

PD-AAP-200



REVIEW OF PRELIMINARY TABULATIONS  
FROM THE COMMUNICATION  
NEEDS ASSESSMENT FOR THE  
INTEGRATED RURAL HEALTH PROJECT  
IN INDIA

AMERICAN PUBLIC HEALTH ASSOCIATION  
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REVIEW OF PRELIMINARY TABULATIONS  
FROM THE COMMUNICATION  
NEEDS ASSESSMENT FOR THE  
INTEGRATED RURAL HEALTH PROJECT  
IN INDIA

Report Prepared By:  
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## ACKNOWLEDGEMENTS

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## EXECUTIVE SUMMARY

The consultant was in India from 28 November to 7 December 1983 to carry out the following workscope:

- "Review the hand tabulations of the Communication Needs Assessment (CNA) Community Surveys from the five Integrated Rural Health Project (IRHP) states.
- Do a preliminary analysis of the results so that health education messages can be developed.
- Develop tables for more detailed computer analysis of community survey data; work closely with the group which has been chosen by the Government of India (GOI) to do the computer analysis.
- Discuss with USAID and GOI an outline for CNA Report writing after the analysis is completed.
- Assist USAID and GOI in planning a national family planning/health communications strategy workshop scheduled for early 1984."

The consultant was in India under contract to Logical Technical Services starting on October 31, 1983 and continuing up to the beginning of this assignment. Hence, work related to the APHA workscope actually began before the dates covered by this assignment.

None of the five items in the assigned workscope could be fully completed during this assignment because: hand tabulations had been completed in only one state and those were not yet in final form; the GOI had not yet chosen the group to undertake the computer analysis; and the hand tabulations were needed to develop tables for the more detailed computer analysis. In spite of these difficulties, useful progress was made on each of these items as described in this report.

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## ABBREVIATIONS

AID	Agency for International Development
APHA	American Public Health Association
CHV	Community Health Volunteer (health guide)
CMW	Currently Married Women
CNA	Communication Needs Assessment
GOI	Government of India
HA (f)	Health Assistant (female)
HA (m)	Health Assistant (male)
HW (f)	Health Worker (female)
HW (m)	Health Worker (male)
IEC	Information, Education, and Communication (for health and family welfare)
IRHP	Integrated Rural Health and Population Project
KAPCARSI	Knowledge, Attitudes, Practices, Channels, Accessibility, Rumors, Socio-demographic Background, and Identifying Key Problems*
PHC	Primary Health Center
SC, ST	Scheduled Caste or Scheduled Tribe
USAID	United States Agency for International Development

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\*This abbreviation is explained more fully in: James A. Palmore, "Monitoring of IEC for Health and Family Welfare Programmes." Centre Calling, Vol. XVIII, Nos. 1 & 2, Jan.-Feb., 1983, pp. 10-14.

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## INTRODUCTION AND BACKGROUND

### Purpose of the Assignment

The purpose of this assignment, as stated in the workscope, was to:

- "Review the hand tabulations of the Communication Needs Assessment (CNA) Community Surveys from the five IRHP states.
- Do a preliminary analysis of the results so that health education messages can be developed.
- Develop tables for more detailed computer analysis of community survey data; work closely with the group selected by GOI to do the computer analysis.
- Discuss with USAID and GOI an outline for CNA Report writing after the analysis is completed.
- Assist USAID and GOI in planning a national family planning/health communications strategy workshop scheduled for early 1984."

The present assignment continues work on a project previously described in earlier APHA reports, (Assignment #582178 and 582197, December, 1982, and May 1983.) Other project related work carried out was supported by the Regional Training Services Agency/Asia (School of Public Health, University of Hawaii); Logical Technical Services (Washington, D.C.); and the East-West Population Institute (East-West Center, Honolulu, Hawaii).

### Itinerary

Most of the work on the present assignment was performed in Delhi, although one day was spent in Ahmedabad reviewing hand tabulations for one district of Gujarat. Chandigarh was also visited one week earlier to review progress on Haryana and Punjab under the contract with Logical Technical Services as mentioned previously.

### Methodology

The methodology for the Communication Needs Assessment has been described in the two previous APHA reports. Since then, the following developments have occurred;

- (a) The questionnaires have been translated into appropriate Indian languages (Hindi, Gujarati, etc.)

