6
Precautions to avoid AIDS		
Using condom during each sexual intercourse	69	90
Safe sex	81	89
Checking blood prior to transfusion	60	65
Sterilizing needles and syringes for injection	65	77
Avoiding pregnancy when having AIDS virus	33	32
Don't know	-	2
Not given	10	8
Possibility of child getting AIDS, if mother has		
Yes	79	89
No	2	2
Don't know	4	15
Not given	8	6

* Total may not tally to 93 in case of opinion leaders and 112 in case of community members

83 opinion leaders and 107 community members report knowledge of AIDS positively; whereas 6 and 5 respectively have not heard of it. As regards mode of transmission most common answer is sexual intercourse (80 opinion leaders and 100 community members) then it is skin punctures, needles, blades (71 and 89), mother to child (64 and 62), blood transfusion (58 and 41), heterosexual intercourse (39 and 47) and homosexual intercourse (30 and 36). Misconceptions are found with the help of

various actions, which may not cause AIDS. Those who have answered correctly of the misconceptions are presented in the brackets. To list a few of such actions, shaking hands (83 opinion leaders and 103 community members), hugging (80 and 102), kissing (78 and 90), sharing clothes (82 and 89), sharing eating utensils (81 and 86), stepping on urine / stool (78 and 84) and mosquito, flea or bedbug bites (77 and 82). These figures indicate that correct knowledge is reaching everywhere now.

When precautions to avoid AIDS are asked, most of the responses are correct. Sixty-nine opinion leaders and 90 community members reported the use of condom at each and every sexual act, 81 and 89 reported safe sexual practices, 60 and 65 reported checking of blood prior to transfusion, 65 and 77 reported sterilization of needles before injection and 33 and 32 reported to avoid pregnancy when having AIDS virus. These figures also indicate overall better awareness level. On this background it is not surprising to have reported 79 opinion leaders and 89 community members the possibility of woman giving birth to child with AIDS virus.

It can be concluded here that knowledge of AIDS is widespread because of the large-scale campaign. Most of the respondents reported correct answers to various questions on AIDS, which is not the case with many of the ANC and childcare and immunization question. It may be because of the fact that this area is considered as women's area and men do not take interest in these issues. Having many children borne and also taken care of well in terms of delivery and immunization men are still ignorant on these important RCH issues. Being the decision makers in the family, their involvement alone would lead the RCH programme to success.

Strong points of ZSS

- ZSS has worked very effectively in Maharashtra. They undertake the literacy and post-literacy programmes successfully, so people are used to attending these classes and learn from the literacy volunteer. The thought that this routine of attending classes can bring success in spreading the RCH message is a right move.
- ZSS comes under the control of collector of the district. He is the president of this committee. Therefore the committee can work directly under the guidance

of the collector. ZSS can get the benefit of the vision of the collector and support from the related departments to run the scheme. So if collector decides to show he results, it is cent per cent possible.

- Collector of Nagpur district himself took interest, paid attention and put a lot of efforts in designing this project. RCH being a new subject to those working in the area of literacy, he conducted the meetings of ZSS officials frequently for successful implementation of the scheme. The programme run as per the plan given by the Government.
- In the scheme itself it is decided that the worker spreading the RCH message is local person. There are many advantages of having a local person as a key person of the scheme. He / she knows everybody in the village and thus have good rapport. If he / she advises on even on sensitive matters like family planning also people are ready to listen to him / her. They don't consider such a local person as a government person, who has come to the village to teach them.
- Being a local person he / she is available to people everyday. People can meet and consult him as and when they want. It is not like some health functionary comes once a month to help them. These everyday meetings also are important, so that whenever needed, somebody who is trained in these matters is available.
- Inclusion of folk medium in this scheme also is a right step. Folk medium of spreading information is a very effective medium. It appeals faster than the print media or even the discussions and lectures.
- Wall writings and pasting posters help people to understand the issue. Whatever message is to be sent is shown pictorially. People understand it better than the words. People see the posters displayed in the public places about population policy, importance of small family, age at marriage and gender discrimination.

Some observations regarding RCH through ZSS

- ZSS conducts post-literacy classes now. So those who have learned to read and write come to the class. So all illiterate men and women are missed here. In post-literacy class volunteer does not teach but make the people read the books, specially prepared for them. That means he does not take any class to tell RCH information.
- In, either literacy or post-literacy class, younger lot of couples that is the couples below 35 years of age are missing. Most of this group is literate and has no need to attend these classes. So though the volunteer is ready to spread the message, it goes to only the older lot of men and women. For such an older class RCH information sometimes may not be necessary, as it is necessary for the younger generation. Thus the target is missed in this programme.
- The target group for RCH programme is thus not adequately covered in literacy classes. One person in the village, *Swayamsevak*, is trained for RCH. But if he / she can not come in contact with the people who need RCH information most, then what is the use of the training? He / she cannot spread the information, what they are supposed to.
- Workshops for adolescents are organized in school and colleges, but what about those who are out of school? Some programme should have been arranged for this group also.
- Many women have the RCH information. However one cannot say that this information has reached through ZSS. Considering the various schemes running on the villages level under different departments of the government, there are many sources of information available to village women now.
- Health functionaries, especially ANM comes to village in once or twice a month. She mainly visits for ANC and immunization of children. For these sessions, thus, only women are present and no men. Whatever information is given by the ANM reaches only to women, who have no decision making

- power. Therefore though information is reached to them, very less comes in practice.
- No messages regarding RCH reach men. They do not even know about the immunization of children. Then let apart the ANC, post-natal care and reproductive tract infections. Men generally find it offending, if the questions on RCH or Maternal and Child Health (MCH) are asked to them. They feel the interviewers are testing them, like in examination rather than the interview.
 - All the rallies as well as programmes of *Kala Jathha* are conducted either in bigger village or PHC or SC village. They did not reach the interior smaller villages where the need of the message is much more and for whom such schemes actually emerge. It should be carefully seen at district level that such villages are covered for all the activities planned.
 - It was seen that, in this project, no official at the *tehsil* level is involved. Design of the project has been done in literacy section at district level and no details are conveyed to officials at tehsil or village. Even the medical officers of the PHC are unaware of this scheme. They have delivered the lectures in this scheme on RCH -as DHO told them- but not knowing the scheme. Thus absolutely no involvement from health department.
 - It is actually the MO of the PHC, who can reach the villages and not the DHO. Therefore involvement of MO would have been leading this project to the success. On the similar lines head master of the school is a very special person in the village. He knows the requirements of the people in the village and his ideas would have helped for successful running of the programme. Those who are working on the village level in the field of health and education would have been in the making of the project.
 - Literacy department gets large sums of money for the literacy programmes from the centre. They have their expertise in the field of education. Thus there is no need of money as well as work other than what they are supposed to, that is teaching. Therefore they are also reluctant to run this project.

- Though, Nagpur has done well in spreading RCH information through ZSS, they also have not worked for the whole year. It sometimes becomes evident that, they started running the project only after the process of evaluation of this scheme started from MOHFW.

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