CHAPTER II

PROPOSAL

"There is nothing more difficult to carry out , nor more doubtful of success, nor more dangerous to handle than to initiate a new order of things"

Michiavelli in "The Prince"

2.1 INTRODUCTION

In Pakistan, community social structure and belief systems are defined and dominated by men, which perpetuate gender imbalances and contribute to poor outcomes in family planning and reproductive health. Family planning program has assumed increasingly important role over past four decades but men's participation and circumstances have received scant attention. Traditionally contraceptive practice has relied heavily on female sterility, IUD and oral agents taken by women. The family planning program has been organized to be almost entirely staffed at grass roots level by women.

However, as loci of behavior change in light of fertility control, women may have the most limited options. Indeed. it is probable that women are unlikely to use family planning without the permission of their husbands, because even the Islamic scholars, who permit the use of modern birth control methods, stress that it should be used only with the mutual consent of husband and wife. (Harrison, 1989:291). Thus the prescriptions that promote behavior change must take into account women's constraints.

Thus, there is a big organizational problem of lack of male involvement in the program. In fact, we have ignored the fact that 'two are required to make a baby. Among the reasons for lack of male focus are two facts; first, the woman is the bearer of children and thus regarded as a more 'natural' focus ; and second, more female than male methods are available.

Moreover, Family planning providers have the preconceived notion that men will not be interested in family planning (Danforth N,1993:1). The research shows that rural Punjabi men are neither unconcerned about their families' well-being nor irresponsible. These men have simply not been taught adequately, or at all, about the full range of available contraceptive methods (Agha S, 1992).

Furthermore, it is often assumed that a woman would be more amenable to family planning messages and would be accessible to family planning providers because of her contact with health services dealing with reproductive health. Men have therefore left the responsibility for family planning to their wives and partners. There is no a priori reason for assuming that women are more motivated for family planning than men (Harrison, 1989:291).

Successful implementation of family planning program requires both male participation and cooperation, taking a holistic picture of women's constraints like restricted mobility, low working status, low family decision making power and men's sociocultural and economic dominance in decision making. Gender is an important pointer to vulnerability. An Amnesty International Report dated 10 June, 1997 states

that torture was common in prisons, women were discriminated against and court imposed punishments were often cruel and in-human. Torture including rape is wide spread in Pakistan (Bangkok Post, 11 June, 1997:6).

Due to high illiteracy rate and pressure from husbands, most women do not have access to family planning services (Anonymous, 1990:63). The norm in Pakistan is for women to stay home and take care of house and children. It is not common for women to join labor market and their mobility is often restricted to such an extent that only 25 percent women in Pakistan Demographic Health Survey (PDHS), 1990-91 stated that they could go alone to visit a hospital for their illness and majority of them, even, could not go without Purdah (veil).

The working status of the women, too, is low in Pakistan. According to PDHS 1990-91, only 16. 8 percent of women are currently working in Pakistan. Moreover, opportunity for employment is limited for the females. Thus, women's lack of economic control limits their purchasing power. A working wife has more status with her husband, and the resultant improved spousal communication leads to more contraceptive use (Chaudhry RH, 1983:101). The low working status of women encourages early marriages and restricts the chances of spousal communication about family planning.

Further, social structures in Pakistan pressures women into early marriages. Woman has no role in making decision about her marriage and it is her brother or father who decides when and with whom she will marry. The median age of marriage in

Pakistan is 18.6 years. A social concern is expressed if the wife does not become pregnant during the first year of marriage. Women are a reproductive asset, for the extended family encourages numerous progeny as a way to further extend the family, secure more labor which can be exploited, and assure old age insurance (Inayatullah A, 1964).

In terms of decision making regarding use of contraceptives, women in PDHS (1991) and Pakistan Contraceptive Prevalence Survey (PCPS) 1995, reported that men were more often responsible for the decision to use contraception than the women themselves, although women were far more likely to actually obtain information and use contraceptives. In Pakistan, in PDHS, 1990-91, 65.7 percent of men reported having knowledge of female sterilization against only 9.3 percent with unprompted knowledge of male sterilization.

There is a wide disparity between woman's knowledge and use of contraceptives in Pakistan. In PCPS, 1994-95, 91 percent of currently married women reported knowing at least one method, only 28 percent of them have ever used and only 18 percent of them are currently doing so. Further 26% women reported that they had discussed contraception with their spouse at least once during the year. Only 5% of the couples discussed family planning more than twice , 21% discussed once or twice, while 74% have never discussed.

Thus the contraceptive use remains low (17.8%) even knowledge is very high (91%) and family sizes remain high due to sociocultural, political, economic and gender

factors, relating mainly to lack of female control over decision on fertility. Therefore, Pakistan has the highest unmet need (Loffredo, 1994:), which has not been converted into effective contraceptive usage, partly because of family dynamics of male dominated society. Women, who bear most of the costs of childbearing, may want fewer children, while men, who receive most of the benefits, may want more (Robinson WC; Shah MA; Shah NM, 1981:91).

> "In Bangladesh, among the reasons for low contraceptive acceptance rates as opposed to a high awareness level is women's reluctance to practice family planning, they are opposed in adopting a method by their husbands
> (Rahman M,1984:119-26).

Pakistan, however, is a male dominated society and males dominate in each and every sphere of life including Politics, Cabinet, Parliament, Army, Police, Airforce and all other departments like Sports. The men are more educated, 50 percent literacy rate as compared to women with 25 percent literacy rate; 93 percent of men serve as household heads as compared to 7 percent women. Thus men may play a key role in bringing about gender equality since they exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and program decisions taken at all levels of government. Failure to target men in family planning interventions, thus, has weakened the impact of the program.

Family planning initiatives and information should move from involvement of the female alone to both sexes. Women need men as partners who understands the risks they might be exposed and strategies for their prevention. Study findings in regard to education and communication suggest that education programs aimed at both partners were more effective than those aimed at only one of the partners (Khan NI; Reynolds

R; Haider SJ, 1973:641). The existence of male dominance makes it necessary to include males in programs and to educate them (Roberts BJ; Griffiths W,1969).

As part of its family planning program, the government of Pakistan initiated a ***Continuous Motivation Scheme (CMS)*** in 1973. In this system, the country was divided into "circles" of 60-1000,000 persons each. A Population Planning Officer (PPO) was in charge of each circle and supervises 6 motivator teams made up of 1 male and 1 female motivator. The 7000 motivators have had little success, partly because most of them are young, unmarried, and nonresident in their areas of service. (Goraya KA, 1979:177). Inadequate training and supervision and inadequate supplies of contraceptives resulted in an ineffective program. (Reynolds J, 1987:2). Again, the field workers, especially males, showed an appalling lack of knowledge of contraception and were vulnerable to corruption (Harrison FC, 1989:294). Thus CMS and Contraceptive Inundation were never implemented as planned ; they failed in a sense before they were put to test (Ayesha Khan 1996:37). Thus these different results through different studies suggest that the scheme itself did not fail, either it was not implemented in the sense it was proposed, or there were a number of drawbacks like recruitment of workers from outside the community, lack of proper training and motivation to workers, and finally lack of control over corruption.

The second experience was ***Mardan Project***. Mardan, Pakistan, is a city of 270,000 in the NWFP, province. The project was launched in 1988 by the Urban Community Development Council (UCDC), an NGO, involving primarily male workers and actively addressing issues relating to family planning with males from a traditional

tribal society. The UCDC project had 2 goals: sensitize and inform men about the benefits of birth spacing and family size limitation; and promote family planning practice by making information and contraceptive supplies available through household distribution, community clinics, and referral (Kamal I; Flower C, 1991:17). Male motivation played an essential role in creating awareness of and defusing organized opposition to family planning in the community (Spielman E, 1993:8). In 4 years, contraceptive prevalence among married couples rose from 9% to 21% (Finger WR, 1992:8-9). The successes of this project attest to the potential for men to be effectively mobilized to promote and provide, as well as use, family planning (Population Reference Bureau (PRB), 1993:4). Thus the similar kind of projects may be implemented in other provinces like Punjab but with further improvement in the form of prior sensitization and motivation of the workers themselves.

Therefore, as demonstrated by the abovementioned projects, successful implementation of family planning in Pakistan can be achieved by targeting men through Male Workers. More personnel trained to provide information and counseling reflecting male concerns about family planning may encourage greater utilization of the services by men (UN, 1992, Asian Population Studies). Acceptance of vasectomy could be increased through recruitment of male workers (Warriach, 1996). The Pakistani men may be reluctant to obtain contraceptives from hospitals, chemists, or clinics. But, they may feel comfortable selling and buying contraceptives to and from men. Men could be involved in family planning programs in the workplace with regard to condom distribution through male workers (Danforth &

Jezowski, 1994. The most successful programs were those whose consumers and salespersons were of the same gender (Tippling S,1993).

