D: Supporting Report

for Chapter6 in Main Report

Information, Education and Communication (IEC)

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PART I

Survey Results Related to IEC Issues In the Survey on Current Situation of Reproductive Health in Sagar Division Conducted by ORG-MARG

1 SURVEY RESULTS RELATED TO IEC ISSUES IN THE SURVEY ON CURRENT SITUATION OF REPRODUCTIVE HEALTH IN SAGAR DIVISION CONDUCTED BY ORG-MARG

1.1 ACCESSIBILITY AND EXPOSURE TO MEDIA

Community and Household Level

The followings are results of the Community Survey conducted by ORG-MARG in 2001. 13 urban communities and 80 rural communities in Sagar Division were surveyed, and key informants in the communities were interviewed in the Study.

Table 4A-1 Proportion of Households (HH) in the Community by Media Accessibility

Type of Media Medium	% HHs in the Community which has the Media Medium	Urban		Rural	
		Number of the Community	%	Number of the Community	%
Radio	0	0		1	1.2
	□10%	4	30.8	31	38.8
	10 - 20%	3	23.1	20	25.0
	20 - 30%	1	7.7	10	12.5
	30 - 50%	4	30.8	11	13.7
	> 50 %	1	7.7	7	8.8
TV	0	0		1	1.2
	□10%	0		52	65.0
	10 - 20%	1	7.7	13	16.3
	20 - 30%	1	7.7	5	6.3
	30 - 50%	3	23.1	5	6.3
	> 50 %	8	61.5	4	5.0
Newspaper	0	0		42	52.5
	□10%	3	23.1	36	45.0
	10 - 20%	3	23.1	1	1.2
	20 - 30%	3	23.1	1	1.2
	30 - 50%	3	23.1	0	
	> 50 %	1	7.7	0	
Telephone	0	0	0.0	46	57.5
	□10%	4	30.8	33	41.3
	10 - 20%	6	46.2	1	1.2
	20 - 30%	2	15.4	0	
	30 - 50%	1	7.7	0	
	> 50 %	0		0	
Total N of Community		13	100.0	80	100.0

Source: JICA Development Study on Reproductive Health in MP – Community Survey, ORG-MARG, 2001

Table 4A-2 The Proportion of Total Households by Media Accessibility

Type of Media	Urban		Rural	
	Total No. of HHs	%	Total No. of HHs	%
Radio	1,553	27	5,320	18
TV	4,056	71	4,223	14
Newspaper	1,911	33	772	3
Telephone	1,071	19	604	2

Source: JICA Development Study on Reproductive Health in MP – Community Survey, ORG-MARG, 2001

Table 4A-3 Accessibility of Other Media in the Community

Type of Media	Urban		Rural	
	N	%	N	%
Cinema	7	53.8	18	22.5
Dramatic presentations			4	5.0
Puppet shows			4	5.0
Live musical performances	2	15.4	3	3.8
Other			2	2.5
None of the above	4	30.8	**52**	**65.0**
No response	2	15.4	2	2.5
Total No. of Communities	13	100.0	80	100.0

Source: JICA Development Study on Reproductive Health in MP – Community Survey, ORG-MARG, 2001

Individual Level

The followings are results of the KAP Study on Health and Health Care Seeking Behaviours conducted by ORG-MARG in 2001. The household in the same communities for the Community Survey in Tikamgarh and Damoh were selected, and 1,080 ever-married women aged 15-49 years old and their 976 husbands were interviewed.

<Ever-married Women>

Table 4A-4 Frequency of Newspaper or Magazine Reading (Ever-married women 15-49 years old)

(in percentage)

Hours per day	Tikamgarh		Damoh	
	Urban	Rural	Urban	Rural
Never	**86.7**	**97.7**	**93.0**	**97.0**
1 hours	11.1	1.6	5.8	1.5
2		0.2	1.2	0.4
3	1.1			0.2
4 +	1.1	0.5		0.9
Total No. of Women	90	444	86	460

Table 4A-5 Frequency of Radio Listening (Ever-married women 15-49 years old)

(in percentage)

Hours per day	Tikamgarh		Damoh	
	Urban	Rural	Urban	Rural
Never	**83.3**	**88.5**	**87.2**	**89.8**
1	13.3	6.5	9.3	7.4
2	1.1	4.1	3.5	2.0
3	2.2	0.2		0.2
4+		0.7		0.7
Total No. of Women	90	444	86	460

Table 4A-6 Best Time for Listening Radio (Ever-married women 15-49 years old)

(in percentage)

Time	Tikamgarh		Damoh	
	Urban	Rural	Urban	Rural
0				
Early morning (5-9a.m.)	20.0	17.6	9.1	6.4
Late morning (9-12 noon)	33.3	29.4	81.8	53.2
Mid-day (12-1 p.m.)	26.7	17.6	9.1	21.3
Early afternoon (1-4 p.m.)	13.3	9.8	9.1	4.3
Late afternoon (4-6 p.m.)	6.7	9.8	9.1	8.5
Evening (6-8 p.m.)	26.7	31.4	18.2	31.9
Night (8-12 midnight)	6.7	17.6	9.1	23.4

Table 4A-8 Frequency of TV Watching (Ever-married women 15-49 years old)

(in percentage)

Hours per day	Tikamgarh		Damoh	
	Urban	Rural	Urban	Rural
Never	16.7	**69.4**	31.4	**69.8**
1 hours	17.8	18.0	12.8	8.0
2	28.9	7.2	20.9	12.8
3	18.9	2.5	19.8	6.1
4+	17.8	2.9	15.1	3.3
Total No. of Women	90	444	86	460

Table 4A-9 Best Time for TV Watching (Ever-married women 15-49 years old)

(in percentage)

Time	Tikamgarh		Damoh	
	Urban	Rural	Urban	Rural
Early morning (5-9a.m.)	4.0	0.7	3.4	3.6
Late morning (9-12 noon)	33.3	14.7	27.1	21.6
Mid-day (12-1 p.m.)	26.7	28.7	28.8	26.6
Early afternoon (1-4 p.m.)	16.0	8.8	16.9	20.1
Late afternoon (4-6 p.m.)	5.3	5.1	16.9	4.3
Evening (6-8 p.m.)	14.7	23.5	16.9	18.7
Night (8-12 midnight)	49.3	40.4	64.4	49.6

Table 4A-10 TV Channels Watched (all mentioned) (Ever-married women 15-49 years old)

(in percentage)

Hours per day	Tikamgarh		Damoh	
	Urban	Rural	Urban	Rural
Doordarshan	82.7	92.6	81.4	89.9
Metro	22.7	19.1	42.4	9.4
Sony	45.3	7.4	25.4	15.1
Star Plus	20.0	2.2	30.5	6.5
Star Movies			10.2	0.7
Star News			3.4	
Star Sports			3.4	0.7
Discovery	1.3		8.5	
Zee TV	26.7	4.4	8.5	12.9
Zee Movies	1.3			2.9
Others	5.3	1.5		
Don't know		0.7		2.9
Total No. of Women	75	136	59	139

1.2 AWARENESS AND KNOWLEDGE OF RCH AND RCH SERVICES

Since data shown in the **Chapter 2 of Volume 4- Data Book,** only points and issues will be raised here.

(1) Knowledge of Family Planning Methods and Source of Information

There is a big difference between women and husbands regarding the source knowing currently used family planning method.

<Ever-married women>

- For female sterilization husband is the major source. ANM/LHV, government doctor and relatives/friends are following.
- For condom, husband is the major source again followed by government doctor.
- Although only a few women using pills, the major source is husband.
- For the male sterilization, AWW is the major source.

<Husbands >

- For female sterilization "friend, relative, neighbours" (38%) is the major source. TV (30%) and government doctor (25%) are the second and the third .
- For condom TV (70%) is the major source. They also obtain information from radio (35%), ANM/MPW (23%) and friend/relative/neighbour (21%).

(2) Knowledge of Birth Spacing and Source of Information

<Ever-married women>

- It seemed that knowledge on the birth spacing is quite popular, and there is nor big difference between urban and rural area.
- Still about 10% women say 1 year or less.

- TV is the most popular source of information (74% in urban and 42% in rural) followed by "friend, relative or neighbour"(17%). In rural area, "ANM/MPW" (about 10%) is the third major source.

<Husbands >

- It seemed that knowledge on the birth spacing is quite popular, more than in women. There is not big deference between urban and rural area.
- Still about 5% husbands say 1 year or less.
- Similar to women's response, TV is the most popular source of information followed by "friend, relative or neighbour"(24% in urban and 36% in rural). Radio (15% in urban and 24% in rural), Reading (30% in urban and 19% in rural), and Government doctors (32% in urban and 18% in rural) are also the source of information.

(3) Knowledge of Availability of Health Facilities/Providers and RCH Services Provided Them

<Ever-married women>

- **Awareness of the nearest government health facilities**
  - 92% of women are aware of the nearest government health facility.
  - 8% of women are NOT aware of any nearest government health facility.
  - *55% of women who are aware of the nearest government facility say PHC is the* nearest one, and only 26% mentioned SC.
- **Awareness of place/person for ANC**
  - 33% of women in rural area are aware SC/ANM/LHV as a place or person for ANC, and 28% say PHC. 6.5% of women also say private practitioner.
  - In urban area, 54% of women are aware district hospital as a place for ANC, 30% are aware private practitioner..
- **Awareness of place/person for Immunization for children**
  - 46% of women in rural area are aware SC/ANM/LHV as a place or person for immunization, and 28% say PHC. 12% of women also say district hospital.
  - In urban area, 53% of women are aware district hospital as a place for ANC, 13% say private clinic and hospital.

