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PANDORA FAMILY PLANNING PROGRAM

SIMULATION

Trainer's Package

A Management Simulation Exercise for Family Planning Managers

Written by:

Paula Caproni
Vincent David
Sylvia Vriesendorp

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CONTENTS OF TRAINER'S PACKAGE AND ASSEMBLY INSTRUCTIONS

The trainer's package contains the following materials (numbers in between parentheses indicate number of copies needed to conduct the simulation)

- Trainer's guide (one for each trainer)
- Participant's manual (number of participants + 5)
- Map of Pandora (number of participants + 5)
- Country description (number of participants + 5)
- 5 different cases (number of participants in each group + 1)
- 5 different sets of day-in-the-life cards (one set/group)
- idea-cards (one set/group, none for villagers)
- 1 communication voucher (100)
- 2 travelvouchers (22)
- budget information (2)
- mission statement (4)
- Optional 3 different organizational charts (4)

The folders for the different groups should be put together as follows:

MOH/Family Planning Division

1 set FP/MOH/ day-in-the-life cards, 1 set idea cards, 1 FP/MOH case, 1 participant's manual, 1 map and country description, 3 different budget information sheets; 1 mission statement; 3 different organizational charts, 10 travelvouchers; 20 communication vouchers; some carbon paper. When applicable: telephone directory with numbers for all connected groups

Regional Health Office/Family Planning Coordinator's Office:

1 set of FP/RHO day-in-the-life cards, 1 set idea cards; 1 FP/RHO case; 1 participant's manual, 1 map and country description; 1 budget sheet (the memo written from MOH to RHO), 1 mission statement; 3 different organizational charts, 5 travelvouchers; 20 communication vouchers; some carbon paper. When applicable: telephone directory with numbers for all connected groups.

Peoples' General Hospital/family planning clinic

1 set of FP/PGH day-in-the-life cards, 1 set idea cards; 1 FP/PGH case, 1 participant's manual, 1 map and country description, 1 mission statement, 3 different organizational charts, 3 travelvouchers; 20 communication vouchers; some carbon paper. When applicable: telephone directory with numbers for all connected groups.

District Health Center:

1 set of FP/DHC day-in-the-life cards; 1 set idea cards, 1 FP/DHC case; 1 participant's manual; 1 map and country description, 1 mission statement; organizational charts for RHO and MOH; 3 travelvouchers; 20 communication vouchers; some carbon paper. When applicable: telephone directory with numbers for all connected groups.

Villagers:

1 set of village day-in-the-life cards, 1 village case; 1 participant's manual, 1 map and country description; 1 travelvoucher, 20 communication vouchers

THE PANDORA FAMILY PLANNING PROGRAM
SIMULATION
Trainer's Guide

Developed, tested and revised by
Paula Caproni, Vincent David and Sylvia Vriesendorp
The Family Planning Management Training Project
Management Sciences for Health
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INTRODUCTION

This simulation is designed to supplement the management training seminars, developed and conducted by the Family Planning Management Training Project. The training and simulation, taken together, are designed to strengthen the leadership and management of family planning programs in developing countries. The goal of the simulation is to provide participants with an opportunity to practice general management skills in a realistic and engaging setting and to enable participants to see the consequences of their behaviors and decisions. It is designed to encourage and reinforce program attitudes which focus on the goals and needs of the clients which the program serves. This simulation is useful as a training tool for members of health services systems, as well as for trainers who would like to increase their understanding of the system for which they are designing and conducting training programs.

By providing participants with a simulated environment, an organizational structure, and a set of roles and problems, this simulation recreates a day in the life of four key groups in a family planning system: the top leadership (the Ministry of Health), the regional administration, the health facility, and the villagers the organization is intended to serve. Throughout the simulation, participants will encounter technical and interpersonal issues and problems, in a range of complexity and importance, which are similar to those they might face in their real world. These issues and problems include, but are not limited to

Technical:

- * policy formation
- * strategic planning and goal setting
- * financial management, including planning, budgeting, and control
- * human resources management
- * logistics
- * public relations
- * management information systems
- * monitoring and evaluation
- * information, education, and communication
- * development of alternative delivery systems
- * program implementation

Interpersonal

- * the relationship between the organization and the client system
- * the nature of the manager's work
- * teamwork
- * delegation
- * group dynamics and intergroup relations
- * communication and feedback
- * conflict
- * coordination
- * personal versus organizational goals (organizational politics)
- * motivation and commitment
- * leadership/followership

The simulation is designed to be realistic, engaging, flexible, and simple to administer. As in the real world, there are no predictable outcomes or pre-established right answers.