To encourage men to discuss family planning and desired family size with their wives and support family planning use by wives, and strengthen information about , and availability of, family planning methods that require direct male involvement; nongovernmental and government family planning programs need to expand outreach activities (Hardy Cleavland K, 1992). Male workers may play an important role as Educators, Motivators, Counselors, Providers and may strengthen the information, education, and communication (IEC) campaign, especially interpersonal communication strategies targeting men in trade union movement, colleges, homes and community training centers. Expansion of educational facilities to the rural population will stimulate changes in attitudes and increase acceptance of family planning programs (Farooqi MNI, 1984, 90).

Further, being one member of the same community, Male workers will be more able to know the client's perception. Male Family Planning workers can help identify realistic changes in the sexual behavior of men by listening to their feelings (Gordon G, 1992: 45). And repeated encounters by male workers will foster contraceptive use among male members of the community. It has already been shown in Pakistan that repeat visits bring in far more acceptors than just 1 visit and repeated personal contacts should be maintained with the target population (Eger G, 1976: 24). The density of services and frequency of contact with family planning workers, are greater in countries with successful family planning programs (Sathar ZA, 1992:78).

Analysis of studies indicate that Outreach generates incremental contraceptive use, and continues to foster contraceptive use because of high frequency of encounters, and generates a significant demand for contraception; and weakens sex preferences for offspring (Phillips JF; Hossain MB; Arends-Kuenning M, 1996:217).

Therefore, this study is an endeavor to identify behaviors which could be adversely affecting use of family planning and to study and foster change to reduce or prevent poor family planning outcome. Perceiving efficacy and situational variables influencing male compliance use of family planning methods form part of this study that addresses men.

There exist a number of broad social, economic and cultural factors that discourage men from participating in family planning or encouraging their wives to do the same. They may express their concern and worries about the loss of virility and late life insurance by small number of children, especially sons, fear of impotence after vasectomy, religious beliefs and fear of supernatural punishment, lack of sexual satisfaction with use of condoms, fear of promiscuity on the part of women using female methods and a new form of control over their bodies and hence change the power dynamics of marriage. Proper counseling is therefore needed to dispel doubts. Male workers will serve as a tool to an education program intended on male community of Tehsil Arifwala, District Pakpattan, Pakistan.

2.1.1 Tehsil Arifwala, District Pakpattan

Distrct Pakpattan lies in the southeast area of the Punjab and also Pakistan. This is one of the peripheral districts of the country, separated only by one district at its south and its east sides from India. The land is one of the most fertile areas of the country and agriculture is the major source of income. Business and private service rank next and are related to agricultural crops in one or another way. Government service is another source of income but only selected families rely on this. Thus the socio-economic characteristics including literacy rates, per capita income, etc. of the people in average are similar to other parts of the country and can represent people of other areas. Thus the results of the study could be generalized without any difficulty. Moreover, the researcher himself has been appointed at the same place, so it is more convenient and feasible for him to conduct research. The population of the District according to Bureau of Statistics, Punjab is 1,512,000 . The population of Tehsil Arifwala is 720,170 and thus the male population calculated from national average at the ratio of 107:100 (ESCAP, 1996) is 372,260. And the population calculated as target population between the age of 15 to 60 is 186,130, that is also called **reference population.**

2.2.1 GOAL

1. To control high population growth and its after effects
2. To reduce Infant and maternal mortality as a result of short birth spacing
3. To achieve 38% contraceptive prevalence rate during 5 years (1998-2003) with rate of at least 4% increase per each year.

4. 2.2.2 AIM

To meet unmet need of contraceptives

2.2.3 OBJECTIVES

(A) General Objectives:

1. To develop a Strategic Model for family planning behavior change among male members of community in Pakistan.
2. To propose an appropriate methodology to target men in Pakistan Family Planning Program.

(B) Specific Objectives

1. To recruit and use male workers as family planning motivators targeting men living in Tehsil Arifwala, District Pakpattan.
2. To devise a training program for Supervisors and Male workers using Behavior Change Strategic Model.
3. To evaluate the competence of workers by recording behavior as number of clients consulted during specific time period and by identifying the verbal and nonverbal behaviors of male workers during consultations, which either inhibit or facilitate communication with their clients.
4. To evaluate the effectiveness of Behavior Change Model through KAP of workers and target male population about family planning.

2.2.4 HYPOTHESES

1. A Family Planning Training Program according to Behavior Change Model will sensitize and motivate Male Workers.

2. Prior sensitization and motivation of Male Workers will enhance their competence and effectiveness.

3. Male Workers will bring a behavior change among men (husbands) to use contraceptives.

4. A behavior change among males will have a positive influence on their female partners to use contraceptives.

2.3 PROPOSED PLAN (figure 2.1)

A four years project (Jan, 1999- Dec 2002) has been proposed to target men in family planning through male workers. The project comprises three phases

1. Preparation and Training. This phase will last for five months from January, 1999 to May, 1999. During this phase all needed resources including manpower, materials and money will be arranged and training will be provided to workers and their supervisors.

2. Implementation. This phase will start since June, 1999 until Dec, 2003; and will include introduction of workers to the community; observations of activities of all workers; record keeping by workers and their supervisors; regular meetings among

IGURE 2.1 PERT CHART FOR ACTIVITIES DURING DIFFERENT PHASES

PHASE	ACTIVITIES	JAN, 99	FEB, 99	MAR, 99	APR, 99	MAY, 99	JUNE 99-SEP2000	OCT-DEC 2000	OCT-DEC 2001	OCT-DEC 2002	OCT-DEC 2003
REPARATION AND TRAINING	1. FORMULATION OF COORDINATION TEAM										
	2. RECRUITMENT OF SUPERVISORS										
	3. TRAINING OF SUPERVISORS										
	4. RECRUITMENT OF WORKERS										
	5. TRAINING OF WORKERS										
	6. TRANSPORT AND BUILDINGS, FINANCE ARRANGEMENTS										
UPERVISION AND IONITORING	FIELD WORK AND MEETINGS										
:VALUATION	1. INTERVIEWS WITH WORKERS										
	2. INTERVIEWS WITH MALE POPULATION										

workers and supervisors, and among supervisors and management team (co-ordination team).

3. Evaluation. Two kinds of evaluations has been proposed, i. e. , process evaluation by regular observations and record analysis; and outcome evaluation by structured interviews with the workers in order to evaluate the competence of the workers; and structured interviews with sample male population in order to evaluate the effectiveness of workers. Interviews with workers will be carried out twice, first in Oct, Nov & Dec 2000 and then in Oct, Nov & Dec, 2002. The interviews with sample male population, too, will be done twice in 2001 and then in 2003. A cost effective analysis has been proposed through comparison with National Family Planning Program, by calculating cost/acceptor for two programs.

2.4 PHASE I PREPARATION AND TRAINING

2.4.1 PREPARATION OF RESOURCES

A) MANPOWER

"In order that people may be happy in their work, these three things are needed: They must be fit for it; they must not do too much of it and they must have a sense of success in it"

John Ruskin

STEP 1. Research Team formulation.

a) Coordinating group

A group of 6 members will be constituted as under.

1. Representative to Central Coordinator, Prime Minister's program on Family Planning and Primary Health Care, Islamabad, Pakistan.

2. Representative to Provincial Coordinator, Prime Minister's program on Family Planning and Primary Health Care, Punjab, Lahore, Pakistan.

3. Representative to Divisional Coordinator, Prime Minister's program on Family Planning and Primary Health Care, Multan Division, Pakistan.

4. District Coordinator, Prime Minister's program on Family Planning and Primary Health Care, District Pakpattan Sharif, Pakistan.

5. An Education-Communication Specialist, to be deputed by the Education Ministry of the Punjab, Pakistan.

6. A Social Worker of good repute from local community, who will be a volunteer. Social worker will represent as community member to participate in program. "For community members to be able to participate meaningfully in a national family planning program, they must become fully integrated into the organization of the program (ESCAPE, 1988:3)". This group will take primary responsibility for coordinating the implementation and completion of the research.

b) Workers and Supervisors

Apart from coordinating team, Male workers will work as agents to educate and motivate male community of the area. Male supervisors will carry out supervision, monitoring and evaluation, i. e., data collection and participate formulating study conclusions and recommendations; and Principal Researcher as Methodology Coordinator. The role of Methodology Coordinator will be to provide a

methodological framework for the study, to facilitate the different steps in the process and also to participate as an active member of research team.

Step 2. Recruitment of male workers and their supervisors

Recruitment of workers and Supervisors will be purely on merit. In past, the most serious organizational failing came from political interference in the recruitment of teams. A common complaint was that National and Provincial assembly members told the officers whom to hire (Harrison, 1989:292). Applications for supervisors will be called in mid November, 1998 through announcement in national newspapers and selection will be completed until mid December, 1998. The applications for workers will be called in mid January, 1999 and selection will be completed until mid February, 1999. The criteria for consideration of application and selection of a candidate will be mentioned quite clearly in order to avoid any complications afterwards.