<Husbands >

- **Source of hearing about women's health dare during pregnancy**
  - ***31% and 52% of husbands in urban and rural area have never heard about women's health.***
  - TV (20%) and friend/relative/neighbour (20%) are the major source of information.
- **Source of hearing about child's health**
  - ***27% and 46% of husbands in urban and rural area have never heard about child's health.***
  - TV (21%) and friend/relative/neighbour (20%) are the major source of information.
- **Source of hearing about nutrition fro women**
  - ***31% and 56% of husbands in urban and rural area have never heard about nutrition for women.***

- Friend/relative/neighbour (20%) are the major source of information. The second major source is TV (40% in urban and 16% in rural).

- **Knowledge of anaemia among women**
  - ***58% and 84% of husbands in urban and rural area have never heard about anaemia among women.***
- **Awareness of the nearest government health facilities**
  - Most of husbands are aware of the nearest government facilities.
  - 42% and 61% of husbands in urban and rural area reported PHC or CHC are the nearest facility.
  - Only 27% husbands raised SC as the nearest facility.

PART II

A Case Study report:

The Role of IEC on RCH Behavior Change

The Role of IEC on RCH Behaviour Change

(A case study)

February 2001

JICA Development Study on Reproductive Health
In
Madhya Pradesh, India

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Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker
BDO	Block Development Officer
CMHO	District Chief Medical Health Officer
DEMO	District Extension Media Officer
FGD	Focus Group Discussion
FP	Family Planning
IEC	Information Education and Communication
IFA	Iron and Folic Acid
IPC	Inter Personal Communication
JSR	Jan Swasthya Rakshaks
LTT	Laparoscopic Tubectomy
MMPW	Male Multi-Purpose Worker
MP	Madhya Pradesh
MSS	Mahila Swasthya Sangh
NGO	Non Governmental Organisation
PNC	Post Natal Care
RCH	Reproductive and Child Health
RTI	Reproductive Tract Infection
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
VT	Vasectomy

1 Introduction

When the Government of India launched its new Reproductive and Child Health (RCH) program in 1997, this program represented a marked shift in the government's policy. The program moved from its past pre-occupation of meeting sterilisation targets to the introduction of a decentralised participatory planning process based on community needs assessment. The countrywide RCH program covers an extended range of services for unwanted fertility, maternal health, RTI/STI infection, child health and adolescent health.

The new paradigm embodied in the RCH program echoes the deliberations of the International Conference on Population and Development (ICPD) held in Cairo in 1994. The ICPD signalled the coming-of-age of a quiet transformation in the arena of maternal and child health with a new emphasis on gender equity and reproductive health, and a move away from the operational objective of population control.

Information, Education and Communication (IEC) have always been a significant component of the government of India's family welfare program. The accent, so far, has been on awareness generation about the programme and service facilities, with the presumption that this would ensure increased utilisation. However, it is now evident, that the time for awareness generation is past. If change in behaviour is desired, a specific programme which promotes behaviour change will be required.

Subsequently, Government took the initiative in beginning the process that would define the strategy for communication for the country's RCH program. Thus in setting for itself the goal of strategy development for IEC, the ministry asserted its intent to align the actions of the IEC component with the broader goals of the RCH program.

The Ministry invited experts from the fields of communication, management, obstetrics and gynaecology, paediatrics, training international donor agency represnetatives and NGO partners to deliberate with government officials on articulating a strategy for communication which would advance the new paradigm for reproductive and child health care. A new strategy which would make the leap from awareness generation to behaviour change, from being instructive to being empowering, and from taking the generic approach and to taking the individualised approach.

Such shift in emphasis, it was expected, would require localised communication efforts so that diverse needs of different audiences in varied socio-cultural contexts could be meaningfully addressed. It would require decentralised planning to facilitate better quality and access, and interaction with audiences to improve service delivery as well. It would require a change in the media mix that has traditionally been employed, for instance, in rural areas, face-to-face communication)or Interpersonal Communication IPC) would be much more significant. At the same time, serious concerns were identified. Among them were: the meagre capacities at district and block level, paucity of institutions able to deal with resultant training needs and the implications of these shifts on the structure of the system to enable it to respond the new communication challenges.

The meeting was the first in a series of events, which helped to articulate a strategy for communication for the RCH programme. The next steps are the probation of this document by the state governments and a trial of the proposed strategy in a few states. After taking into account comments received from states as well as other consultative groups, the document will be issued as the new strategy for communication for RCH.

When the State of Madhya Pradesh came out with its Population Policy it deemed that communication would play a vital role in creating a conducive environment in dispelling the

myths as well as psychological barriers among the couples inclined towards the use of family planning services.

A communication strategy will be developed to cater to different segments of clients. They shall be reached through an appropriate mix of interpersonal communication and mass media campaigns.

The communication strategy will aim at creating a sense of pride among couples about the small family norm, promoting and encouraging male participation in a major way, adherence to the legal age at marriage, awareness of government benefits and schemes etc.

Social mobilisation by community leaders is essential to the success of the programme that emphasises behavioural changes. The support of religious leaders and village pradhans is crucial. The District Family Welfare Bureau will arrange a series of meetings, training programmes for these leaders to garner their support and involve them in family planning programme implementation.

2 Scope of the Study

This Case Study focussed on Ratinandan*, a village in district Tikamgarh. It pertains to the assessment of the role of Information, Education and Communication (IEC) in bringing about behavioural change in village community concerning the Reproductive and Child Health (RCH) theme and the extent of its effectiveness. It also sought to document community perceptions on the role of health workers as IEC facilitators.

3 Objectives of the Study

Document the role and capacity of block and village level government organisations and individuals responsible for IEC and health education.

(1) Record villagers' sources of relevant and useful RCH information.

(2) Determine villagers' level of trust in RCH IEC sources.

(3) Identify the IEC messages considered to be useful by the community.

(4) Determine people's RCH related IEC needs.

(5) Identify constraints to appropriate RCH IEC.

(6) Conduct gap analysis between villagers' awareness and practice and identify causes for the same.

4 Methodology Pursued

A mix of the following approaches was used:

- Focus group discussions
- In-depth informal interviews
- Observation

4.1 Focus Group Discussion (FGD)

Three FGDs were organised both among men and women. One single-caste group of Adiwasi

women was assembled. Two multi-caste groups, one with men of all local castes and one with women of non-Adiwasi castes, were assembled.
However, some men sought to remain in the adiwasi women's group. The FGD Facilitator did not seek to deliberately ask them to leave so as not to offend them. She attempted to make up for the distortion by focussing more elaborately on women and kept encouraging them to freely participate in the discussions. She also occasionally involved the more vocal women to keep the agenda focussed on women.

4.2 In-depth Informal Interview

Individual interviews were conducted with the Block Medical Officer (BMO), the ANM, the aanganwadi worker (AWW), Traditional Birth Attendants (TBAs, known as dais), a male multi-purpose worker(MMPW) and a grocer (a potential supplier of contraceptives) to supplement and complement the findings of the FGDs.

4.3 Observation

Observation was used to analyse participant interactions in groups.

5 Study Sample and Broad Characteristics

- One BMO, one ANM, two trained TBAs, one Anganwadi Worker, one male multi-purpose worker, a lady Janpad Adhyaksh and her son constituted the audience segment for in-depth informal interviews.

- The group discussions brought together members of the village communities. Separate groups of men and women were interviewed. The men's group consisted of Yadav, Jain, Adiwasi, Kushwaha, Teli and Rajput. Their ages ranged from 18-70.

- There were two women's group discussions:
  - The first consisted of Adiwasi women (with some Adiwasi men as well who chose to stay around). The women's ages ranged from 16-60.

  - The second was a women's multi-caste group consisting of Brahmin, Jain, Yadav, Teli, Rajput and Kushwaha. Their ages ranged from 18-55.

6 Study Findings

6.1 Health Functionaries

- The IEC and health education role is predominantly played by the District Extension Media Officer (DEMO) and the District Chief Medical Health Officer (CMHO). The block-level officials do not perceive IEC to be their role.

- The Jan Swasthya Rakshaks(JSRs), earlier known as Community Health Guides, have been trained to promote health messages and work as IEC agents. These JSRs are not govt. employees and do not receive either any remuneration or honorarium from the government. Villagers see them as doctors, so they act like it, according to BMO. The outreach is a problem. There is just one JSR for 1000 population.

- Health service providers have also been entrusted with village IEC work. ANMs, MPWs, aanganwadi workers, dais and the Mahila Swasthya Sangh (MSS) are expected to conduct meetings, offer counselling services and create awareness about health issues among villagers. But these service providers appear to be lacking in the requisite capacity and have rather been ignoring their IEC functions. The health functionaries cited resource inadequacy as a major reason for their poor involvement in IEC.

- According to the MPW and the BMO, village group meetings held by MSS members and the group counselling sessions held by the aanganwadi worker or the ANM were cited to be relevant sources of information for the community. The Aww's meetings occurred more frequently while those by the ANM were cited to be rather rare.

- Health service providers were only fulfilling targets: spacing method acceptors, immunisation of children and women and LTT. ANMs and MPWs were seldom involved in information dissemination.