There is considerable freedom for participants to bring their own knowledge and experience into the simulation. As a result, the participants breathe the life and variety into the simulation.

This guide will provide you with guidelines for facilitating the simulation. We hope you enjoy the experience.

HOW THE SIMULATION WORKS

This simulation is designed to keep trainer intervention to a minimum. After the initial set up and introduction (which is described below) the simulation should run on the energy of the participants, not through the direction of the trainer. Since the success of any simulation is highly dependent upon the enthusiasm and commitment of the participants, the primary task of the trainer is to create conditions which promote participant involvement.

Facilities and Materials

Four or five separate work areas (depending on the number of groups participating), are needed to run this simulation. The groups could share one large room, as long as they don't disturb each other, and cannot overhear each others' discussions. Various arrangements have been used in past training, and all have worked. Recreating real-life obstacles, one could put the villagers and/or the Ministry of Health in places that are not visible to the other groups, or less accessible. The trainer should have access to a room which is large enough to accommodate all participants for the introduction and final debriefing, as well as a central area from which s/he can coordinate and monitor intergroup movements.

The following materials are needed and should be included in the trainer's package:

- Trainer's Guide
- Participant's Manual
- A map and description of Pandora
- The cases (each group receives a separate case describing its particular setting)
- The mission statement of the Family Planning Program*
- Day-in-the-life cards (a separate set for each group)
- Idea cards*
- Budget information*
- Organizational charts*
- Communication Vouchers (20 per group)
- Travel Vouchers (10 for the Ministry of Health, 5 for the regional administration, 3 for each health facility, and 1 for the villagers)

* These items are not given to all groups. (See instructions for assembling the folders.)

In addition to the materials provided, the simulation requires

- Pencils/pens and paper for the participants
- Flip charts/markers or black board/chalk (at least one for the debriefings, preferably one for the MOH, the regional health office and the health facilities)
- Name tags for participants (name, group, role)
- Carbon paper
- (Optional) access to telephones or intercoms/walkie-talkies

Group selection

The trainer may decide to assign participants to groups randomly or systematically (for example, using previous work groups), depending upon the learning environment s/he wishes to create. Teams which are most effective in promoting learning for the players are those in which the skill levels within the group are varied in terms of areas of competence and managerial ability.

Experience from previous simulations show that it is advisable to assign participants to the various groups beforehand. This should be done by or in close collaboration with the training staff of the course. In the past, groups have been put together in such a way that the male/female ratio was about equal among groups, and that each group had at least one potential leader. Furthermore, if participants represent different levels in the health system and/or different professional categories, it is advisable to mix these in each of the groups. Finally, to maximize individual learning, good results have been obtained by placing participants, to the extent possible, at a level higher or lower than the level they work at in real-life.

The trainer does not assign individuals to particular roles within the groups, although group members, once inside their groups, must do so. The Ministry of Health and regional health office must decide which functions should be represented in their group and which group members should be in each position. They can use the organizational charts provided to each group as guidance. The health facilities' and villagers' positions are specified in the day-in-the-life cards. By not having the trainer assign roles, participants initially must work as a team to decide for themselves the best way to get their work done.

Participant Preparation

The day before the simulation, the trainer will briefly introduce the simulation. This introduction will be based on the introduction in the participant's manual. At this point, the participants will have been assigned into groups. The trainer will hand out the following to each participant:

- Participant's manual
- Map and description of Pandora
- The appropriate case (depending on the group to which the participant has been assigned) so they can familiarize themselves with the simulation.

The participant's manual presents the purpose of the simulation, the rules, and the suggested process. Participants are asked not to discuss the case with anyone (from outside their own group) before the simulation begins

One may consider to give out photocopied sheets of the day-in-the-life cards to members of each group. It will reduce the amount of time spent the next day reading the cards. However, it adds to an already considerable amount of reading on the evening before

Understandably, participants may be skeptical and anxious about the simulation. They may doubt the ability of the simulation to capture their "real world". The trainer should legitimize their concern by explaining that (1) the simulation cannot possibly reflect the complexity of their everyday world and, at best, it can set the stage by raising some of the issues, constraints, and possibilities they face in their world, (2) the participants are encouraged to bring in the realism based on their own experience. It is not a test!

The participants may also be concerned about their ability to perform well in the simulation. The trainer should let them know that (1) their anxiety is normal and expected, particularly at the beginning of the simulation, (2) the anxiety will probably subside as they become more involved in the exercise and more focused on specific tasks, and (3) the exercise is intended to be a challenging and enjoyable learning experience.