(a) CRITERIA FOR SELECTION OF A SUPERVISOR

Candidate must be, at least

- a graduate, (would be able to understand and then apply to his knowledge gained through training and also to monitor and supervise the activities of workers, and be able to take appropriate decisions at appropriate times)

- married person (A married person will feel comfortable while gaining knowledge about family planning and then applying it; and while collecting data at the time of evaluation)
- 25-40 years of age (Minimum age of 25 will discourage early marriages if someone wants to join the team; and efficiency of a man may suffer after 40)
- having two or less children (having less children will serve as an incentive)
- permanent resident of the same community, where wants to be recruited. (This will be convenient for the supervisors to carry on their duties within their own area and may influence personally some people to change their behavior toward family planning).

(b) CRITERIA FOR SELECTION OF A MALE WORKER

Candidate must be, at least

- a matriculate (Be able to understand the nature of his work and educated people usually are regarded with respect in their own area and people will listen to them. Further, it will minimize the chances of corruption in recruitment as Secondary School Certificate will be required to prove qualification.
- married person
- 25-45 years of age (The rationale behind is same as given in criteria for selection of supervisors; the upper age limit 45 is to overcome any difficulty to find an eligible candidate from the same community)

- having not more than three children (Having job with less children will be considered as incentive, further no one can make an objection upon them that they, themselves, are not practising family planning).
- permanent resident of the same village, where wants to be recruited. (Local people will know whole members of community personally and it would be possible for them to know and identify potential client and further they may influence at least some people personally to use contraceptives and change their behavior. It would be convenient for them to carry on their activities; and chances of corruption and absence, will be minimized)
- be willing to spare at least one room as service outlet. (It will motivate workers as they would feel a sense of authority and further they would be able to provide service for 24 hours).

Further, a storekeeper will be recruited to perform duties at the Store.

B) BUILDINGS

The worker's have to donate one room of their house for family planning activities, on part time basis. All the residents of workers will be declared as service outlets of the program and be made visible for the convenience of the target population by fixing direction/sign boards. This room would serve as substore for contraceptives and their record and might be used as counseling room when needed. A room at that Basic Health Unit, convenient to all workers will be declared as Supervisor's office.

At least eight rooms are required for store and offices for members of coordination team at Tehsil Headquarters. Building of Civil Hospital Arifwala may be used for this purpose as offices have shifted to new THQ Hospital, Arifwala.

C) TRANSPORT

Transport is an essential part of communication system and is necessary for distribution of supplies and to make consultation with clients (workers), supervision, support and distribution of supplies to workers (supervisors), mobile teams (Coordination Team and Principal Researcher). All workers must own one Bicycle to carry out their duties in their respective area, a worker on a bicycle or on foot gets closer to community and becomes better known (Lartson; Ebrahim; Lovel & Ranken,1991). All supervisors will use vehicles of Prime Minister Program of Family Plqanning & Primary Health Care to perform their duties. Coordination group mobile teams will use transport of their parent department for overall supervision. Further, when required, vehicles can borrowed from other members in Health Department or other departments.

D) FINANCIAL AND COST ASPECTS

a) CAPITAL COST:

ii) Training Expenses

Training material	(workers)	no.	24	Rs.	2,000	Rs.	48,000
	(Supervisors)	no.	1			Rs.	5,000

Refreshments	no. 1		Rs. 10,000
Total			Rs. 63,000

Salaries during training period

Workers	no. 360	Rs. 1500 per month	
	1 month	Rs. 5,40,000	Rs. 16,20,000 (3 months)
Supervisors	no. 12	Rs. 3000 per month	
	1 month	Rs. 36000	Rs. 1,80,000 (5 months)
Instruction Manual for supervisors Rs 250/one			Rs 3,750
Instruction Manual for workers	Rs 200/one		Rs 76,000
Total			Rs 18,79,750
Grand Total			**Rs 19,42,750**

b) OPERATING COST/MONTH

Salaries of Workers	Rs 1500	Rs.	5,40,000
Salaries of Supervisors	Rs 3000	Rs	36,000
Storekeeper	Rs 2000	Rs	2,000
Communication Materials	Rs 50/worker/month	Rs	12,000
Contraceptives	Rs 100/worker/month	Rs	36,000
Total		**Rs**	**6,26,000**
Grand Total		**Rs**	**26,918,000**
Total cost of the Project		**Rs**	**28,860,750**

c) FINANCING

The usual sources of financing can be categorized into public and private sources as under (Lee & Mills, 1984).

Public sources	Private sources
1. General Tax revenue	1. Private health insurance
2. Deficit financing	2. Employer financed services
3. Earmarked taxes	3. Nongovernment organizations (NGOs)
4. Social insurance	4. Community self help and fund raising
5. Local tax revenue	5. Private household expenditure
6. State run lotteries and betting	

Constraints in the funding of family planning programs tend to lead many governments to consider imposing user charges. This may be productive in situations where the contraceptive use is already high but may be counter-productive in situations where the cost of gaining family planning is already high and contraceptive use is low (Sathar ZA, 1992: 79). Thus, in Pakistan, it will be unwise to rely solely on methods of financing that are current in more affluent countries as to rely on technology practiced in those countries. Thus, financing of the project will be a combined effort relying on multiple sources. For capital cost request will be made to NGOs to provide funds. Any single NGO or more NGOs will share to provide funds in this regard. Then Government will participate alongwith NGOs to run the project regarding operating cost. For example, Government may provide salaries of some of the staff and contribute to provide contraceptives and communication material. Further, government may instruct its all employees to cooperate with the program

staff to carry on their activities. Special advice by government will be issued to Surgeon at THQ, Hospital to perform vasectomies without any cost.

2.4.2 TRAINING OF WORKERS AND SUPERVISORS

"The family welfare planning idea requires fieldworkers who are properly trained and both male and female motivators must be recruited to treat the whole family as a unit of education" (Khan, 1973). The workers and their supervisors will be trained by demonstration, discussion and role play with help of training materials in the class room and also in the field. Class room training and on-site support are effective primarily by motivating workers to visit more clients (International Center for Diarrheal Disease Research, Bangladesh, ICDDR,B, 1988).

2.4.2.1 Training of Male workers

a) Duration, Trainers, Time, Venue and Topics

The supervisors will have the primary responsibility for training to their respective workers. The whole training session of 50 days, excluding holidays will be divided into 5 sessions. First session will be about introduction of workers, their job description and family planning using Behavior Change Strategic Model; and will last for 10 days. Second session will last for ten days in order to describe contraceptive methods, their properties and their feasibility for a particular couple using "Cafeteria Approach". [8] Third session will cover Communication Skills including Counseling[8], and will last for ten days. Fourth session will last for 5 days

and workers will be trained about record keeping. Fifth session will be fieldwork under direct supervision and will last for 15 days. This is assumed that whole training session will be completed within two months including public holidays.

The timings of each and every session will be to 5pm with a lunch break at 12-1 noon and a short tea break at 3-3.30 afternoon. Supervisor's office at Basic Health Unit, may serve for all the lectures and in room demonstrations and activities. The supervisor may request for extra space to the Incharge BHU, if needed.

8am

b) Objectives[7]

1. To sensitize, to educate and to motivate workers by acknowledging the spirit of the program.

2. To make workers competent enabling them

. To identify contraceptives

. To know the properties and side effects of contraceptives (Table 2.1).

. To identify potential clients (who is in need)(Figure 2.3)

. To help the clients to choose most appropriate contraceptive method in relation to their situation and needs

. To distribute contraceptive

. To make referrals to hospitals, whenever and wherever appropriate

TABLE 2.1
CONTRACEPTIVES AND THEIR COMPARATIVE ADVANTAGES AND DISADVANTAGES

Method	Major advantages	Disadvantages	Comment
Pill	Effective, unrelated to coitus, helps protect against anemia & PID, can be provided nonclinically	some side effects small mortality risk, must take daily, not indicated for adolescents	Progestin only pill more suited for breastfeeding mothers
IUD	Long-term Effective Unrelated to coitus	No protection against ectopic pregnancy, some increase in bleeding & PID, requires more clinical backup	Can be inserted postpartum, Newer improved forms are available
Condoms	Non systemic Easily stored No side effects	Not always effective, May reduce pleasure	Each condom should be used once
Injectables	Long acting Unrelated to coitus, Can be provided nonclinically	Minimal side effects, Removal of implants require clinical backup	A thorough gynecological examination required before starting, May be costly in Pakistan
Tubectomy	Effective, Unrelated to coitus	Virtually permanent	Minilaparatomy very safe on outpatient basis
Vasectomy	Effective, Unrelated to coitus	Virtually permanent	Non scalpel technique or a small incision
Spermicide	No side effects, used only when needed	Require care, interrupts sex act	Not available in Pakistan
Rhythm	No side effects Approved by Catholic Church	Relatively ineffective because of difficulty in counting safe period	Determining time of ovulation can be difficult if thermometer not available Checking mucus in absence of clean water is not hygienic
Withdrawal	No side effects Approved by Catholic Church, and Muslim Ulmas	Relatively ineffective because of difficulty in pulling out at particular time, frustrating	one of the least effective methods related with adverse emotional reactions, encourage use of other method

PID:Pelvic Inflammatory Disease

Adapted from Preventing the tragedy of Maternal Deaths: A report on Safe Motherhood Conference, Nairobi, Kenya, 1987; Community Medicine by I*lyas et.al.,1994*

3. To make workers effective through enabling them

. To convey the message appropriately and comprehensively

. To satisfy their clients

. To convince their clients to use contraceptives

. To get feedback.