- MPWs are supposed to reside in the village. They don't. This is why mandatory night meetings are never held. Since each MPW is assigned to provide health services to 4-5 villages, MPWs never have time to work on IEC.

6.2 Observations of the Study Team

- In the village and its surroundings, little IEC material was seen. One or two posters had been put up in the Panchayat Bhawan. Women were unlikely to ever see them. The janpad adhyaksh said that IEC material was given to the ANM but she made little effort to display it.
- The villagers, due to illiteracy, would not easily understand posters put up in the Panchayat Bhawan. The posters, therefore, lack in influencing capacity for which they had been designed.
- The study team observed wall paintings with slogans and announcements about dates for polio drives, eye camps etc. at strategic points.

7 Community Perceptions

7.1 Its RCH related Behavior and responses on needs

- Men in the village were aware that vasectomy for men was effective for limiting family size, but they did not adopt it because of misconceptions that it weakened them.
- Women who had had LTTs reported side effects such as a heavy white discharge, aches and pains etc. This had a negative effect on other women.
- Some women were aware of spacing methods. However, they were not using them since they did not know where to go to get them.
- Villagers, and women in particular, said that they need to know much more about RCH. They specifically mentioned ante-natal check-ups (ANC), post-natal care, safe motherhood, infertility, RTI/STI, AIDS, immunisation. They were particularly

interested in finding out more about RTIs/STIs, spacing methods, hygiene and mother and child care.

- The men would welcome to become aware of FP methods, ANC,PNC and RTI/STI.

- The older generation's conservative attitudes restricted information reaching the villagers. For example, the Sarpanch's son, who had five daughters, said that he would have a vasectomy if his father let him. But his father was opposed because he wanted his son to have a male heir.

- Villagers' awareness of an RCH issue was seldom converted to use. Socio-cultural prejudices and myths precluded the use of modern methods. For example, the *Sarpanch's daughter-in-law knew that limiting family size was important and* wanted to do so but her father-in-law and friends discouraged her.

- Everyone in the village agreed that it is important to educate girls. But the level of girls' education is very low. This happens because villagers claim that educated *girls couldn't find husbands of a similar educational level. Villagers said that most* men don't go beyond primary either. Once girls are older than 14 or 15, dowry price increases. So villagers don't educate their daughters.

7.2 Villagers' Sources of IEC

- The dai was cited as the most relevant source of information and awareness. In addition to delivering babies, she provides women with RCH information. Contributing to her success is the fact that she is not from a caste higher than most viillagers and is thus treated as a peer.

- Road plays (nukkad natak) and puppet shows (kathputli tamasha) designed to create awareness through entertainment were cited as a source. The success of Pulse Polio can be largely attributed to the use of these folk media, which the government uses to educate rural people about the importance of immunisation.

- The villagers also mentioned radio and television as sources of information and awareness but because of intermittent exposure to these media -- there are frequent power cuts -- people have "lost the habit" of paying attention to health messages and see radio and television only as entertainment: watching serials or listening to music. People seldom watch the news or health-related programmes.

- What largely developed from the group discussions and the interviews was that people, and women in particular, relied primarily on inter-personal communication (IPC) for their health questions. Their most reliable sources of IEC cited by women were husbands, mothers-in-law and their parents' families. In the case of a woman who had given birth to five female children, her parents counselled her to have a tubectomy. Her sisters-in-law and sisters all were operated on, after having decided that they had sufficient children.

- The women also rely on friends and acquaintances for information. They exchanged information or shared problems at village wells or at a nearby lake where they congregate to get water and wash clothes. They also meet on the way to the forest where they go for morning ablutions. But they said that in most cases friends knew as little about health matters as themselves.

- Government camp announcements are announced through announcements on mike.

- The chowkidar (a village security guard) also passes on messages and gives information about camps and other government health activities.

- IPC had the greatest effect on motivating women to use permanent methods. Husbands, mothers-in-law, wives' natal families and friends were the main sources of RCH messages. The most common messages were about antenatal check-ups and family planning methods.

- Through puppet shows and songs in local dialects have been disseminating messages about polio immunisation and malaria, other messages like FP methods, breast feeding, AIDS etc. have not been put on these media.

7.3 Villagers' Level of Trust in Sources of RCH IEC

- Villagers trusted RCH IEC messages predominantly from non-government sources.

- The community believed that the government had abandoned them.

- Trust in government officials has been eroded because of suspected corruption. Villagers felt that budgets meant for IEC are diverted. The villagers gave the example of government incentives paid to women for LTT operations. They are supposed to be paid Rs. 40 for an LTT plus free transportation. But in reality, villagers must pay Rs. 55 of their own money for transportation, fees and medicines. Moreover, they receive no referral cards, also supposed to be part of the package.

- On woman cited an example of corruption. She said that the ANM pockets the Rs. 500 given by the government to women who give birth to a girl child in their first or second delivery. This money is meant as a family planning incentive. The money doesn't reach its target nor does the family planning message.

- Villagers trust the dai on health matters. As she is lower caste herself, lower caste women as well feel that they can trust her. The women could relate to her and looked up to her to provide solutions to their problems. But they were aware that the dai did not know everything and sometimes could not help them. The dai referred women to private doctors in the block capital or the District Capital. Women felt that if the dai (TBA) were provided adequate training in IEC, she would be an effective communicator.

- A woman in one group said that it was difficult for them to evaluate health messages as right or wrong, just based on their own knowledge. If the message came from a source trusted as an authority, and if the women believed that the source had no ulterior motive, the women accepted the truth of the messages.

- Discussions revealed that information about government camps, launched at periodic intervals, was the only kind of information to reach people. Villagers pointed out that they were aware of intermittent pulse polio drives, LTT and eye camps. Since these activities are linked to target, these are the only communication activities whose messages reach people.

- Since the MSS meetings and other counselling sessions are held only sporadically and only higher status village groups are involved, lower-caste women are excluded from RCH information.

- The lack of faith in the ANM among villagers was a major deterrent to their asking for information. All the villagers agreed that the ANM was only interested in making money. She provided services only if paid in cash. Villagers said that the medical products meant to be freely supplied were charged for. This eroded villagers' trust in the ANM further and made it difficult for them to approach her for information.

- The regional political and power situations also constrain the access to information. The feudal attitude still prevails in the area. Dominant groups create barriers to information access by lower castes. For example, whenever MSS meetings are held, lower-caster women are excluded.

7.4 RCH Messages considered Useful in the Village

Immunisation for women and children

Sterilisation camps (especially LTT)

Eye check up camps

Malaria eradication

8 Other Observations

- The caste system dominates everything in the village, with Yadavs holding power. The sar panch has been in office for 25 years.
- The dai is the person most trusted for health information by villagers.
- Electricity, water, schools, dispensaries etc. are available in the village. It also has an aanganwadi.
- Health workers have been given IEC work to do, but they don't do it and therefore are judged as ineffective by villagers. The health services, which they do provide are target-based.
- The ANM is most distrusted by the villagers.
- Awareness and literacy are levels are low.
- The ANM sells contraceptives and medicines meant to be supplied free.
- Villagers have little faith in family planning methods.
- Villagers claimed to have had bad experiences both with LTT and VT.
- Most villagers have a conservative attitude about family planning. They prefer not using any method and when they use one, it is sterilisation for women.
- Training provided by the government has not been effective.
- Private medical practitioners charge high rates.

- There are no medical stores in the village. Grocery stores do not sell contraceptives.
- IEC networking at the block and village level is ineffective and non-functional.

9 Recommendations

- There is a need to identify area specific and audience segment specific social and cultural beliefs and misconceptions about modern FP methods. Also there is a need to address inappropriate communication emanating from previous negative experiences.
- Creation of strong peer groups for positive role in advocacy.
- Improve access, visibility, availability and quality of FP services.
- Need for conducting specific and special communication drives on IEC related to RCH. It would be worthwhile to engage community based volunteers.
- The Programme Managers in education have to address the community beliefs regarding their reservation pertaining to girls' education.
- Transforming the TBAs into local change agents. Expand their role of safe delivery conduction to include focus on nutrition and health education. They have to play an enhanced advocacy role as communicators for girls' education and women's status.
- Development of folk media, skits etc as popular communication support needs to extend to RCH IEC activities.
- IPC needs to be acknowledged as the most significant approach to IEC. It is necessary that the RCH Programme Design should centre on IPC strategies.
- The IEC has to become a major role and function of the gram sabhas. The village / block level functionaries need to identify themselves as resources for the gram sabhas. The lateral linkages amongst ANMs, TBAs, AWHs, JSRs and MPWs (male) and the village kotwal have to be operationalised. In addition the team needs to draw upon vocal and acceptable community members to undertake planned advocacy initiatives and monitor service deliverance.

Note: The name of the village and all personal names have been changed to protect the anonymity of sources.