Introductory session

On the day of the simulation, the trainer needs about one half to a full hour to instruct the participants - in more detail than the previous day - and to get them started. During this introductory session, the trainer

- * Welcomes participants to the simulation
- * Reminds participants which group they belong to
- * Distributes one simulation folder to each group, and reviews contents [See assembly instructions for contents of the various folders.]
- * Reviews the role of the trainer(s)
- * Answers questions from the participants
- * Reminds participants that there are no predetermined right answers to any problem they face
- * Directs the groups to their work areas

NB It is advisable to read out loud some of the day-in-the-life cards to the participants to familiarize them with the kind of problems they will have to solve.

Participant Roles

The simulation is designed to accommodate between 12 and 25 participants. The simulation has been used successfully with groups as small as three and as large as six. Ideally, each group has 5 or 6 participants. The following levels/key groups are represented in the simulation:

Ministry of Health - MCH/FP Division which is responsible for policymaking, donor relations, planning, organizing, motivating, and controlling all family planning services in the country,

Regional Health Office - Family Planning Coordinator's Office which is responsible for effectively and efficiently implementing the family planning services in the region (province),

(Regional) Peoples' General Hospital - Family Planning Clinic which has been responsible for providing comprehensive family planning services and counseling to the population of Provincetown and surrounding areas for the last three years,

Longview District Health Center which provides out-patient and limited in-patient general health and MCH services to the residents of Longview District within Highlands Region, and which is about to introduce family planning into its MCH program;

Villagers of Noncosia who want to be healthy, responsible wives, husbands, and members of their local community

The regional hospital's family planning clinic OR the district health center can be left out without affecting the exercise if there are not enough people. The participation of both the health facilities adds to the dynamics but is not essential.

The role of the trainer(s)

It is advisable to have at least two, preferably three staff on hand to serve as facilitators. One of them should be the principal trainer. After the simulation exercise has been introduced and started, the facilitators have three major responsibilities during the simulation. 1) they serve as mail carriers, transmitting communication vouchers from one group to another; and 2) they serve as drivers, directing one group to another and collecting the travel voucher, and 3) they may decide to introduce external crises at a given moment. In addition, the facilitators can take on any other role as they see fit, or as requested by one of the groups. However, their roles should be limited and specific (e.g. to represent an institution, organization or ministry not needed all the time). Facilitators may refuse to accept a role and may limit their involvement (in time or scope).

The simulation will probably get off to a slow start since participants will be familiarizing themselves with the rules of the simulation and their day-in-the-life cards. They will be struggling with how to work as a group to solve the problems, and it may take some time for the participants to realize that they, not the facilitators, are now directing the outcome of the simulation. The simulation should become quite active by the end of the second hour.

Rules of the Simulation

The rules of the simulation are simple and straightforward. They are presented to the participants as follows:

1. You are to act as though you are actually in the positions represented by the group to which you have been assigned. The simulation should become your "real world" for the day.
2. Communication between groups can take place in two ways: in written form through the use of communication vouchers (memos) or orally (in person) in which case a travel voucher is needed to move from one place to another.

Communication vouchers: Each group receives twenty communication vouchers. You may use as many as you need. The trainer has extra vouchers if you need more. Communication vouchers are to be delivered to their destination by the trainer.

Travel vouchers: depending on the group you are in, you will receive one or more travel vouchers. These vouchers are to be considered as cars and are only good for one round-trip for a group of no more than four persons at a time. Each group receives a limited number of travel vouchers. Travel vouchers are used by indicating to the trainer that you need a driver, and "paying" her/him a travel voucher. These vouchers are transferrable to other groups.

NB: If telephones, intercoms or walkie-talkies are available, do use them. A telephone line between MOH and Regional Health Office adds an interesting touch of reality. A telephone connection with the health facilities is desirable but not necessary. The villagers should not have a telephone (or at least no easy access to one).

3. You are free to meet as often as you wish within your own group. As long as you respect the guidelines for the communication vouchers and travel vouchers, you are free to meet with members of other groups throughout the simulation.
4. You are free to use any resources (books, notes, handouts, etc.) that you feel might be useful.
5. There is no one best solution to any problem. Do not worry about the right answer. Experiment with new behaviors/ management techniques, this is the time to do so without taking any risks. Be creative and try to come up with something that works.

Recommended Time Schedules

The simulation is designed in such a way that it can run anywhere in between from 3 to 6 hours (excluding a half-hour introduction the day before and the debriefing). Three hours is an absolute minimum, as it takes usually one-and-a-half hour for the simulation to get really going. After three hours there is too much unfinished business. It is advisable to reserve, if possible, a full day for the simulation. It is not a good idea to schedule other sessions after the debriefing. It is quite an intense experience.