4. To make workers competent through enabling them

. To keep record of full target population (approx. 500) with their household numbers in Target Population Register.

. To maintain record of their consultations in Client Consultation Register

. To Maintain record of contraceptive distribution in Contraceptive Expense Book. . To maintain record of referrals made for vasectomy and for complications of contraceptives separately in Referral register.

5. To make workers confident in order to apply their knowledge and skills learned during previous sessions.

c) Training material

1. Training Schedule

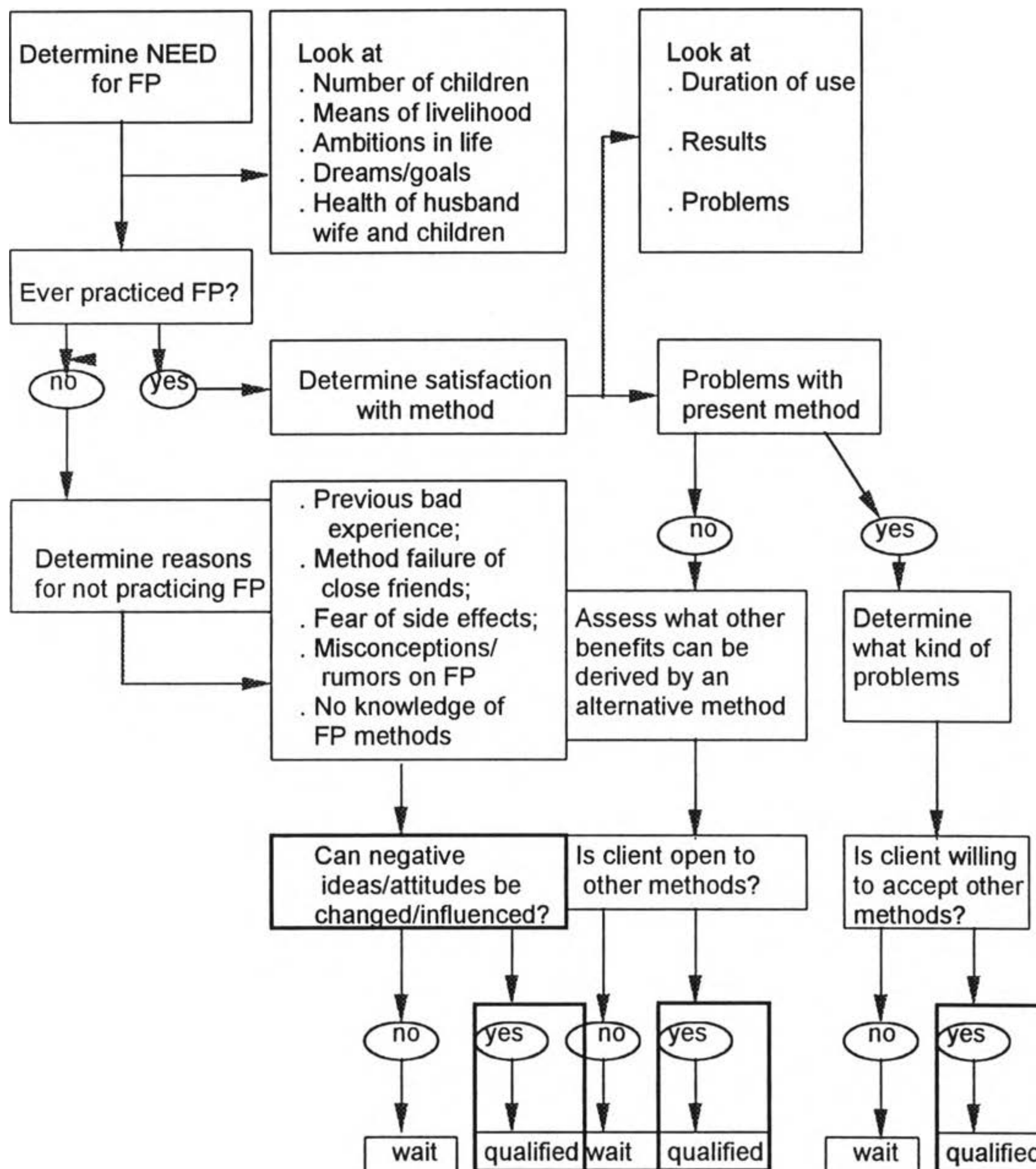
2. An instruction manual will be provided to each of the worker. Instruction manual will be comprising of following parts.

Part A. Health Behavior Change Model. (Importance of family planning)

Part B. Contraceptive methods and their qualities and side effects

FIGURE 2.2

FLOW CHART TO IDENTIFY POTENTIAL FP CLIENTS



SOURCE:

IECH BUREAU BHUTAN.

Part C. Criteria for selection of male worker and their job description.

Part D. Communication skills including counseling

3. Printed handouts like Leaflets, posters, banners, etc.
4. Overhead Projector and transparencies
5. White board/ Flannel board
6. Flip Charts
7. Slide Projector and slides
8. Videos
9. Contraceptives
10. Registers

d) Methodology

The training during this sessions will be provided through

1. Lectures
2. Demonstrations
3. Group discussions
4. Reading Instruction Manual
5. Role Play
6. Fieldwork

2.4.2.2 Training of Supervisors

a) Duration, Trainers, Time, Venue and Topics

The education-communication specialist and Principal researcher will have responsibility to train supervisors. The supervisors will be trained at Municipal Committee, Arifwala, Auditorium. The whole session will be for 25 days excluding holidays. The days will be distributed as mentioned under message. This is assumed that full session will be for one month including holidays. The daily timings will be 8am to 5pm with one hour lunch break at noon and half hour coffee break in the afternoon.

b) Objectives

To enable supervisors to work competently as

1. Planners in order to plan and allocate work of the individual worker
2. Coordinators in order to coordinate with each of individual worker and to work as a channel of communication between workers and coordination team
3. Leaders in order to solve worker's problems, to improve working methods and to ensure good working environment physically and socially
4. Policymakers closest to workers (to provide flexibility according to a worker's individual requirement to improve the effectiveness and performance)
5. Trainers in order to train, demonstrate, support, help and encourage workers to perform their work
6. Evaluators in order to monitor program and conduct field investigation.

c) Message

key tasks for training to Supervisors will be

1. Criteria for selection of workers and supervisors (Phase I)(one day)
2. Job description for workers and their supervisors (Phase III)(two days)
3. Importance of family planning and contraceptive use using Behavior Change Model (figure 2.3)(Four days)
4. Knowledge about contraceptive methods (Table 2.1)(three days)
5. Communication Skills[8] (Four days)
6. Training skills[9] (three days)
7. Record keeping (two day)
8. Monitoring and Evaluation skills (Phase III)(four days)

(Two days will be reserved for revision, dummy interviews, etc.)

d) Training Material

1. Instruction Manual for Supervisors will include Criteria for selection of supervisors and workers, job description of supervisors, Training or teaching skills, and monitoring and evaluation skills; in addition to all sections included in Worker's Instruction Manual.
2. Contraceptives
3. Printed handouts like pamphlets, leaflets,, posters; and other communication material like banners.
4. Overhead Projector with transparencies and slides
5. Registers