Timetable

Date	Time	Persons / Groups interviewed
24 Jan. 2001	10 am	Group discussion with different caste men
	1pm	Break for lunch
	2 pm	Group discussion Adivasi women (some men were present)
	7 pm	Informal meeting with Manoj Chaubey, Exec Director of SRUM an NGO
	6pm	Report compilation
25 Jan. 2001	10am	Interview with the Sarpanch
	11am	Interview with the Sarpanch's daughter-in-law
	12pm	Interview with a grocery store owner
	1pm	Interview with the son of Janpad Adhyaksh
	2pm	Break for lunch
	3pm	Interviews with the ANM, Dai, Anganwadi worker
	5pm	Report compilation
26 Jan. 2001	10am	Interview with the BMO
	11am	Group discussion with women of different castes
	1pm	Break for lunch
	2pm	Report compilation

Annex 1

VOICES

"Though the village Shishu Shiksha Kendra was established a long time back till date there are hardly any facilities. There are no toys and hardly any food is given to the children. Occasionally a handful of uncooked **Daliya** is only given to them."
A male villager in the men's group discussion

"We rely on the **Dai** for all our needs and information. She does not charge as much money as the ANM and she even agrees to take payment for conducting deliveries on instalment basis or in inkind form."
All villagers cutting across different communities

" We don't encourage our girls to study and even if they do not after the Primary level as it will be very difficult for us to find grooms for them."
a) ***An Adiwasi woman***

" The ANM does not tell us anything about Family Planning methods or other health issues. We think she hardly knows anything at all and even if she does she is only interested in making money. She even sells the medicines which are meant for free supply."
A male villager

" I will not allow my son to undergo vasectomy because I was forcefully sterilised by the government and no good has come out of it. I feel weak and have continuous aches."
An elderly man who had undergone sterilisation in the 70's decade

"I have some knowledge about Family Planning methods and health issues. I want to share it with my compatriots in the village but nobody listens to me as I belong to a lower caste."
b) ***An Adiwasi male***

" The society in this district is very feudalistic. In some villages the Yadavs dominate and in others the Thakurs or the Jains. The Sarpanchs are generally elected from the majority community. Politics has a stranglehold on all walks of life. At times the district administration is paralysed because of it."
An NGO worker

"People are unaware of basic health issues as they are too poor and illiterate. They are too busy trying to sustain themselves to think about anything else."
Sarpanch of the village

"I want to get myself operated as I don't want any more children but my friends are against it. They say that I must give birth to a boy before I get myself operated."
Sarpanch's daughter-in-law

" I am willing to sell contraceptives in my store but before that the villagers must be made aware of them."
A grocery store owner

"If the ANM services have to be improved then there should be a new criteria for selection of ANMs. They should be atleast Standard 10 pass. The only way to improve the system was by

linking pay to performance criteria. The Janpad members should also be given more powers so that they can act as effective implementors of the various schemes at the village and the block level."

Son of the Janpad Adhyaksh

" I attend to the queries of the villagers regarding the health issues and also train the members of the Mahila Swasthya Sangh (MSS). I inform them about the government schemes related to the health issues. This information is then passed on to the villagers in group sessions. I also do individual door-to-door counselling."

Auxiliary Nurse Midwife

Annex 2

NOTES

Notes - January 24, 2001

Focus Group Discussion in Ratinandan

The village with population of 1658 persons, is located in Tikamgarh District, located on rough uneven terrain on the slopes of a hill. It is about 10 kilometres from the block capital, and 20 kilometres from the district capital. Unlike some villages, it cannot be bracketed as dirt-poor or prosperous, but somewhere in the middle socio-economically. It is inhabited by various castes, such as Brahmins and Kayastha as well as Scheduled Castes (SCs) and Scheduled Tribes (STs), among whom the Other Backward Castes (OBCs) dominate. Yadavs, an OBC group, are the village's majority householders. Yadavs hold sway over village affairs and opinions. The sar panch, has been ruling the roost for thirty-five years and while he was on pilgrimage, his elder son, then his wife, were elected to the sar panch position. After returning from his pilgrimage, he took over the reins of power again and heads the panchayat to this day.

Village facilities. Though the village boasts three primary schools (including a private one), an aanganwadi centre, a health care centre, and other facilities like open wells, electricity, etc., the male participants claim that in reality some of these facilities are phantoms. To illustrate this, one male villager claims that though the Shiksha Shishu Kendra was established in 1998, to date it still offers very little. It has no toys and hardly any food, meant to be distributed to the children. Another man said that that the ANM sent by the government to deliver health services demands 100 rupees just to check the fever of a sick child and as much as 500 rupees for a delivery. Not only that, the male participants said the ANM is only willing to deliver services to people with whom she has developed strong rapport. The men reported that the untrained dai performs most of the deliveries. She charges less than the ANM and is willing to visit members of all castes at lower prices. She gives credit and allows people to pay on the instalment plan. At times she has accepted payment through in-kind contributions, such as wheat, sugar cane, etc.

Attempts at alleviating poverty. According to several Adiwasi Gond men who sat in on the Adiwasi Gond women's discussion group, Adiwasi Gond formed a committee called Ekta Parishad. Its main objective was to reduce poverty in the community through different programs initiated by Adiwasi Gond. The organisation attempted to farm unused and unoccupied land but this effort was thwarted by the majority community of higher caste persons. One Adiwasi Gond man claimed that crops worth 300,000 Rs. were destroyed by the "other community," as the "other community" did not take kindly to the efforts of the Adiwasi Gond to better their lot. They lament that even the government machinery hasn't been of much help even though this Adiwasi Gond group held a dharna (protest and demonstration) in front of the district court for fifteen days, but they could obtain only Rs. 50,000 as compensation. This was distributed to the leading members of the Adiwasi Gond community itself, leaving very little for the rest of the members.

At present, the majority of the householders in the Adiwasi Gond community are working as labourers in different parts of the country, for example, Delhi, Punjab, and Haryana, where they migrate before the harvesting season. These same people often stay in these urban areas to work on construction sites.

Information about RCH. In both the multi-caste men's group and the Adiwasi Gond women's group, it was said that the basic source of information about RCH issues was the ANM, but they added that they feel she is apathetic and gives information only when prodded. Both groups also said that the ANM makes no attempt to provide information or raise awareness about RCH issues on her own. When villagers ask for iron and folic acid (IFA) tablets and tetanus toxoid injections, the ANM usually puts them off. Even though the aanganwadi worker works at the centre, she provides no information on health issues, said both groups.

Both groups reported that television and radio, potential sources of information, are relatively useless, since power cuts often last for long periods of time. So villagers have little opportunity to watch television. When they do, they prefer watching entertainment programs. When they listen to the radio, they listen only to film songs.

Print media. The only reading material available to the villagers is a newspaper called Rozgar Nirman, "Employment Opportunities." Not only is it of little interest, it is also stored away in the panchayat bhawan, out of reach of most villagers.

Status of girls The topic of girls' education was raised only in the Adiwasi Gond women's group. They said that village girls are provided basic primary education, although few Adiwasi Gond girls participate. Only Jains send some of their girls for post-primary education. Neither men nor Adiwasi Gond women place much emphasis on girls' education. Adiwasi Gond women feel that if they educate their girls they will find it difficult to find suitable grooms and to meet the dowry demands, which can reach Rs. 200,000 for higher socio-economic levels of the community and thousands of Rupees for lower ones. The older a girl is, the higher the dowry. This sounds as if community members would want to have older and more educated girls but the feeling is that this is running a high risk of pricing one's daughter out of the market. So, the women say that girls are married off at twelve or thirteen, with the gauna ceremony (going to the in-laws) being performed at the age of fourteen or fifteen. When asked if any girl had ever attempted to refuse marriage, the male onlookers in the Adiwasi Gond group refused to even countenance the idea. They felt that girls had no right to speak for themselves.

Family planning service provision. In the multi-caste men's group, a villager recounted incidents of camps being conducted at the block level for laparoscopic tubectomies (LTT). Women were offered incentives and transportation by the government, but what finally happened when the women were herded into the camps, and what the government promised in the way of monetary incentives and transportation were totally different. The women were left stranded after their sterilisations. Vehicles promised for the return journey were not provided. The women were given the usual 40 Rs. incentive, but they were required to pay 55 Rs. for various charges invented for transportation and medicines. Furthermore, the government skimped on the post-operation antibiotics, giving the women only sixteen antibiotic tablets for eight days, rather than the usual dosage of many more. They were issued no follow-up cards, which have the date of the LTT, the date for the removal of stitches and the medicines prescribed, which are used by the doctor on future visits, in the case of complications. Without it, there is no evidence that the LTT has ever been performed. The villagers on whom the LTT had been performed were ignorant of the existence of this follow-up card as well as of the true dosage of the antibiotics. There was a general feeling among the villagers that though the government gives money as an incentive, even more money is pocketed by government officials by omitting parts of the procedure such as the ride home and the antibiotics and adding others, such as the "fees" which the women are forced to pay. This leads the villagers to total disillusionment with the health system.

When we asked the men why they consistently referred to the ANMs as lackadaisical, they said that this was because the ANM had no interest in her work and was only interested in her

salary, making money from selling medicines and charging for services which are supposed to be free. The men also suggested that if the government took some punitive measure such as freezing her salary for a period of time, the ANM might reform.

Knowledge of family planning methods. Most of the men and women we spoke to were ignorant of short-term methods and knew only about LTT and vasectomy. Although the men were aware of vasectomy they expressed scepticism about it. They said that almost three decades ago, at the time of the government's forced sterilisation program, some men from the village had been sterilised. This period left strong memories in its wake. Since then there has been no other male acceptor in the village. The men commonly believe that vasectomy weakens them physically, decreases their libido and may cause death. When one man, who had been forcefully sterilised, was asked why he hadn't recommended the same method to his son, who had fathered four children, he replied, "What good has come from me having it done? Why should I want my son to do it? I would rather see my daughter-in-law sterilised."