- (b) One state (Gujarat) had completed field work and the initial hand tabulations by the time I left India. Since then (see Appendix E), a second state has completed the work. At the time I left India, Punjab, Haryana, and Maharashtra anticipated completing the work in January of 1984. Himmachal Pradesh did not anticipate completion until March of 1984. Apparently (see Appendix E), there have been additional delays in two states.

## OBSERVATIONS, FINDINGS, AND RECOMMENDATIONS

None of the principal objectives stated in the workscope were fully accomplished during this assignment, for the following reasons:

- (a) Hand tabulations had only been completed in one state (Gujarat) and even those were not in final form. Thus the consultant was only able to review tabulations for one district. Partial results for Punjab were also reviewed under the earlier contract with Logical Technical Services, but these were unchecked and in poor form for a careful review.
- (b) The group to undertake the computer analysis had not yet been chosen by GOI.

Review of the hand tabulations of the CNA surveys was completed for one district in Gujarat and partially in Punjab, but not for other areas. The results could not be analyzed because the tabulations were not completed. Since the development of tables for the more detailed computer analysis is facilitated by the results of the hand tabulations, it also was only partly accomplished. Developing an outline for the report is contingent on having preliminary results and little was accomplished on this item. Preliminary work on planning a national workshop was carried out.

In spite of the difficulties enumerated above, useful progress was made. For example, review of the early results for Gujarat suggested the utility of a memorandum on how to use the hand tabulations (Appendix A). In Gujarat, the consultant went through the process described in Appendix A with selected staff of the Ahmedabad Regional Health and Family Welfare Training Centre and it was found to be instructive.

Some preliminary suggestions related to the national workshop were also summarized in a memorandum (Appendix B) and subsequently discussed with appropriate persons at the Ministry and USAID/India. One result of these discussions was the suggestion that the workshop be divided into two sections, the first a more formalized presentation of results and the second a workshop on implementation. Two weeks would be planned, with the first week devoted to the formal sessions and the second to the implementation of new strategies.

A memorandum was also begun on the computer analyses, and this is attached as Appendix C, along with additional information contained in the letter attached as Appendix D.

Additional information related to this assignment is contained in the report prepared by the Mid-Project Evaluation Team, for the IRHP. This report has been given, in draft form, to relevant staff members at USAID/India and to Logical Technical Services. The final form of the report should be available soon.

APPENDICES

DRAFT FOR DISCUSSION

December 2, 1983

MEMORANDUM

FROM: James A. Palmore

SUBJECT: Using the Hand Tabulations from the CNA in Preparation for  
the Workshop on Communication Strategies

---

As you may remember, we agreed to prepare hand tabulations for each  
PHC in eighteen groups as follows:

Currently Married Women Questionnaire

1. SC,ST with more than 3 children
2. SC,ST with 3 children or less
3. Non SC,ST with more than 3 children
4. Non SC,ST with 3 children or less

Married Men, Community Leaders, and Development  
Functionaries Questionnaire

5. Married Men, SC or ST with more than 3 children
6. Married Men, SC or ST with 3 children or less
7. Married Men, non SC,ST with more than 3 children
8. Married Men, non SC,ST with 3 children or less
9. Community Leaders
10. Development Functionaries

Health Service Providers Questionnaire

11. Male health assistants
12. Female health assistants
13. Male health workers
14. Female health workers
15. CHVs (Health Guides)
16. Trained dais
17. Untrained dais
18. Private practioners

The tabulations for each of the eighteen groups were also to be added  
together for eighteen district-level hand tabulations.

The first thing I would suggest doing with these hand tabulations  
is the calculation of useful percentages. These can be written on the

hand tabulations themselves, preferably using a different color ink  
(e.g., red). Examples of useful percentages are as follows:

Health Service Providers Questionnaire

- a. Percent who think it good to have a family  
with three or more children (item C-3)

$$\left( \frac{\# \text{ of yes answers}}{\# \text{ of yes answers} + \# \text{ of no answers}} \right) \times 100$$

- Note that the # of yes answers and the # of  
no answers should add up to the total number  
of cases. If they do not, the hand counts  
were not correct.