6. Slide Projector and slides.
7. White Board/ Flannel Board
8. Videos.

e) Methodology

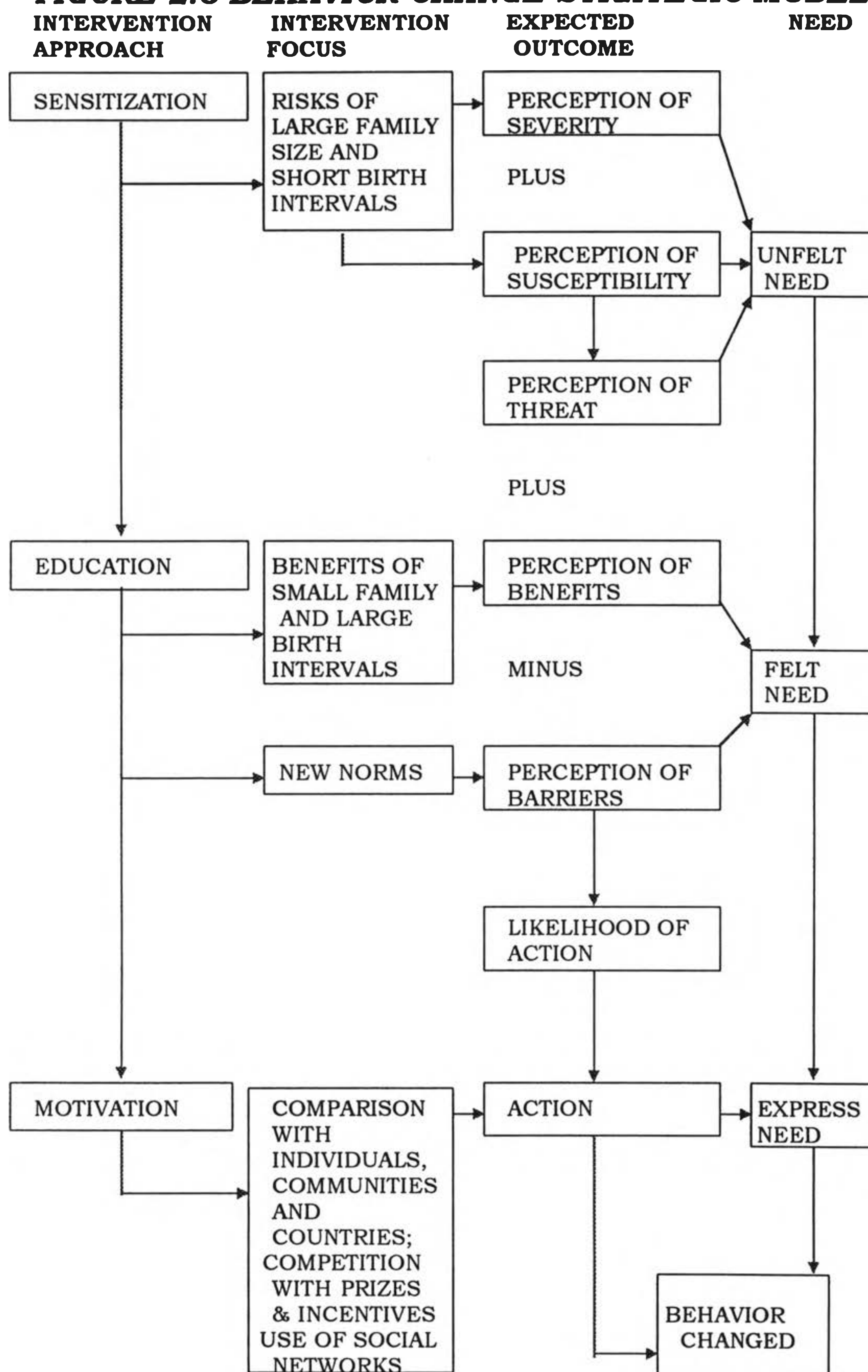
1. Lectures
2. Demonstrations
3. Group discussions
4. Role Play
5. Watching videos
6. Reading instruction manual.

2.5 BEHAVIOR CHANGE STRATEGIC MODEL (FIGURE 2.2)

NEED

This model suggests how we will process unfelt need toward expressed need by community. The studies in FCPS suggest that there are at least 38 percent of currently married women in Pakistan, who need contraceptive use either for birth spacing or limiting their family size. But, only 17. 8 percent are currently using contraceptives including 5 percent users of traditional methods. Therefore, there is at least 20 percent unmet need in Pakistan, which is one of the highest in the world. The studies further suggest that the low acceptability of contraceptives is the main reason of low contraceptive use. Table suggests that wanting of more children or

FIGURE 2.3 BEHAVIOR CHANGE STRATEGIC MODEL



PREPARED WITH CONSULTATION TO

1. HEALTH BELIEF MODEL (Health and Human Behavior by Kaplan et al, 1993).
2. NEED CONCEPT (Promoting Health by Ewels & Simnett, 1991)
3. STAGES OF EDUCATION (Community Medicine by Ilyas et al ,1981)

preference for a specific gender, especially son, is the single causative factor which accounts for 43 percent of non use of contraceptives. The second highest reason is the religion (about 11 percent) and third, the lack of knowledge about family planning. In fact, for a long time the cost of contraceptives in Pakistan has been highly subsidized without much improvement in contraceptive prevalence rate. The cost of contraceptive does not appear to be a major factor in lower prevalence rates, at least in the south Asian context (Karim SM, 1992:86).

Thus, we can conclude that the need is there but only in the view of experts but not, in view of community. In other words, only experts feel this need but community, itself, does not. The main aim of this model is to process this unmet need in such a way that community, not only, itself feels it but expresses it. Processing of unmet need into expressed need will be achieved through different IEC activities during different stages.

The IEC activities will be mainly based on two way or Socratic method that means interchange of the knowledge between two or more people, assuming that learner already possesses some information (Ilyas et.al., 1981). "Results of metanalysis by Steven Mazzuca, 1982 show, Didactic interventions had an effect on health behavior of 0. 26 units, which was not significant. However, behavioral interventions had an effect of 0. 64 units, which was significant. This suggests that behavior change programs were more than twice as effective as knowledge based programs" (Kaplan; Sallis & Patterson, 1993). The concurrent and consecutive use of one way or didactic method, whenever needed, will facilitate to achieve the objectives. This method is to

instruct client directly assuming that he knows very little about current situation (Ilyas et. al. ,1981).

I. SENSITIZATION STAGE

This stage will make people receptive through enhancement of their perceived susceptibility and perceived severity of the problem. Information may go a waste unless people are made sensitive. About 38% population of Pakistan can be sensitized easily but the remaining 62% illiterate mass need terrorizing\violent methods which produce fear and danger for life (Ilyas et al, 1981). A ***Risk Concept*** will serve best in this stage. Some people will change their behavior, if they feel an intense and personal risks of unwanted pregnancies, if they have an emotional acceptance of the behavior needed to avoid it and a concern to protect others whom they love by avoiding dangerous pregnancies (IECH Bureau Bhutan, 1995).

The perceived susceptibility refers to subjective probability that I could suffer (at risk). One of the main goals of prevention campaigns is to convince people that they are at risk, so they will be motivated to take precautions to prevent themselves " (Kaplan; Sallis & Patterson, 1993). People will change their habits if the pain is greater than benefits or even the memory of the pain is great enough them (IECH Bureau Bhutan, 1995).

The perceived severity is that what they perceive about the consequences of the non use of contraceptives. The perceived severity is much more influential on behavior

than the actual severity. Perceived severity and perceived susceptibility combine to form the overall perceived threat (Kaplan; Sallis & Patterson, 1993). Perceived threat is minimal if someone does not feel oneself at risk for a less severe or even severe problem and thus unlikely to take an action. Enhanced perception of threat will be achieved by two ways. By Direct Classical Conditioning i. e. by making people recall their own experiences of risks of multiple pregnancies and large family size. The second way is transmission of other's attitude by looking at others i. e. Vicarious Classical Conditioning. Direct Classical Conditioning are very strong and pervasive (Carlson NL, 1993). When people become receptive, they seek to get further information (Ilyas et. al. , 1981).

a) Activities

The common people will be approached by Male Workers either at their workplaces or their homes or meeting places and will be told risks of large family size and short birth intervals to children, women and more importantly to men themselves. For men, rational arguments to practice family planning can be focused on the economic burden of supporting and educating many children (IECH Bureau Bhutan, 1995). Then risks to community like overcrowding leading to communicable diseases; lack of recreational facilities leading to psychological diseases and other health problems; which will, in turn, lead to the need of expanded health facilities; and thus shortage of health facilities leading to a vicious cycle affecting health of community.

Further, the risks to our nation and country, i. e. , digestion of economic growth by high population growth and secondly, deprivation of dignity among other nations, by wasting billion of dollars they provided to overcome the problem.

A support to workers will be provided through using Mass Media and other publicity channels like posters, pamphlets, etc.

b) Expected Outcome

Thus, aim of this stage is to make male people perceive severity of the problem as consequences of low use contraceptives and to perceive susceptibility that they, themselves, are at risk. Thus perceived threat will make people receptive for further information.

II. EDUCATION STAGE

People will change their behavior if they know what they can do to avoid the risks (IECH Bureau Bhutan, 1995). Perceived benefit generally refers to how effective the behavior is in producing a health benefit. Perceived benefit is similar to Bandura's concept of outcome efficacy i. e. one's belief that a behavior will produce a specific effect " (Kaplan; Sallis & Patterson, 1993). In this stage, people will be educated about the benefits of using contraceptives. When the benefits are clearly identified, it encourages perseverance (Ewels & Simnett, 1992). The underlying idea is **motivational relevance** i. e. the consequences of a particular behavior to the

actor, in this case benefits of using contraceptives. The attitudes are more likely to be accompanied by behavior if the effects of behavior have motivational relevance to the individual (Carlson NL, 1993).

At the same time, the misconceptions and concerns acting as barriers to contraceptive use will be dealt accordingly. Perceived barriers to behavior also influence action. The perceived benefits and perceived barriers must be considered together in a cost benefit analysis " (Kaplan; Sallis & Patterson, 1993). Lessening of perceived barrier will be achieved through **'Dissonance reduction'** by improvement in action. Dissonance is perceiving a discrepancy between our attitudes and behavior. Thus people will revise their opinion and actions about family planning in order to reduce dissonance (Carlson NL, 1993).