The Adiwasi Gond women seemed to have no knowledge about short-term spacing methods and were aware only of permanent methods like LTT and vasectomy. Although they were interested in LTT for themselves, they were not interested in vasectomy for their husbands and in fact, were highly distrustful. Most of the men as well knew only about permanent methods, but one or two had heard about the existence of condoms. They had no idea where to obtain them in the village.

Except for men under financial stress, none were interested in limiting family size. Economics seems to be the only factor motivating couples to have an LTT. Even then, they are not interested in vasectomy. One of the men we talked to, who had completed Standard Eight, had two sons. His wife had been sterilised. This was unusual. The others present all had more than four children. When asked why he thought of limiting, he said that he couldn't feed more than two children. Another man said that he had had his wife operated on after she gave birth to three girls and two boys. This too was done for financial reasons. Still another had a boy and a girl but he wanted another male child, as he was afraid that calamity might strike his only son, so he wanted to continue bearing children and have another male child.

Caste constraints on information flow One of members of the multi-caste male group, who had completed twelve years of education, and thus is more broadly informed than some of his less educated peers, knew about family planning methods, AIDS, and some other health issues, which he learned about from the radio and other sources. However, he complained that whenever he wants to pass this information on or to educate friends, his advice falls on deaf ears, even if it is sound. He attributes this to the fact that he belongs to a lower caste.

Constraints on behaviour change: Older generation's conservatism. One of the men i.e. the Sarpanch's son, in the multi-caste men's group said that he has five daughters and he would like to stop at this point and have his wife sterilised, but the elders in his family are opposed to the idea, as they want a male heir.

The male discussants said that when the government attempts to educate people about something, these attempts seldom bear fruit. The men said that a training camp was conducted by the government to develop health volunteers to raise awareness. In the case of this village, this failed. The two trained volunteers from this village did not disseminate any information or create any awareness about RCH issues. They failed to work as links between the government and the community. When these trained volunteers were asked by the villagers where they had gone and for what purpose, they simply said that it was a fun trip for them. One of them now works in Delhi and the other is an alcoholic.

Information constraint: few reliable sources. Both the men's and the women's groups stated that, in addition to rural medical practitioners (RMP: dokter sab) and dais, friends, relatives and family members are the only reliable sources of information. Traditional healers also provide indigenous medicines, in which they have confidence.

Manoj Chaubey, executive director of SRUM, the Society for Rural Upliftment and Mobilisation, an NGO working in Tikamgarh. Tikamgarh District is feudal, more pronounced in villages where Thakurs dominate. In some villages it is the Yadav and in a few it is the Rajputs or Brahmins. The dominant group wields absolute power. The sar panch is always elected from the majority community and even where the seats have been reserved for women or ST/SC, the influential members of the dominant community have ensured that the deputy sar panch is elected from their community. In this way, the women and the ST/SC sar panch are reduced to the status of puppets and it is the deputy sar panch who pulls the strings.

Politics has a stranglehold in all walks of life. The bureaucracy becomes a rubber stamp. Most of the appointments for government jobs are polictial and the sar panch and Janpad are all political players. Therefore the district administration at times becomes paralysed and can't function when faced by the vested interests of the political players. Most of the sar panchs are only serving their own purposes and hardly do anything to alleviate the suffering of the villagers.

Some people like Rudra Pratap Singh from Larhwari, the ex-chairman of the Janpad, has worked to improve village status. D.N. Mishra is another ex-chairman of the Janpad. He has done a lot of welfare work for the villages with little funding.

Chaubey works to cerate awareness about issues related to peoples' lives. He has worked on issues like Panchayati Raj, literacy, health awareness, family planning and environmental issues with the help of folk media. He has used the medium of folk songs, nukkad natak, and puppetry for messages on the above issues. He has written songs in Bundel Khandi about literacy and environmental issues and used nukkad natak to create awareness about ORS.

Notes - January 25

Today we focused on one-to-one discussions, with some of the village residents and health workers.

Sar panch

Replying to our comment that there seemed to be no knowledge or awareness amongst the villagers regarding RCH, the sar panch said that the reason for this was village illiteracy and poverty. Another reason that he cited for villagers' lack of knowledge was that they are too busy surviving. They may in desperation approach the village ANM, who then refers them to the hospital in Baldevgarh. If they ask for medicine, they are told that she doesn't have any as the government has stopped supplying medicine, but once a villager offers her some money, suddenly these medicines become available. When villagers ask her for iron folic acid (IFA) tablets, the ANM flatly refuses to admit that she has any. The sar panch said, "In fact, I have decided that I will write to the government and tell them that our ANM does not have the IFA tablets with her, so they must supply her with some of these." His ironic suggestion to the government was intended to provoke the ANM into supplying the tablets, one way or another.

The sar panch says that the ANM has been immunising children, but not much more. He further states that the ANM hardly ever makes an effort to organise group meetings and counsel women about RCH. It is the aanganwadi worker who conducts group meetings with women from time to time. (We noted that this was the first time that someone said that the aanganwadi did anything). The sar panch felt that the ANM has no interest in serving the villagers, even though she lives there. The majority attitude is that she is only ready to offer her services if she gets money from the villagers. We wanted to know if there were any medical stores in the village from where people could get different kinds of medicines and contraceptives. The sar panch said that there were no medical stores in the village. The people have to go to Tikamgarh or the block level for medicines, though sometimes the private doctors also sold medicines but charged according to the paying power of the clients. The sar panch also told us that the contraceptives which were supposed to be supplied free of cost in the health centres and government hospitals can be found in the private medical stores where they are sold at market rates. We asked the sar panch about the MPWs and the sar panch said that they hardly ever visit the village and even when the lone MPW of the village visits he is only interested in selling the medicines which the government has asked him to supply free of cost. The sar panch seemed to have no knowledge about the MSS and he said that there were no JSRs in the village, though some time back, that is about six months ago there was an announcement about the recruitment of JSRs. Some of the villagers had even filled out the forms and applied for the post but nothing had come out of it.

About the private medical practitioners and the traditional healers, the sar panch informed us that they have no fixed rate for consultation and medicines. They charge varied rates. The minimum amount always comes to Rs. 40 for injections. It rises to Rs. 50 and if the patient has to be given a drip, then it is Rs. 100. The ANM, who is supposed to provide free services, charges Re. 1 just to apply tincture to small wounds. The sar panch feels that it is unconscionable that villagers pay what he considers excessive amounts for services and medicines, because at times, villagers don't even know what they are getting. To quote the sar panch, "For all we know, these doctors may be giving us water instead of glucose in the drip. We have no idea what medicines they are providing us and we have to blindly trust them."

Sar panch's daughter-in-law

The sar panch's daughter-in-law was married at eleven. Her gauna (co-habitation in the home of the in-laws) was performed when she was sixteen. She remained childless for three years after her gauna. So people started saying that she had evil spirits or she was barren. Her husband took her for treatment to Tikamgarh, then at nineteen she conceived. Since then, she has had five girls with one arriving every three years. She used no spacing method to achieve these intervals. Her last birth was very difficult. So she wants to limit through LTT.

When asked about family planning methods and other health issues she said that she needs more information but nobody tells her. She says that the ANM hardly provides her with any information (or anybody else for that matter). (Interestingly, in the subsequent interview with the ANM, we were told that the daughter-in-law was in the MSS -- see below.) For every medical problem, she said, she has to go to Tikamgarh, where she consults a private doctor. She strongly believes that the ANM herself doesn't know anything the family planning methods, which is why the ANM is unable to provide information.

When we told her about methods, she was very curious and asked for more information. She asked about contraceptive prices. When hearing the answers, she beamed with pleasure. She said that she realised that they could afford these methods. She asked about where they could be found.

We asked her if the private doctor whom she consults has ever told her about temporary spacing methods. She said no.

When we discussed her education, she told us that she had studied until Standard Eight before her marriage. Now, fifteen years later, she said that she wants to continue. She has filled out forms to enter Standard Ten.

We asked her about her sources of information about RCH. She replied that she watches the television a lot. She watches serials and song and dance programs but couldn't give the name of one when asked. She added that she has also seen advertisements for Copper-T and Mala-D on the television but she is not very clear about exactly what they are. She also listens to the radio, mostly to film music. She never reads the newspaper because she can't remember how to read, but from time to time, her husband reads it aloud to her.

We asked her that since she had gone through a lot of pain and misery in giving birth to five children if she had she ever counselled friends, relatives or acquaintances about family planning. She replied that she has talked about it with her friends. She also said that she has decided on LTT. Her father-in-law and husband both support her decision, but her friends and acquaintances who have asked her not to do so. They say that she must give birth to a boy before she has the operation. She thinks that they feel this way because once she gave birth to a stillborn baby boy in her seventh month, and this means that there is still a boy in her. Her family thinks that she is too weak to give birth to another child. Her two sisters-in-law and five other sisters have all had LTT. The daughter-in-law has decided that she will definitely opt for this method.

Grocery store contraceptive marketing potential

The main general store owner said that he does not sell contraceptives now, but he would do so if people were made aware and there was a sales margin in it for him. Under these conditions he thought that people would buy. He also thought it was important to raise people's awareness, however.

Janpad Adhyaksh

We met with the son of the Janpad Adhyaksh, whose mother is the real Janpad Adhyaksh (top official in the block), but most people say that he is the de facto Janpad Adhyaksh. He is a zamindar who owns about 80 acres of land. We talked with him about how the government system functions, from the district level down. At the block level, the Block Medical Officer (BMO) is the only source of information about health personnel and activities, including IEC and IEC materials, which the BMO gets from district officials. The BMO then passes on the information to the ANMs, MPWs and JSRs, whose job it is to assure that it reaches villagers.