- b. Percent who think it is not all right to feed  
a child with measles (item G-3)
- c. Percent who think it is not all right to feed  
a child with diarrhoea (item G-5)
- d. Percent who answer that the first breast feed  
should be given to a child more than 24 hours  
after the child's birth (item G-32)

Currently Married Women Questionnaire

- a. Percent who have not heard of any method of  
preventing pregnancy (item D-1)
- b. Percent who think the reason for Marasmus  
or Kwavshiorkor is that "somebody cast an  
evil eye" (item G-18)

Note that the "useful" percentages are stated above in terms of  
identifying problems. The higher each percentage, the more of a problem  
we have. If, for example, a high percentage of health service providers  
think it is not all right to feed a child with diarrhoea, there is a  
problem that needs to be addressed.

1

The second thing I would suggest doing is carefully examining the percentages you have calculated. The criteria for looking at them would be:

- i. Which problems are particularly prevalent?
- ii. Are they concentrated in any particular groups of the eighteen for which we have separate tabulations? For example, is the problem less common among health service providers than the four currently married women groups?

It may be helpful to write answers down in a simple table like the one following:

<u>Group</u>	<u>Percentage who think that feeding a child with diarrhoea is not all right</u>
CMW, SC/ST, gt. 3 *	_____ %
CMW, SC/ST, 3 or less	_____ %
CMW, non SC/ST, gt. 3	_____ %
CMW, non SC/ST, 3 or less	_____ %
MM, SC/ST, gt. 3	_____ %

etc.

These tables allow the comparison of groups and also the comparison across some of the characteristics on which we subdivided. The latter type of comparison is made by looking at the numbers, for example, of the men as compared to those of the women in the same parity and caste groupings. Are the men higher or lower than the women even when they have the same caste group and roughly the same number of children? You can also compare,

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\* CMW is an abbreviation for currently married women. Gt. is an abbreviation for greater than and gt. 3 means greater than 3 children.

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among the women, those who have more than three children with those that have three or fewer, controlling for the caste group. (This comparison across groups is, however, made easier by using the types of table illustrated on page 6 of this memorandum.)

The third thing I suggest is to compare the results across PHCs in the same district. Take, for example, the hand tabulations for community leaders for each of the PHCs in a district. Prepare a table like this one:

<u>PHC</u>	<u>(only for Community Leaders) Percentage who think that feeding a child with diarrhoea is not all right</u>
"Name of PHC No. 1"	_____ %
"Name of PHC No. 2"	_____ %
"Name of PHC No. 3"	_____ %

etc.

Are there important differences between the PHCs?

After completing the first three steps explained above is a good time to begin thinking about two important questions:

- I. ARE THERE WAYS WE CAN CHANGE OUR COMMUNICATION STRATEGIES TO ADDRESS THIS PROBLEM?
  - (a) Through mass media or through interpersonal communication or both?
  - (b) What messages are needed to counteract the problem?
  - (c) Etc.

II. ARE THERE CHANGES IN COMMUNICATIONS TRAINING  
THAT MAY ALLEVIATE THE PROBLEM?

- (a) Who needs to be trained?
- (b) What would be the content of  
that training?
- (c) Etc.

These questions should, of course, be kept in mind still as we proceed to the next steps of examining the hand tabulations.

So far, we have arranged the percentages as if they were "univariate" or one way tabulations. With the hand tabulations we have, we can also arrange the data somewhat differently (to more clearly bring out the differences of interest), presenting the results in the form of cross-tabulations.

A simple illustration of a cross-tabulation is the following table, using only four groups from our eighteen--the four currently married women groups.

<u>Caste Group</u>	<u>Number of Children</u>	
	<u>3 or less</u>	<u>More than 3</u>
SC,ST	_____ %	_____ %
Non SC,ST	_____ %	_____ %

In the four cells of the table, we would enter the same percentages as we had in our second step, but the differences by number of children and/or by caste group stand out more clearly in the table above than they did in tables prepared in the second step of the analysis.

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Another illustration of this type of table is the following one,  
which introduces another classification into the table:

Caste Group	Number of Children and Sex of Respondent			
	3 or less		More than 3	
	MM	CMW	MM	CMW
SC, St	_____ %	_____ %	_____ %	_____ %
Non SC, ST	_____ %	_____ %	_____ %	_____ %

Now, you can compare married men with currently married women, married men by number of children and CMW by number of children, the two caste groups controlled for sex of respondent and for number of children, etc.