Further, people will be supplied contraceptives and referral services. Some people will change their behavior because they have convenient access to the supplies and services and because they live in an environment where family planning is legal, acceptable and economically desirable (IECH Bureau Bhutan, 1995).

a) Activities

People will be told about benefits of large birth interval and small family size. The possible benefits of use are obvious; the avoidance of unwanted pregnancy and avoidance of STDs. The benefits of using contraceptives outweigh the costs and that the costs of non use outweigh the benefits (Pitts M & Phillips K).

The more important task during this stage, for workers, is to judge the barriers, the client perceiving and hesitating to use contraceptives; and then to apply appropriate strategies in order to reduce the perception of barriers.

"One obstacle to reducing fertility in Pakistan is that men feel they must prove their virility by producing sons and the more sons the more virile man is. In fact, the husbands, especially uneducated husbands, do not allow their wives to use contraceptives. According to many studies, many more women would use them than presently do if their husbands would approve" (Family Planning Association of Pakistan, 1989). Therefore, the workers will educate them by description of new norm. The most irrefutable proof of a man's virility is not his ability to have children but his capacity and his commitment to raising them. There is no comparison between a single act of intimacy leading to conception, and the entire life of attention, sustenance, protection, education, guidance and dedication that is required to raise children.

"Men consistently determine what is consistent with religion; they are usually traditional in their views. Fears are common: fear of supernatural punishment, fear of social stigma, fear of contraceptive side effects and economic loss, and uncertainty." (Schuler SR; Hashemi SM, 1992). There is an association between fieldworker's performance and reported religious opposition (Bernhart & Uddin, 1990). Thus male workers will make them know new norms, at present, are: contraception/sterilization is consistence with Islam and Islam may be the only divine religion which supports human free will such that a man can organize his affairs

according to his own social and economic circumstances (Jullandri, 1996). All other Islamic countries including Bangladesh are practicing contraceptives freely; and further, it is sinful to bring children into the world and not provide for them.

Men fear vasectomy because they perceive it to cause impotence. Besides some men prefer their wives be sterilized rather than themselves because if men lose all their children they can have other children with other wives. "The urban population in Dhaka seemed supportive of male contraceptive use in general. However, certain factors interplay that prevent men from assuming responsibility toward actual male method use, even when they approve and support of spacing and limiting family size. The discomfort associated with the use of condoms, their unreliability in providing protection from pregnancy, together with misconceptions and perceptions relating to the fear of losing energy and productivity from using condoms and from being vasectomised, were reported" (Jahan SA; Thwin AA; Nasreen S; Ahsan RI, 1996:5). Male worker's will provide education to counter this myth and thus will increase the number of vasectomies. Male sterilization is surgically much simpler, less expensive and has less side effects than female sterilization. Further, they can enjoy sex better because there is no fear of having any more children.

Moreover, being household head, they may want more children, preferably son to share their financial responsibility regardless of the consequences of short birthspacing and large family size. Thus, male workers will make men recall that "parents achieve their goal by biological chance" (Nag M, 1991) to have a son, but

they may have a daughter, instead and therefore, the equal chance of the economic loss in term of Dowry.

> " (McGinn, et. al, 1989) states
> The Ministry of Health and Social Welfare in Burkina Faso believes that men are open to learning about using modern contraceptives but have concerns about family planning. They are reported to fear losing their children to all to familiar ravages of disease. They fear the new drugs and devices which, according to them are reputed to harm their users and fear also that their use may change the balance of social control between men and women. "

In addition to the broad social, economic and cultural factors that discourage men from participating in family planning or encouraging their wives to do the same, they may express their concern and worries that their wives would become promiscuous if they could prevent pregnancy. More generally, they may think contraception would allow women to assert a new form of control over their bodies and hence change the power dynamics of marriage. Thus, a male worker can make use of this opportunity to promote male contraceptive methods, so that minimizing the chances of promiscuity and control of women on their bodies. Their suspicion can serve a strong tool to shift the burden of contraception from female methods toward male methods, especially vasectomy.

b) Expected Outcome

After this stage people will be more likely to take action when their perception about benefits will be enhanced to maximum and their perception about the barriers will be reduced to minimum. Thus the highest likelihood of action occurs when the perceived threat of the problem is high and perceived benefits of a behavior outweigh the perceived barriers " (Kaplan; Sallis & Patterson, 1993).

III. MOTIVATION STAGE

Inspite of fact that people have become sensitized and most likely to take action, they still require to be motivated, urged to act for their own benefit. For this purpose, appeal to emotions such as fear, ambition, concern, belief and jealousy work best (Ilyas et.al.,1981).

Another way to motivate people is to provide incentives. The incentive amount is a powerful motivating factors as the rate of acceptance has responded promptly to the raising and lowering of the amount (Siripala D,1988). The evidence suggests the countries of south Asia are more inclined towards incentives, whereas those in east Asia are more inclined towards disincentives (Karim SM, 1992:86). Prizes are an important aspect of competition and these are felt to be effective reinforcers for behavior change (Kaplan; Sallis & Patterson, 1993). Under right conditions when people are coerced doing something or are paid to do so, the act of compliance causes a change in their attitude, and is called 'Induced compliance' (Carlson NL, 1993).

Thirdly, decades of research has shown that people are most stimulated to act because of personal contacts, conversations, meetings and the like (IECH Bureau Bhutan, 1995). Social networks, whether they be spouses, family, friends of the same age and sex, neighbors, villages or community leaders control the spread of any innovations or changes in behavior (Rogers D, 1983). Thus people will change their family planning behavior if they can be supported by other people, spouses, friends, relatives, family, colleagues, worker's associations, or during special meetings. The tendency to identify with family unit or with peer groups provides a strong incentive

to adopt the group attitude (Carlson NL, 1993). They would feel more secure if their own individual knowledge, emotions and skills are reinforced and supported in the direction of desired behavior change.

a) Activities

Male workers will use a Comparison method to create a jealousy among people who have already been sensitized and then educated. This comparison between different individuals, different communities and different countries will motivate to use contraceptives.

Moreover, social movements regarding family planning will be initiated with help of Social worker and the people will be encouraged to take part. Male workers and their supervisors will play a key role in establishing and working of such movements. Mobile cinemas will be used to attract people to gather at public places and to initiate discussions about family planning. Further, message will be conveyed through documentaries shown on the topic alongwith social movies. Furthermore, prizes paid to the winners of the quiz program will motivate people to use family planning. Incentives, to vasectomy acceptors will attract those who really need vasectomy. And incentives to workers with outstanding performance will motivate workers themselves to work efficiently.

b) Expected Outcome

Ultimately because of the continuos and persuasive methods, the people will be motivated and will act as guided.

IV. ACTION STAGE (BEHAVIOR CHANGE)

People will change their behavior, when they feel competent and confident in practicing new behavior (IECH Bureau Bhutan, 1995). Thus whether it is vasectomy, use of condoms, practice of withdrawal or rhythm method, men may feel competent and confident after practicing. Performance of a task can be it's own reward. The production provides a condition reinforcer (satisfaction) (Carlson NL, 1993). As a result of their action and good results achieved by , contraceptive use, they will change their apathetic behavior toward family planning and not only will keep on acting in future as advised but also advocate the practice for benefit of others. When the behavior has changed, the work, objectives and aim of education are complete.

2.6 ETHICAL ISSUES

There are a number of limitations which need consideration during the study. The most important ones are ethical issues, when researcher for sake of his job wants to obtain some data badly, he may overstep the bounds of personal privacy or confidentiality. Another point which is worth noting is that qualitative methods i.e. observations and open interviews, are more particularly concerned with research ethics; and this may be because qualitative researchers are more sympathetic and sensitive to human feelings and responsibilities.

Further, qualitative researcher has far more control about what information is gathered, how it is recorded and how it is interpreted. With quantitative methods it is

generally the informant who provides the information directly by completing questionnaire or whatever, and the researcher has simply to accept what is provided by the informant without much opportunity to question it. The paradox is that the use of qualitative research methods may put the researcher in a considerably more powerful position in relation to indviduals and hence the additional concern with ethical issues in this case.

Two particular ethical issues are concerned in this study. The first arises from participant observation methods, which are essentially deceitful that is participating in a situation and at the same time observing and recording can not avoid some deception about real purposes. The ethical question for concern is then how far we should go in not betraying the trust of the informants. The answer to that question is to be truthful and to explain the most of informants about the nature and purposes of the study.

The second ethical issue is the control and use of data obtained; and it can be handled well by exercising due responsibility by not publicising or circulating any information that is likely to harm the interests of indvidual informants, particularly the less powerful ones.