When asked if the ANMs are dispensing their services properly and how effective they are in communicating health messages, he said that the ANMs "hardly ever" work correctly, even though they have the facilities. The ANMs have the added advantage of living in the village and are in constant touch with the villagers. He noted that most of the ANMs don't stay in their assigned villages, but commute from Tikamgarh or Baldevgarh. The ANMs have been supplied with medicines, along with IEC material, which they are expected to dispense free of cost. The IEC materials are supposed to be displayed. Counseling sessions using information given to the ANMs by the BMO are never held, he said.

He suggested that if ANM services are to be improved, there should be new criteria for the selection of ANMs established. He believes that ANM should have at least a Standard 10 pass.

He said that what happens when ANMs don't live in the villages is that they seldom turn up for their duties. And once they are appointed, they are very difficult to remove. He suggested that when present ANMs retire that they should be replaced by locally recruited new ANMs.

He felt that with a target-based approach at least the ANMs were meeting their targets, but with the target-free approach, they are unlikely to do much of anything. He felt that the only way to improve the current situation was to link pay to performance criteria. He suggested that ANMs' performance might be subject to approval by the nearest Janpad member before receiving their salary. He suggested that something like the yearly contract system developed for the Shikshak Karmis (in the school system) be used for the ANMs as well. Under the Shikshak Karmi's contract, his/her performance must be approved by Janpad members before the contract is renewed.

Auxiliary Nurse Midwife, Dai, Aanganwadi Worker

We met with the ANM at the health centre, which also includes living quarters. The ANM listed her duties as: 1) immunisation, 2) counseling, 3) other health services. She said that she was given a target of 40 LTTs for 2000 and overreached this target, achieving 55. When asked about the availability of contraceptives at the sub-centre, she listed OCs, condoms, and IUDs. She showed us a Copper-T 200. We asked her if the village women ever availed themselves of contraceptive products. She said that they had. Three women had had IUD insertions and nine women had chosen to use the OC brand, Mala-D.

The ANM has received training in interpersonal communications, but doesn't do much counseling herself. She trains the Mahila Swasthya Sangh (MSS) to do this and only does group counseling on occasions where she sees an appropriate group of women gathered. The MSS in Ahar has ten women members. The sar panch is supposed to head the MSS, but the ANM said that he isn't interested, so the ANM performs this task. Most of the MSS are Yadavs with some Jains and two Harijans. The MSS meets once a month to discuss health issues. The last meeting, held on December 17, focused on vaccinations and LTT operations. The ANM also informs the members about any health schemes offered by the government. This information is to be passed on to the villagers. The ANM said that she does counselling door-to-door and on an individual basis.

We asked her where women got information other than what they get from health service providers. She said that the most common place for information exchange was the village well, where they fetch water, or the lake and the forest, where they go to wash themselves.

Then we asked about whom the villagers trusted most for information about RCH. She identified the dai. "People trust the dai more than others for IEC information." Lower in rank after the dai were health providers and MSS members, private doctors and the sar panch. There are ten to twelve trained dais in the village. They live in different parts of the village. All the dais belong to the Vanshkaar caste. They handle the birthing needs of the entire village. Dai status of dai is hereditary. Their husbands were traditionally bamboo workers and musicians, but now they work in other occupations, in part because of a shortage of bamboo. With education, dais can move out of their traditional occupation into others but other castes cannot become dais. The dai said that DANIDA used to provide safe delivery kits, but since the support stopped, so has the use of safe delivery kits. The government does not supply them either.

The dais in the village have been trained by the government through training sessions held in Gwalior, Jatara, Tikamgarh and other nearby locations. They feel that this training is not sufficient for their needs and that they don't know enough about RCH issues other than delivery. They feel that if they had more information about other RCH issues and child health they could be doing a better job. When they don't know how to answer women's

questions about medical advice, they refer the women to the ANM or send them to Tikamgarh.

The dai said that their salary of 50 Rs. is low, and their real source of income is from fees, in cash or in kind, which they receive for births. In the past, the government has given them 10 Rs. for each birth. Now it gives 200 Rs. a year for all the dais in the village.

She said that both men and women were aware of family planning methods. She thinks that they learned about them from radio and television and from health workers. The dai said that villagers feigned not knowing about family planning (This was certainly the claim made in the men's and women's groups which we met). She gave the example of the sar panch's daughter-in-law, who told us that she was unaware of any family planning methods except for LTT, yet she is a member of the MSS who attends meetings.

All three women present, the ANM, the dai and the aanganwadi worker thought that the dai would be the best person for RCH IEC, followed by the Jan Swasthya Rakshak and the doctor.

We asked the ANM and the aanganwadi worker what the differences were between their two jobs. First, the ANM is a nurse and a midwife, and the aanganwadi is not. Second, the aanganwadi's main function is to run the child care centre, distribute dalia to children, pregnant and lactating women, while the ANM does none of this. Third, the ANM does RH work while the aanganwadi does not. Fourth, the aanganwadi assists the ANM in counseling women and conducting group meetings with the ANM on RCH.

The aanganwadi is supplied with only enough dalia for eight pregnant women, eight lactating women, 34 children from six months to three years old, and 34 children from three to six years old per year. For pregnant and lactating women, the principle is first-come, first-served. Parents of children from six months to three years are called from their homes to report. Parents of children between three and six years may come to the aangawadi centre at their discretion. Pregnant and lactating women are give 1120 g. of dalia (170g. x 6 days) and children are given 480 g. (80g. x 6 days). In many villages, the norm is that children be given cooked dalia while the women are given dry dalia, but in Ahar parents are given the dalia to cook at home, since the aanganwadi does not have cooking facilities.

The three women said that public buses are the main mode of transport for the village. Private buses run hourly or half-hourly and they charge 10 Rs. one way to Tikamgarh.

Remarking on corruption, the women said that incentives meant to be paid to the village women for LTTs never reach the women and "eaten" by government officials.

Notes - January 26, 2001

Block Medical Officer

According to the Block Medical Officer (BMO), IEC is handled at the district level by the District Extension Media Officer (DEMO) and by the District Chief Medical Health Officer (CMHO). At present he feels that IEC standards are very poor and that little work is being done.

Once in a while some pamphlets are distributed but they are generally useless and the literacy level of the audience is very low and 80% of the women are illiterate. To make announcements about the various health camps, officials make announcements through

public radio stations or put up banners. But they don't rely on this mechanism only. They also send out health workers to contact people personally and inform them about the camps,

A training camp for Community Health Volunteers (CHV) and Village Health Guides (VHG) is conducted at the district level for two days. In this camp, RCH issues are discussed and volunteers are trained in providing RCH IEC, as well as the methodology of surveys. One of these surveys was on RTIs/STDs and was done by having the volunteers go from door to door questioning women. The women were provided with referral cards and were sent to the block hospital where they were given treatment.

People are informed about RCH issues through pamphlets and the Multi-Purpose Workers hold meetings and go door to door to give people information about RCH problems. When we mentioned to the BMO that some villagers said that they had never received any information from the MPW, he said that it was likely that such people were not at home when the MPW and probably they were in the fields working.

There are two types of MPWs, male and female, and this pair is assigned to (on the average) four or five villages, for which there is one health sub-centre. Thus they cater to about 5000 villagers on the average. When we mentioned that people said that there was never any attempt on the part of the MPW to create awareness among them, the BMO said that probably people didn't understand and furthermore the women were probably too shy to express themselves in front of the male MPWs. He said that women did talk with the female MPWs.

With respect to the district IEC budget, the BMO said that this had been diverted to other areas in the MOHFW for use on other health services.

The BMO said that the Mahila Swasthya Sangh (MSS) was an organisation which conducts meetings at the village level to create awareness about health issues among villagers. The initiative is taken by a female MPW accompanied by the media officer and they explain government programs and policies to the MSS and the MSS members pas this information on to the villagers (This is the first time that we have heard this version -- who is this media officer?) But this seldom happens, as the MPWs are not living in the village so programs are never carried out. Mandatory night meetings never occur. Even during the day few meetings take place as people are involved in other activities. Removing the MPWs or taking action against them would yield little, as they are political appointees. According to the BMO, withholding their rent allowances (which they are supposed to use to stay in the villages) has been tried as has been reporting their non-performance, but this has all come to naught, according to the BMO. As the MPWs see that they cannot be touched their indifference grows.

He said that since the sar panchs don't involve themselves with the MSS, the responsibility has been handed over to the MPWs. But, said the BMO, their performance can only be improved if they are required to stay in the villages, given more intensive training and greater incentives.

The BMO believes that printed IEC material is useless and the only thing that would work at the village level is interpersonal communication, as most village people are illiterate.

The BMO had little confidence in the medium of television, as power outages are so frequent that it is unlikely that much would go out. He did think that folk drama could be an important vehicle for village-level communication. Bhajan mandalis, nukkad wataks and puppet shows can be used to disseminate information about RCH. He said that the government is very much in favor of puppet shows and songs in local dialects and recently used them to publicise pulse poilo.

The BMO said that CHVs as another group which could be used to promote health messages. The CHVs receive no salary, whereas VHGs are paid 50 Rs. a month. There is one CHV for each 1000 people. Their job is to guide people about health and to raise awareness. The government appointed them in the hope that they could work as IEC agents in villages. They have received five or six days' training on how to combat myths and misperceptions, as well as how to communicate health information, fro example, breast feeding, the best possible use of home-available food, safe delivery, etc. But what happens is that these volunteers go to the villages, are perceived as doctors and begin acting as such. The BMO also mentioned that training was held for the medical officers (MO). This was the same training as that which the MPWs received. This too was ineffective due to lack of initiative on their part.