Another type of table that may help in interpreting our results is illustrated below:

Problem	Type of Respondent						
	HA(m)	HA(f)	HW(m)	HW(f)	CHV	CMW	etc.
% who think it is good to have a family with 3 or more children	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %
% who think it is not all right to feed a child with measles	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %
% who think it is not all right to feed a child with diarrhoea	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %
etc.							

To the suggestions above, you may, of course, add your own innovations, but I think the basic methods above will bring out many interesting findings that will assist our early identification of communication needs in the project areas.

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APPENDIX B

DRAFT FOR DISCUSSION

December 2, 1983

MEMORANDUM

FROM: James A. Palmore

SUBJECT: Some Preliminary Notes on the Proposed Workshop on Communication Strategies for Health and Family Welfare, Based on Hand Tabulation Results from the CNA

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Even though the hand tabulations from the CNA are not yet available for most project areas, the results for two districts (one in Gujarat and one in Punjab) combined with impressions gained from conversations suggest some preliminary recommendations for and comments about the proposed Workshop on Communication Strategies for Health and Family Welfare.

1. I suggest the workshop be held in early February 1984 even if all of the hand tabulations are not available. Sufficient information should be ready to hold a meaningful workshop.
2. Some suggestions for the agenda seem in order.
  - (a) Early CNA results suggest that the mass media, including the non-electronic, have not reached large segments of the population despite the many years they have been used and what I imagine are large expenditures of time and money. This suggests two possibilities: either spend more money on the mass media to attempt to reach everyone or reprogram the money into other forms of communication. The relative mix in funding as well as context of mass media vs. interpersonal communication should be an underlying theme of each session in the workshop.
  - (b) A second underlying theme should be the relative mix of changes in the training of communicators vs. changes in the communications themselves. Particularly if the recommended strategies include a relative concentration on interpersonal communication, new training may be a better outlay of effort than new communications themselves.

- (c) The Workshop might well be organized around the twelve key health problems as the main topic areas with the two underlying themes explained in (a) and (b) above as subtopics for each key problem.
  - (d) An illustrative agenda is attached as Appendix B.1.
3. From each state, the minimum participants should be:
- (a) project director
  - (b) project's head IEC person
  - (c) project's head research, monitoring, and evaluation person
  - (d) HFWTC staff involved in the CNA
  - (e) anyone heavily involved in the CNA not mentioned above
4. Center and AID persons should include, in addition to the obvious persons:
- (a) persons, from India or elsewhere, skilled in message design
  - (b) persons, from India or elsewhere, skilled in choosing appropriate media and interpersonal communications mixes

To date, no personnel involved in the CNA have the two above mentioned skills in sufficient quantity.

5. It would be useful to commission one or more background documents on the topics listed in (a) and (b) of point 4 above. Many of the key personnel in the CNA and the project are not fully informed about the basic principles involved in message design and communications channel mixes. Other background documents to be provided should include a summary of the CNA process and copies of the questionnaires and hand tabulation forms.

APPENDIX B.1

DRAFT FOR DISCUSSION

A POSSIBLE AGENDA FOR A WORKSHOP ON COMMUNICATION STRATEGIES FOR HEALTH AND FAMILY WELFARE

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- A. Official opening and welcoming remarks
- B. Organization of the workshop
- C. Desired outcomes for the workshop
  - (1) New messages for the IEC effort
  - (2) New mix of media and interpersonal communication
  - (3) New mix of training communicators vs. designing new communications themselves
  - (4) Others

D.  
E.  
F.  
G.  
H.  
I.  
J.  
K.  
L.  
M.  
N.  
O.  
P.

There should be one session for each of the 12 key health problems. The agenda for each session might include the following subtopics:

- (a) What main communication needs have been identified from the CNA?
- (b) For each main need:
  - (i) What new training is suggested?
  - (ii) What communication messages?
  - (iii) Through which media or interpersonal channel?

- Q. Discussion of priorities given the results of sessions D - P
  - R. Plan of action
  - S. Closing session
-

DRAFT FOR DISCUSSION

December 6, 1983 and February 23, 1984

MEMORANDUM

FROM: James A. Palmore

SUBJECT: Suggestions for the Computer Analysis of the CNA

---

It is difficult in advance to fully specify the tabulation plans for the computer analysis of the CNA because the results themselves will suggest which are the most interesting additional tabulations to be undertaken. Nevertheless, this memorandum suggests what tabulations should be undertaken at a minimum.