2.7 PHASE II

IMPLEMENTATION

"What could be more satisfying than to be engaged in work in which every capacity or talent one may have is needed, every lesson one may have learned is used, every value one cares about is furthered"

J W Gardener

The male workers and supervisors will be introduced to the community in June, 1998. Family planning workers are the major source of family planning information, and education and also influence the sterilization decision (Kafiluddin, 1984). Male workers will provide family planning information, education and motivate people using Behavior Change Model. They will distribute condoms, supply oral contraceptives and make referrals for vasectomy to nearby hospitals or clinics. They will also talk to husbands about the minor side effects of pill and IUD use and refer more serious cases to hospitals and clinics. They will also mobilize opinions of local leaders, teachers, officials, imams and the like. Non acceptors will be contacted repeatedly in order to overcome low motivational levels (Khan; Reynolds; Haider, 1973). They will be required to maintain record of their consultation with clients, distribution of contraceptives and referrals made for vasectomy or for complication or side effects of contraceptives.

Full support would be provided to workers, making use of TV, radio, and press through specially tailored programs and use of local language. For example, there would be an advertisement on TV that there will be two parts of screen. On one *half* , there is someone who is traveling on camel; on the other half of screen, there will be written Hadis (saying by Prophet) allowing Azal (Withdrawal) for family planning.

Within seconds, the scene will change that the person is flying on aeroplane on one half of the screen and there will be a written suggestion on the other half. Why can't we use modern contraceptives for family planning. The idea behind is that if we can use other types of modern technology which was not present in Prophet days, we can use modern contraceptives, too. Attractive publicity boards, hoarding and neon-signs with appropriate messages would be installed at railway stations, hospitals, bus stands and other important public places. All the residents of workers will be declared as service outlets of the program and would be made visible for the convenience of the target population by fixing direction/sign boards. A whole range of printed material would also be widely distributed as ongoing activity.

The main role of supervisor will be

1. To plan the work of their area
2. To allocate work to individual worker
3. To coordinate work with each of individual workers
4. To see that work is done to a proper standard
5. To communicate to

a) workers about aims, objectives, work to be done, changes required and so on

b) coordination team about reports, needs and difficulties faced by the workers.

6. To demonstrate, train, support, help and encourage workers to do their work well
7. To solve worker's problems where needed
8. To improve working methods
9. To maintain safe and healthy working methods
10. To ensure a good working environment physically and socially

11. To work as field investigators

The supervisors would be made aware that to do the job well, certain supervisory tools are needed. These are akin to 'tools of the trade' which a craftsman or other worker would use, and include such things as follow

a) Schedule/ Timetable/ Diaries/ Program, so that a systematic way of planning and controlling activities is achieved

b) Instruction guides and procedures, to help with work which is of a semiroutine or systematic nature for example reviewing activities of workers

c) Rules and regulations

d) Budgets for example extra payments, overtime, TA, DA, etc.

Supervisors would be provided support by

a) Backing up their decisions within their own sphere of responsibilities to raise their status in the eyes of workers and help would be given to redress the decision in future

b) Recognition of proper status by including them into discussions about future plans by managers and by not surpassing them to deal with workers

c) Reliability on supervisors would be maintained about contraceptives and other material supplies when expected. All action promised by supervisors would be taken, in fact

d) Involvement in planning. Supervisors will develop a broader outlook on the task through sharing in planning. Further their own personal development will be enhanced to take increased managerial responsibilities in the future. (Ebrahim & Ranken, 1988).

Regular staff meetings are amongst the important tools of management in order to discuss common problems, review progress, plan future work, and so on. Handled well, they can produce great benefits, but run badly, meetings can lead to frustration, acrimony and poor results (Lartson; Ebrahim; Lovel & Ranken,1991). A monthly two hours meeting will be held for all of 30 workers in one territory and meeting will be attended by their own supervisor and all members of coordination team, and Principal researcher. Their individual and collective problems will be discussed, diagnosed and solutions will be proposed using collaborative approach. At the same time, their individual and collective progress will be reviewed and conclusions will be formulated and recommendations will be made for planning of future work by themselves. All the 12 territories will notify dates of their monthly meetings in advance so that two territories should not have the same date in order to ensure the attendance of members of coordination team.

There will be a fortnightly meeting for all twelve supervisors at Tehsil Headquarters with coordination team and Principal Researcher in order to discuss individual and common problems, to review progress and to plan future work.

2.7.1 ADMINISTRATION OF THE PROJECT

(a) Manpower

Administration is simply the arrangement of work to accomplish the objectives effectively. For this purpose jobs for workers, supervisors and members of coordination team will be quite clearly described. During overall management of the

program "a happy family approach" will be adopted. This school of thought advocates the management is based on human relations and consequent behavior (Evans D, 1991). Its salient features are

1. Multiskilling or job enrichment (workers and their supervisors will be trained and enriched with multiple skills as mentioned during training program).
2. Objectives developed through staff participation. The beauty of collaborative research approach lies in that all staff members participate in each and every step that is to develop objectives at one point and formulating conclusions and making recommendations on another point of time.
3. Managers or supervisors will be trained and will work as leaders instead of as bosses. Leadership is generally defined as the art or process of influencing people so that they will strive willingly towards the achievement of group goals (Koontz & O'Donnel)

Earl P Strong points differences between a boss and a leader. Thus the coordination team and supervisors will

1. coach and advise ; while bosses drive and order
2. depend on their confidence and enthusiasm; while bosses depend on their authority.
3. inspires enthusiasm; while bosses endanger fears
4. solve problems; while bosses fix blame and find faults
5. make work a game; while bosses make work drudgery
6. believe in "we and you"; while bosses believe in "I"

6. **(b) Supplies And Stores**

An effective supply system is essential for smooth running of the program. The range of goods and equipment needed is not itself large, but the confidence that the right goods will be in the right place at the right time is crucial. Supply system, in this case, will be relatively simple and from Tehsil Headquarters to workers through their own supervisors. Tehsil Headquarters will serve as a storage for all goods and equipment including contraceptives, registers for keeping records and communication materials. In the case of urgency, a worker will can contact Store directly, when needed. However, full support for supply of contraceptives will be gained from existing Social marketing system of contraceptives.

A check will be kept on misuse of vehicles by a system of log books and also supervising during routine performance of duties. The complaints lodged by the community members will be scrutinized, inquired and will be responded promptly. A disciplinary action will be taken against the defaulter in order to minimize the chances of corruption.

(c) Maintaining Standards And Discipline

Using collaborative approach all supervisors and workers, themselves, will discuss and will arrive at a consensus regarding disciplinary rules and procedures and then it will be ensured that all members of research team including supervisors and workers know what rules and procedures apply to them and also what part they have to play.

Disciplinary rules will define the minimum standards of behavior at work like, for example, work performance standards, requirements to obey reasonable instructions and the prescribed punishment for serious misconduct. **Disciplinary procedure** sets out an action to be taken when rules are broken or work is unsatisfactory (Lartson; Ebrahim; Lovel & Ranken,1991) .

Disciplinary procedures will

1. be in writing
2. provide for speedy operation
3. state the range of disciplinary actions that can be taken e. g. dismissal, etc.
4. specify that who have the authority to take action
5. ensure that individuals are informed of any complaint and give opportunity to state their case.
6. ensure investigation before a disciplinary action is taken
7. ensure that reasons are given for any penalty imposed
8. give a right to appeal if individual feels that he has been unfairly treated.
9. give individuals the opportunity to improve their conduct after a first warning.

Further, meetings held at regular intervals will help to administration of project.

2.8 PHASE III EVALUATION

Two kinds of evaluations has been proposed, i. e., process evaluation through regular observations and analyzing the records; and outcome evaluation through structured interviews with the workers in order to evaluate the competence of the workers; and structured interviews with sample male population in order to evaluate the

effectiveness of workers. Interviews with workers will be carried out twice, first in Oct, Nov & Dec 2000 and then in Oct, Nov & Dec 2002. As all workers will be interviewed during these evaluations, so there is no need of sampling. The interviews with sample male population, too, will be done twice in Oct, Nov & Dec 2001 and then in Oct, Nov and Dec 2003 (Figure 2.1). A stratified, two staged sampling is proposed, due to a large number of population in the scattered area. A cost effective analysis has been proposed through comparison with National Family Planning Program, by calculating cost/acceptor for two programs.

2.8.1 PROCESS EVALUATION

The program will be monitored through getting information, smelling any warning of failure of program and taking corrective measures. "Information giving warnings of failures, and signaling correct moves, is an essential component of successful family planning programs and should be emphasized (Sather ZA, 1992:79). " The program will be monitored by

1. Analyzing records of worker's consultation with their clients, distribution of contraceptives, referrals made by them either for vasectomy or for dealing with side effects and finally by determining number of new acceptors of family planning.

2. Identifying the verbal and nonverbal behaviors of workers during family planning consultations which either inhibit or facilitate communication with their clients. This is the technique of Activity Sampling , which is extensively use in work study and operational management (Easterby K,et al, 1993). "The observations could

provide more reliable information, though the presence of an observer would influence the worker's behavior (Auble & Niang, 1996:76)". While observations have been used to only a limited extent in health sector research, they are particularly useful for collecting information on actual behavior in a given setting (Field & Morse, 1985; Morrison et al, 1990).