Group discussion with women of different castes

We organised a discussion with Brahmin, Kushwaha, Lodhi and Khawas women as well as a Jain. Their ages ranged from 16-60. All women were married and had an average of three to four children. The education level of the 18-25 age group was five years of primary school. The women above 30 had never had primary schooling. The discussion was very animated with strong opinions. All said that they liked to watch television and they said that the preferred program was a religious series. They had seen ads on family planning, but they didn't pay much attention to them.

When asked about a choice between permanent and temporary methods, there was reluctance to make a choice one way or the other, as both were seen to have disadvantages and few advantages. Women who had been sterilised reported side effects such as a white discharge, weakness and pain. So wouldn't recommend LTT to other women. They would prefer temporary methods but they had neither information about them nor access to them. A woman with four children, three boys and one girl, said that she wanted to become a user, but was unable to do so because of lack of money. Another woman with three girls said that she would use a spacing method if she knew where in the village it was available.

When it was pointed out that they could go to the ANM, they scoffed at the idea, because the ANM only offers services when paid. She never offers advice even through group counseling. The last group session which the women reported knowing about and attending was five years ago. They don't know if more have been conducted recently and if there were any, these women were not invited. The ANM never comes to their side of the village, not even for immunisation. One Brahmin woman remarked that four to five years ago she and other women selected by the ANM attended for training on RCH IEC (RTI, hygiene, sanitation, nutrition, child care, breastfeeding, ORS, ect.) in Tikamgarh and in Ahar. Since there was no follow-up maintenance training, any lessons learned from the earlier workshop have since been forgotten.

The women said that it was difficult to evaluate health messages as right or wrong, so if the message came from the appropriate authority, they took it on good faith that the message was true.

The women reported that the most trusted source for information was the dai. They realised that the dai's knowledge was limited, but the dai referred them to Tikamgarh or to private doctors. They ranked private doctors second, but the women felt that the doctors' interests were more mercenary, whereas they regarded the dais as more of a peer. Third-ranked were friends and relatives.

E: Supporting Report for Chapter 7 in Main Report

Health Management Information System (HMIS)

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PART I

Data on HMIS and GIS Developed by the other Department and Development Partners

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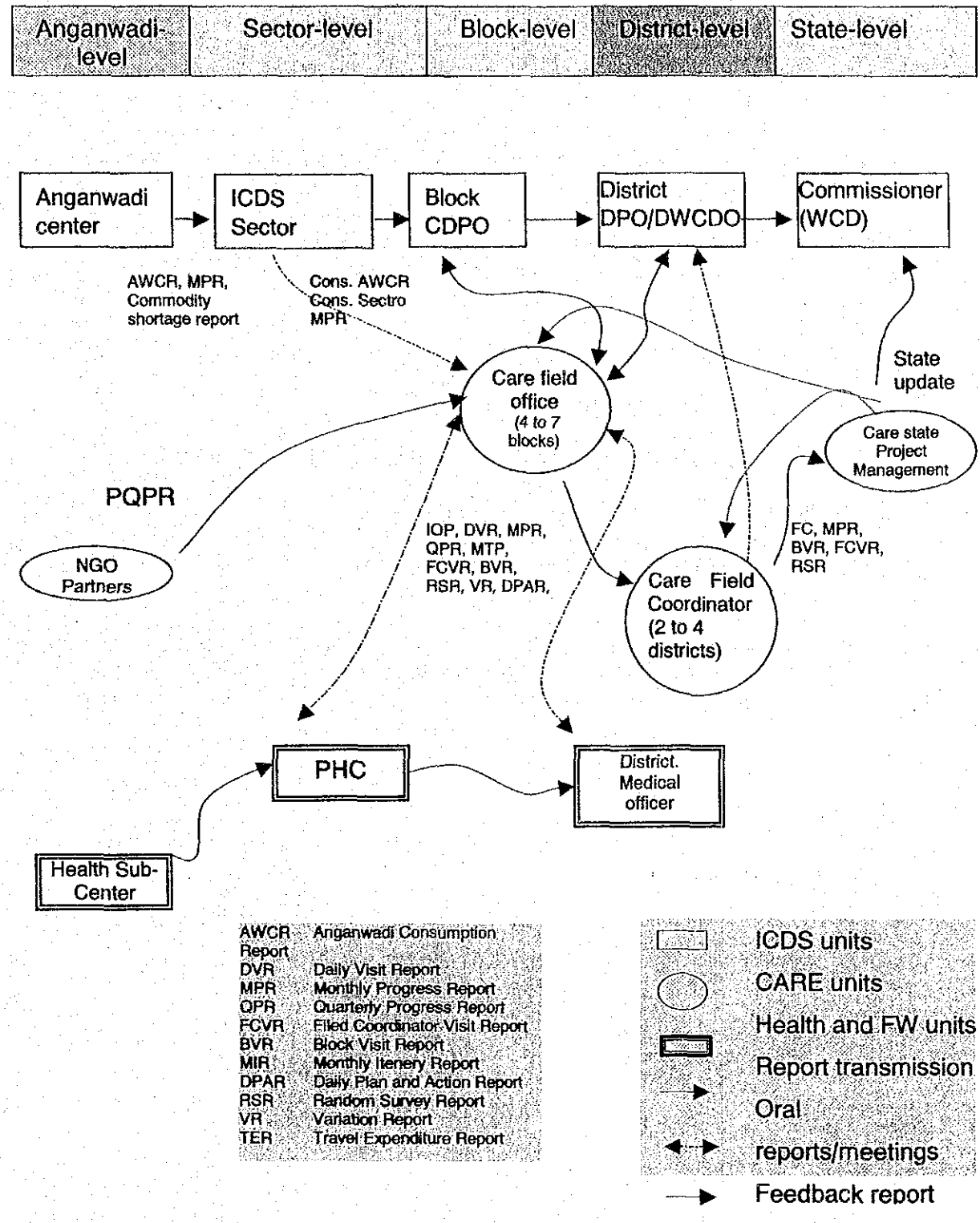
1 HMIS FLOW – CARE AND GOVERNMENT INTERACTION



2 A BRIEF NOTE ON THE STATISTICAL INFORMATION SYSTEM (SIS) DEVELOPED UNDER ADB SUPPORTED PUBLIC POLICY PROGRAM

SIS is envisaged as a statistical database capable of addressing the information needs of planners at the panchayat and district levels. It aims to generate data relating to all developmental and social departments at the district-level. It provides for various data entry formats and reports. The coordinating agency is the Directorate of Economics and Statistics at the state level and the implementing agency is the District Statistics Office at the district level. The unit of SIS is a village or urban local body. Large numbers of variables are included in the current developed version. More and more variables can be added as the usage develops and the data is made available.

Technically, the system has been developed with Oracle as the backend and as the java front end solution. It can address the issue of Indian languages as well.

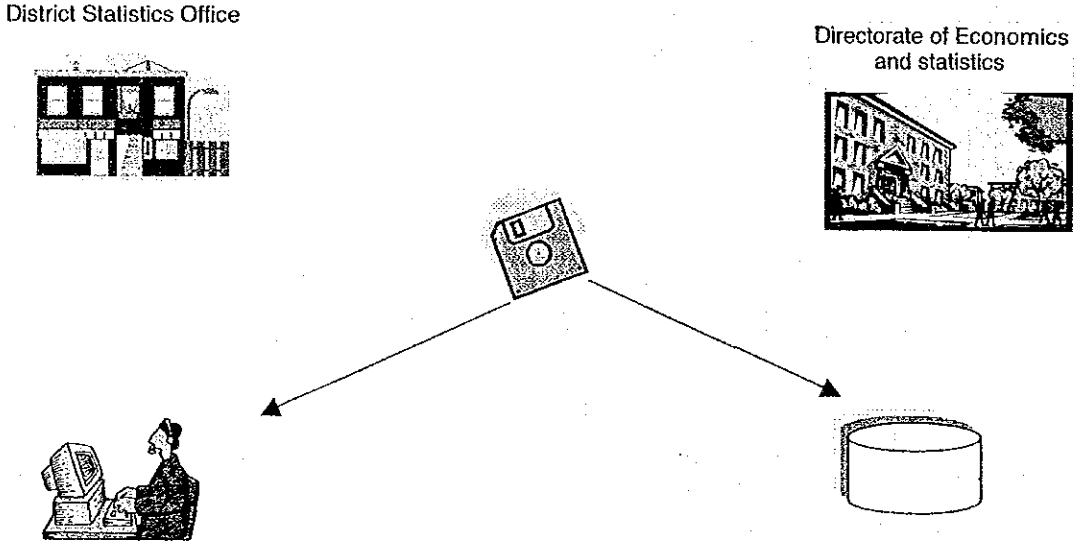
It is presently organised into three tightly integrated layers

Reports - generated on processing the data of the urban and rural birth and death forms.

Urban and rural forms – get validated from the master data.

Masters – provide for data validation and are updated regularly at the headquarters in Bhopal

At present, it is hosted on stand alone PCs in the district and data transfer is made through the floppies. Future plans include networking the state through available private and public internet infrastructure.