The first principle for the tabulations is that they should be carried out for each PHC. Further, the highest level of aggregation that should be used is usually the district level. This principle follows both from the sample design and also from an underlying rationale for the CNA. The sample design dictates little aggregation because it is self-weighting only at the PHC level. For a district, weights must be used to take account of the fact that each PHC has a different population size.\* For a state or the area project as a whole, the sample is not representative because non-project districts were not included and the project districts are not sampled from all districts. Hence, it is usually misleading to combine the data for aggregates larger than a district.

The underlying rationale which also dictates PHC and, at most, district-level tabulations is that local planning and monitoring is the aim. Communication needs are likely to vary from one PHC to another and one district to another and communication strategies should vary accordingly.

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\* A later memorandum will specify how the weights should be calculated.

The second principle for the tabulations is that they should be completed quickly, even if the speed with which they are carried out leads to less elegant analysis than might otherwise be desirable. The tabulation plans suggested are, consequently, simple.

The third principle for the tabulations is the identification of needs for each of the twelve key health problems. Indices of needs in each of the twelve areas are to be found and tabulated by characteristics of the population to locate who has what needs and what messages should be addressed to what subpopulations in each PHC or district.

The fourth principle is to make separate tabulations for each type of respondent: currently married women, married men, community leaders, development functionaries, and health service providers. For some tabulations, it is helpful to subdivide these groups more finely. For example, the health service providers may be subdivided: male health assistants, female health assistants, male health workers, female health workers, private practitioners, health guides, trained dais, and untrained dais.

#### PHC-LEVEL TABULATIONS

The first set of tabulations are at the PHC level. These are more limited than those for the district level because there are relatively few respondents for each PHC: on the average, 200 currently married women, 100 married men, 100 community leaders and development functionaries, and 70 health service providers. What is recommended for the PHC-level tabulations is two series of tables, the largest number simply being frequency counts and percentage distributions for each question in the appropriate questionnaire.

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Series A: Village Profiles for the PHC

The village profiles collected for each village that was in the CNA sample should be labeled Series A.1, A.2, etc., and reproduced as the first series of tables. A maximum of ten tables results. No aggregation should be carried out; the data for the individual villages will give some idea of the variation between villages in the PHC.

Series B. Characteristics of Individuals in the PHC by Type of Respondent

Series B should consist of frequency counts and percentage distributions for each question in the questionnaires. The questionnaire for currently married women should serve as the model for all groups, meaning that some tables will show no information for other groups on a particular item.

Because there are relatively few cases within respondent type, it is probably most sensible not to subdivide further within respondent type for the PHC-level analysis, except among the currently married women. For these respondents, a two group split seems reasonable: currently married women ages 15-29 and currently married women ages 30-44. Hence, each table would have entries for six respondent types:

- (1) currently married women ages 15-29;
- (2) currently married women ages 30-44;
- (3) married men;
- (4) community leaders;
- (5) development functionaries; and
- (6) health service providers.

A total column for all currently married women should also be given.

In some cases, the questions asked of currently married women differ from those in the other questionnaires. In such instances, the information should not be placed in the same table. Instead, separate tables should

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be prepared for the different questions. An example is the following:

- C-10. "Do you think it is good to have a large family?" --Currently married women questionnaire
- G-3. "Do you think it good to have a family with three or more children?" --Health service providers questionnaire and the questionnaire for married men, community leaders, and development functionaries

While the two questions ask about the same subject, they are different questions and should be tabulated in separate tables.\*

#### DISTRICT-LEVEL TABULATIONS

The second set of tabulations are at the District level. These are much more extensive, partly because there are more cases to deal with but also because finer subdivisions of the respondents are desirable. At the PHC level, for example, all health service providers were grouped together. This is a poor grouping because it includes untrained dais under the same rubric as private physicians, male workers under the same rubric as female workers, and generally confuses groups who are distinguished by different amounts of training and access to the medical systems. At the district level, such groupings are no longer necessary.