The observations will be made at regular intervals when workers will be consulting their clients. The nature of activity and process will be classified and recorded at each time, and over a period of time the frequency of each category, as described under, will be calculated as a percentage of all the activities observed. This will provide an opportunity for supervisors, to sharpen their understanding, of the key facets of family planning service delivery, i. e., worker's interpersonal communication skills. The supervisors will be trained to conduct observations during their training programs. During the session participants will be involved in a series of learning activities in both class room and field, which will allow them to discuss, observe and analyze various verbal and nonverbal communication behaviors included in following checklist.

1. Efforts made to make the client feel comfortable.
2. Efforts made to involve the client in consultation process.
3. Appropriate manner of talking to the client.
4. Appropriate manner of listening to the client.
5. Adequate information given on family planning and contraceptives.
6. Reinforcement of client's choice of family planning method.

7. Explanations given regarding procedures carried out and expectations of the client.

8. Worker is acceptably attired.

9. Discretion shown by worker.

2.8.2 OUTCOME EVALUATION

Step 1. Sampling Of Male Population

The population of the District according to Bureau of Statistics, Punjab is 1512,000 . The population of Tehsil Arifwala is 720,170 and thus the male population calculated at the ratio of 107:100 is 372,260. And the population calculated as target population between the age of 15 to 60 is 186,130, that is also called reference population. But it is feasible to select a sample, called study population. , This will be achieved in this case by Probability sampling i. e. in such a way that each person in the reference population has an equal chance of being selected. Sample size required, as calculated according to statistical formula is

$$n = \frac{(Z)^2 (pq)}{d^2}$$

where n is sample size required; Z is number of standard deviation required to achieve required maximum confidence interval; and p is proportion of population saying yes for contraceptive use and q proportion saying no; and d is acceptable error. Thus if we want 95% confidence interval, this means two standard deviation from the mean, and therefore $Z=2$; p is the proportion of occurrence of the state, that is 18% at present and at time of our evaluation we expect it to be 22% after one year of intervention, therefore $p=0.22$, $q=0.78$, and precision of error is 0.05

$$n = \frac{(2)^2 (0.22) (0.78)}{(0.05)^2} = \frac{6864}{25} = 275 + 28 = 303$$

where 28 is 10% expected non response rate.

The sampling will be stratified and two staged. Each supervisor will have to conduct 25 interviews to collect data in 2000. As all supervisors have to collect data, there will be made 12 stratas according to supervisor's own zone. In first stage, sample frame will be 30 workers; 5 workers will be drawn out of his 30 workers by drawing lots, called sample size; and sample fraction will be sample size/sample frame = 5/30 = 0. 167. In second stage each of these 5 workers will make list of all 500± population (sample frame) and then 5 units (sample size) will be selected by systematic sampling; selecting first unit randomly and then after every 100. For example, one worker selects first unit 11 randomly, the next four will be 111, 211, 311, and 411. Thus, sample fraction will be 5/500 = 0. 01. The systematic sampling has been proposed keeping in view its feasibility as compared with random sampling; as all workers have to prepare the list of their target population as part of their duty, thus no extra time and resources will be needed for systematic sampling. Thus, each of supervisors will conduct interviews with 5 selected persons from each of these 5 villages, thus total 25 interviews.

STEP 2. Instrumentation and Data collection

1. Interviews with workers by their own supervisors will provide data about their KAP regarding contraceptives.

2. Interviews will be conducted by the trained supervisors with sample population in October until mid December 2001. In collaborative research approach, there is a

strong threat to validity, due to involvement of program staff in evaluation of their own program. But the advantages of having program staff involved in the process, both in terms of their contribution and their learning outweigh the disadvantages (Judi & Aminata, 1996:81-2). Further, being the member of the same community, they can interpret the meaning and feeling of the community more appropriately.

a) Training of Supervisors to conduct Interviews[10]

Two full weeks will be allocated in late September, 2001, for a training workshop, in order to train field investigators including members of coordinating team and supervisors to conduct interviews including theoretical and practical training such as technique of interviewing, how to introduce oneself to the respondent, to establish rapport and how to fill in schedule. This will also include mock or dummy interviews followed by real interviews with or without the presence of trainer. This will provide an opportunity for staff from all levels including supervisors, to sharpen their understanding of collecting and analyzing data from target population for research purpose. During the session participants will be involved in a series of learning activities in both class room and field, which will allow them to discuss, and analyze the data collected by interviews through sample questionnaire.

b) Conduct interviews In October & November , 2001, interviews will be conducted with their workers, Thus all the supervisors will have to conduct 30 Interviews with all of their workers.

Step 3. Tabulate and Analyze Data

Once the interviews with the workers completed, data will be tabulated manually in December 2001 by several of the working group members. This will be less expensive and also the practitioners will not require to depend on expertise of a computer technician. Thus data tabulation will be completed with use of calculators. It is hoped that this experience will convince them that computer support is not indispensable and that it will give them confidence and skills necessary to conduct simple research activities in their own future.

Step 4. Formulate conclusions and program recommendations

A two day working session will be organized in late December 2001, during which the research coordinating group members and supervisors will discuss the results and will formulate their own conclusions. The role of Principal Researcher will be to structure and facilitate the involvement of the all members in the deliberations while at the same time contributing to the process as a group member. A two step methodology will be used in the working session. On the first day the research findings will be discussed and group will formulate conclusions. On the second day, the group will develop recommendations based upon their conclusion. A critical aspect of the facilitator's role will be to insist that the conclusions and recommendations be formulated in very simple and concise language.

Step 5. Cost Benefit And Cost Effectiveness Analysis

The national, regional and local studies on financing and costing are undertaken to

1. explore the possibility of developing new financial sources or of extending existing sources

2. examine who is contributing towards the cost and to compare with the volume and value of the services he receives

3. identify and measure the cost of delivering services and the source requirement of any changed form of service delivery 4. examine the determinants of the demand for, and utilization of the services with the objective of influencing to obtain an equitable distribution (Lee & Mills, 1984). The cost benefit and cost effective analysis demonstrate the efficiency of the program, where efficiency means that activity is the most efficient way of achieving the aim i. e. has the least cost and effectiveness means whether you achieved or not what you aimed to achieve.

i) Cost benefit analysis tries to appraise an activity by comparing the costs and benefits directly; for this these must be expressed in the same terms usually money. The major difficulty in doing CBA lies in voluming the benefits of a program in monetary terms. Further, it should include all the direct and indirect costs and benefits including opportunity costs "that is the real cost to a society of providing a health service since the manpower and resources are made unavailable for other purposes.

ii) Thus **Cost effectiveness analysis** is used much more widely in health sector and this is comparing programs having same type of outcome, and thus cost per outcome can be compared directly without giving a monetary value. CEA applications in

smaller scale and in experimental schemes have led to 'stadards' in family planning delivery services
(Corazon MR, 1992).

In this case cost per acceptor can be calculated and can be compared with other program. For example, a study concludes that cost\acceptor was $14. 90 in India (1969), $14 Indonesia (1974), $32. 30 Philippines (1977), $2. 16 Sri Lanka (1974) and $7.80 Thailand (1970) (Corazon MR, 1992:46). Therefore, we can calculate the cost/acceptor of our program and can compare with any of the above described figures and also can compare with National family planning program.

For example, in the year 2000 A. D, the national rate are 22% CPR, while the rate in the project community is 27%. It will be assumed that extra 5% is due to the project. The cost/acceptor will be calculated by dividing the whole expenses in national family planning program by total 4% number of new acceptors. Our target population, for example, is 100,000, that means 4% acceptors as a result of National Family Planning Program are 4,000; and 5% acceptors as a result of new project are 5,000. The budgets allocation of both the programs for Tehsil Arifwala are Rs.1,000,000 for National Family Planning Program; and Rs.1,125,000 for the new project for the same period. In this way the cost/acceptor is Rs 250 for National Family Planning Program; while the cost/acceptor for 5% of the acceptors is Rs 225 for the new program. That means our program is more cost effective/efficient than National Family planning Program.

And on the other hand if the cost/acceptor of our program is more than Rs.250 that means National Family Planning Program is more cost effective/efficient than our program. However, it is necessary to keep in mind that there are two assumptions those may affect the validity of analysis. First assumption is that the CPR increased, in Tehsil Arifwala, as a result of National Family Planning Program will be the same as other parts of the country. Secondly, it has been assumed that apart from the Allocated Budgets, other cost/per acceptor of the both programs, may be direct or indirect, are equal.

Step 6. Dissemination of Results

Principal Researcher will have the responsibility to get the results published at national level. All kind of support provided by any group member will be welcomed warmly. On the first day, for each of 9 categories of worker's behavior studied, the research findings will be discussed and group will formulate conclusions. On the second day, the group will develop recommendations for each of the categories based upon their conclusion. A critical aspect of the facilitator's role will be to insist that the conclusions and recommendations be formulated in very simple and concise language.