Health and vital statistics: The SIS has the provision to include health facilities – location, type and numbers in the system. SIS also has facility for data entering of birth and death information as provided in the new formats, and generating various reports.

NGO/State /Union Govt. : NGO AND DONOR

3 GIS APPLICATIONS DEVELOPED BY OTHER DEPARTMENT – DATA SETS

3.1 DEPARTMENT/ ORGANIZATION : DANLEP

Health facilities mapping

Organisation : DANLEP

Functions of the Organization: Leprosy Eradication Programme

Contact Person : Mr. Sharma/ Mr. Manoj

Nature of the Application : Health facilities mapping

Area of the Study : Madhya Pradesh & Chattisgarh states

Source maps & other database:

Source & Details	Publisher, Satellite, etc.	Scale	Approx. period of study	Others
Survey of India toposheets	Survey of India (SOI)	1: 250,000	1960- 70	

GIS Software : PC ArcInfo / ArcView

GIS data format : PC ArcInfo coverage

Projects/ Datum : -no-

Software DBMS : PC ArcInfo DBF

GUI : ArcView

Themes in the digital maps : Transport Network, Drainage Network, Village as point, Forest.

Details of attribute data : PHC, SHC, CHC, Civil dispensaries, Ayurvedic dispensaries, Sector hq, NMH hq, NMA hq, etc.

Comments

As they used SOI sheets of 1:250,000 scale, the villages are shown as a point. Many villages and sub-centers have been missed. No projection & datum are present.

3.2 DEPARTMENT/ ORGANIZATION APPLICATION CENTER, **: MP STATE REMOTE SENSING**

MP Council of Science & Technology.

NGO/ State Govt. / Union Govt.	: Dept. of Science & Tech, MP State & Dept. of Space, Govt. of India.
Functions of the Organization	: Prime organization for developing the GIS applications to meet the needs of the State government, and the applications related to MP in Department of Space (DOS).
Contact Person	: Dr. Subrato Khan

The various projects they have undertaken are mentioned in the following pages.

Project 1 : NNRMS (National Natural Resources Management System)

Objective of the project : This project has been designed to enable uniform village-level GIS database creation for the entire country. Initially, they are developing a District Information System and distributing it to the districts.

Location of the Study : Madhya Pradesh state (But so far they could complete the project for Dathia district only. Work in Sidhi district is in progress and will be completed by the next two months.

GIS Software : WS ArcInfo 7.2.1 for Unix

GIS data format : WS ArcInfo coverage

Projects/ Datum : Polyconic & everest spheroid with the origin and center of the district.

Software DBMS : PC ArcInfo Database file

GUI : WS ArcInfo with AML programming.

Details of Themes & source maps

S. No	**Layer**	**Source data & Methodology**
1	Transport Network	SOI Toposheets & updated with recent IRS ID satellite merged data of Pan & LissIII (FCC with 5 meter spatial resolution)
2	Drainage Network	
3	Watershed Mapping up to Micro-watershed	Derived from drainage network & slope map
4	Land Use/ Land Cover	Derived from Satellite data of 6 seasons.
5	Village Boundaries with Detailed Attribute data	Cadastral maps, census data and other data collected from the villages.
6	Contours	SOI 1:50000 toposheets
7	Slope Maps	Derived from contour data
8	Forests National Parks & Sanctuaries	Boundaries extracted from SOI 1:50000 toposheets and classification on IRS IC satellite data
9	Geo-Morphology Mines & Geology	Geological Survey of India (GSI) Maps for reference & derived using satellite data

Details of Attribute data

Source & Details	Publisher/ Satellite etc.	Year of Study
Census data	Directorate of Census Operations	1991 *(This database has been modified using the information gathered from the villages)*

Project.2 Rajiv Gandhi Drinking Water Mission Project

Objective of the Project : Evaluation of underground water resources in the Indian sub continent using Latest available data like satellite information and geological data and ground verification involves water levels in wells and bore-wells.

Location of the Study : Part of Madhya Pradesh state (They are undertaking the project toposheet-wise as per the instructions from NRSA on behalf of the Department of Space.

GIS Software : WS ArcInfo 7.2.1 for Unix

GIS data format : WS ArcInfo coverage

Projects/ Datum : Polyconic & everest spheroid with the origin & center of the district.

Software DBMS : PC ArcInfo Database file

GUI : -NA-

Details of themes & source maps

S. No	**Layer**	**Source data & Methodology**
1	Transport Network	SOI Toposheets & updated using recent IRS ID satellite merged data of Pan & LissIII (FCC with 5 meter spatial resolution).
2	Drainage Network	
3	Geology Mapping	Derived from the satellite data (4,3& 2 band combination) with ground verification.
4	Geo-Morphology	
5	Well / Bore well points	Using GPS.

Project.3 IMSD Project (Integrated Mission Sustainable Development Project)

Objective of the Project : Part of the national-level project to develop database for entire India.

Location of the Study : Part of Madhya Pradesh state (They are under taking the project toposheet-wise as per the instructions from NRSA on behalf of the Department of Space.

GIS Software : WS ArcInfo 7.2.1 for Unix

GIS data format : WS ArcInfo coverage

Projects/ Datum : Polyconic & everest spheroid with the origin & center of the district.

Software DBMS : PC ArcInfo Database file

GUI : -NA-

Details of Themes & source maps

S. No	**Layer**	**Source data & Methodology**
1	*Transport Network*	*SOI Toposheets & updated using recent IRS IC satellite* merged data of Pan & LissIII (FCC with 5 meter spatial resolution)
2	Drainage Network	
3	Watershed Mapping up to Micro-watershed	Derived from drainage network & slope map
4	Land use/ Land cover	Derived from satellite data of 6 seasons.
6	Contours	SOI 1:50k Toposheet
7	Slope Maps	Derived from contour data
8	Forests National Parks & Sanctuaries	Boundaries extracted from SOI 1:50k toposheet and classification based on IRS IC satellite data
9	Geo-Morphology Mines & Geology	Geological Survey of India (GSI) Maps for reference & derived using satellite data

Details of Attribute data

Source & Details	Publisher/ Satellite etc.	Year of Study
Census data	Directorate of Census Operations	1991

MP Forest Department

Department/ Organization : M P Forest Department

NGO/State /Union Govt. : State Government

Functions of the Organization: Forest Protection & forest development in the State.

Contact Person : Mr. Praneesh Tiwari- CF (planning)/ Mr. Khan –ACF (Planning)

Project.4 Forest Database Creation for Raisen & Vidhisha Disticts

Objective of the Project : Forest stock estimation and forest density mapping

Location of the Study : Raisen and Vidhisha districts.

GIS Software : Carries, EasiPace

GIS data format : Carries

Projects/ Datum : No

Software DBMS : Carries

GUI : -NA-

Details of themes & source maps

S. No	**Layer**	**Source data & Methodology**
1	Forest Density Information	Classification of LissIII data using Easi/Pace Software with some ground verification.
2	Forest Type Information	
3.	Forest Blocks and Administrative Boundaries	Digitized from the forest maps and toposheets.

Comments

The project for Raisen district was carried out by NRSA and for the Vidhisha district by IIFM. But Madhya Pradesh Forest Department is dissatisfied with the results. They found many errors in both the projects during accuracy assessment.

Project.5 Forest Management Information System

Objective of the Project : Forest database creation and development of forest management information system.

Location of the Study : Raipur district (Now this district is in Chattisgarh State)

GIS Software : Carries, EasiPace

GIS data format : Carries

Projects/ Datum : No

Software DBMS : Oracle

GUI : Visual Basic

Details of themes & source maps

S. No	**Layer**	**Source data & Methodology**
1	Forest Density Information	Classification of LissIII data using Easi/Pace Software with some ground verification.
2	Forest Type Information	
3.	Forest Blocks and Administrative Boundaries	Digitized from the forest maps and toposheets.

Details of Attribute data

Source & Details	Publisher/ Satellite etc.	Year of Study
Forester's Field Measurement Books		Updated
Forest Density and Forest type statistics	Derived from the interpretation of satellite data	-NA-

Comments

This project was started in 1993 by Seimens India and still continuous. MPFD did consider implementing the same for the entire state. Since Raipur has been shifted to Chattisgarh district, MPFD wants to start the work again for Madhya Pradesh State and is looking for World Bank loan.

3.3 Regional Research Laboratories

Department/ Organization : UNDP cell, RRL

NGO/State /Union Govt. : Government of India

Functions of the Organization: Reserch Organisation

Contact Person : Dr. MVRL Murthy.

UNDP- DST-GOI TDC-TRC Network Project

Objective of the Project: To raise employment, reduce poverty and improve the quality of life in the Rural Areas. The program aims at developing support strategies, structures, mechanisms and skills for sourcing, delivering and maintaining technologies for rural transformation and economic development.

Area of the Study : Damoh

GIS Software :

GIS data format :

Projects/ Datum :

Software DBMS :

GUI :

} Considering GRAM++ software but not yet finalized.

Details of themes & source maps

S. No	Layer	Source data & methodology
1	Detailed Village Mapping	Ground Survey using Total Station and Patwari map
2.	Block level mapping for Village Boundaries Major Roads Telecommunication Banking Market Facility Cold Storage/ Godown Industrial Training Centres	Block/ Tehsil map and ground survey

Attribute Data

House-hold information from survey.

Comments

This project was started in 1999. Both the household survey and the geographical survey are in progress. They are finalizing the software and data formats for the GIS component and the GIS work will be started after collecting all the databases.