The first task at the district level is to prepare summaries of the PHC-level tabulations for the whole district. Hence, there are also Series A and Series B tabulations for each district.

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\*

This example is the result of an error. G-3 is the question that was intended for all respondents, but the master copy of the women's questionnaire was inadvertently left unchanged.

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Series A: Village Profiles for the District

A district may have as many as 240 villages covered in the CNA sample. Consequently, district-level Series A tabulations should not simply reproduce the village profile data but should instead summarize them. Item 1 can be summarized by the mean population and the range. Items 2 through 16 can be summarized by counts and percentage distributions of yes or no answers. Item 17 needs both the counts (with percentages) and the means and ranges of the distances. Items 18, 19, and 20 can be handled like item 17. Item 21 can be handled like items 2 through 16. Item 22 should be summarized like items 17-20. Item 23 can be summarized with a mean and range.

Series B: Characteristics of Individuals in the District by Type  
of Respondent

Series B for districts should be prepared in exactly the same way as for PHCs. These tables will provide the district totals for the PHC-level Series B.

Series C: More Detailed Tabulations

Series C for the districts should follow a model much like that described in the 17 February 1984 letter to Mr. John Rogosch and illustrated in the Report on the West Malaysian Family Survey 1966-67 on pages 212-408.

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APPENDIX D

17 February 1984

Mr. John Rogosch  
Health/Nutrition  
USAID  
Embassy of the United States  
of America  
West Building, Chanakypuri  
New Delhi 110021  
INDIA

Dear John:

Under separate cover I have mailed to you five copies of the book Report on the West Malaysian Family Survey 1966-67. The style of tabulations in that report are, I believe, a starting model for what should be attempted for the CNA as the initial set of computer runs. What is needed, as you will notice, is to:

- (1) decide what are the critical indicators to use as dependent variables; and
- (2) choose appropriate other indicators from the KAPCARSI list (many from the S) as cross-tabulation variables.

A principal task during my next visit will be accomplishing items (1) and (2).

Michael and I have met several times since his return and both of us have met with June Mehra to brief her. There have also been many discussions of Naik's visiting dates. The timing is not critical for the East-West Center, as long as the visit is completed in the current budget year (i.e., before September 30, 1984). What is probably more important is timing the visit to get the maximum benefit from Mehra's work.

Hope all is well with the Delhi crew. Regards to all of you.

Cordially,

James A. Palmore, Jr.  
Research Associate

JAP/km

APPENDIX E

1320 EST\*  
TEWCH 7430331ZC SAH050 LAN207 QTGC10 4-005077N046  
HRXQ CC UTNX 164  
STATE DEPT WASHINGTON DC 164/158 15 1043A EST VIA TRT

EAST WEST POPULATION INSTITUTE  
DR. JAMES PALMORE  
1777 EAST WEST ROAD  
HONOLULU

- TEL: 808-948-7234

1. SORRY FOR DELAY IN RESPONSE. CNA DATA COLLECTION IS COMPLETED IN ONLY TWO STATES, AND QUALITY OF TABULATIONS APPEARS VARIABLE. WE'RE ALSO TRYING TO FINALIZE A COMPUTER GROUP. WE WOULD LIKE YOU TO COME FOR TWO (2) WEEKS BEGINNING O/A MARCH 15 TO WORK WITH COMPUTER FIRM IN DEVELOPING DETAILED ANALYSIS PLAN. AS YOU SUGGESTED, WE WOULD LIKE YOUR CONSULTANCY TO BE COVERED UNDER THE EAST-WEST CENTER'S CENTRAL AID GRANT, AND I WILL CABLE AID/W REQUESTING YOUR SERVICES WHEN YOU CONFIRM YOUR AVAILABILITY.

2. WITH REGARD TO NAIK, WE'VE RECEIVED A CABLE FROM EW CENTER REQUESTING CERTAIN BIODATA AND ALSO INDICATING APRIL 1 TO JUNE 30 AS THE PROPOSED DATES FOR HIS FELLOWSHIP. HOWEVER, NIHFW WON'T RELEASE NAIK UNTIL AFTER APRIL AND I'VE INFORMED EWC OF THIS. CAN THE TIME BE ADJUSTED.? JOHN ROGOSCH HN/USAID/NEW DELHI.  
AMEMBASSY NEW DELHI INDIA 03534 L1333

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