By closely monitoring the activities of the various groups during the actual simulation, the trainer will be able to determine when it is time to stop. S/he should keep in mind that one and a half hour debriefing is needed to wrap up the exercise and extract the relevant learning.

Lunchbreak

In the original design, participants were told to stay in role during lunch. It was hoped that the exercise would not lose its momentum, as it often takes time before roles are well assimilated. However, experience has shown that few people actually stay in their roles. The trainer may consider other arrangements, such as breaking for lunch in between exercise and debriefing, or having an open buffet.

Debriefings

The purpose of the debriefing is to provide an opportunity for all groups to discuss the simulation together in a plenary session and to extract the relevant learnings. Specifically, participants will have an opportunity to ventilate feelings about the simulation and to discuss the main issues faced by each group, as well as the decisions each group made and why, how they made their decisions, the organization and management concepts used, the impact of one group's decision on other groups, the impact of decisions on group members' motivation and commitment to the program. Two different debriefing scenarios are suggested in Appendix II.

Crises

Accumulated experience with this simulation in a number of different settings, has shown that the introduction of external crises at certain points during the simulation has created additional learning opportunities. What happens when crises occur? Some crises are already written into the day-in-the-life cards. These are the internal crises, that management may or may not address. However, the external crises are beyond the manager's control, and seriously challenge the manager's ability to be prepared and stay in control. Appendix III lists a number of crises that have been used with interesting results. The trainer is encouraged to be creative and bring into the exercises the kind of crises that are realistic and have relevance for the management of the family planning program in his or her particular country.

ADAPTING THE SIMULATION

One of the major advantages of this simulation is that it can be adapted to meet specific training needs. For example, the trainer may decide to change the cases and the day-in-the-life cards to better reflect the real world, to emphasize particular family planning, safe motherhood or child survival issues or organizational skills, or to take advantage of a specific participant skill level. The simulation has been used in general management training, human resource management training, child survival and safe motherhood courses, as well as in academic (MPH) settings.

The simulation could also be used to illustrate MIS concepts (the flow as well as the use/nonuse of information), financial management (budgeting and resource allocation), strategic planning; donor relations, etc. In addition, the positioning of the simulation in the broader training context may have some additional benefits

At the beginning of a course the simulation may:

- serve as an icebreaker
- serve as a diagnostic tool (determine training needs)
- help participants articulate their training needs
- serve as a teambuilding exercise.

In the middle of a course the simulation may:

- serve as a monitoring tool (is the training on target ?)
- strengthen group cohesion
- infuse new energy/enthusiasm or revitalize the group
- serve as a mechanism for participant feedback on preceding training
- serve as a diagnostic tool to unveil additional training needs

At the end of a course the simulation may:

- serve as a bridge between classroom theory and real-life application
- serve as a mechanism for participant feedback on the completed course

APPENDIX I

SESSION GUIDE AND OBJECTIVES

SESSION THE PANDORA FAMILY PLANNING PROGRAM SIMULATION

PURPOSE AND CONTENT:

In this session we will recreate the everyday life of family planning program managers at all levels of the system, provide you with an opportunity to practice management skills and assess the consequences of your behavior and decisions

You will enter a simulated family planning system in a small developing country and you will encounter a number of problems you have to deal with. Within your team, you will apply the skills and experience obtained during this course, as well as your own, towards identifying key issues and resolving major problems. Interaction with your colleagues in your own and other teams, will play a major role in the success of the simulation.

DURATION: hours

OBJECTIVES. At the end of this session you should be able to

- 1 Understand the major technical, organizational and political problems involved in delivering family planning services,
- 2 Understand the role of management in achieving organizational objectives,
- 3 Recognize the most important management subsystems and activities needed to strengthen family planning services in your country,
- 4 Understand the relationships between different levels and centers of interaction in an organization.

READINGS. Participant manual
Description of the country of Pandora
Case

APPENDIX II

SUGGESTIONS FOR DEBRIEFING

Debriefing scenario (A)

The trainer can facilitate the debriefing in any way that seems appropriate. The particular training context will determine to a great extent what the trainer wants to highlight or emphasize.

The following is merely a suggestion based on what has happened during previous debriefings.

Time allowance one to one-and-a-half hour

Preparation four or five large sheets of paper (depending on the number of groups participating) OR two/three blackboards divided in 4 or 5 columns Each sheet or column is headed by the name of one of the groups

As introduction, spend about 5 to 10 minutes asking individual participants what they have personally learned from going through the exercise

Then, starting with the villagers, ask each group to report on what happened. Emphasize the achievements/ successes and the obstacles/problems they encountered and write major points on the sheets/blackboard Usually, other groups will interject conflicting or different versions and comments. Acknowledge them but don't get into discussions (you will run out of time very quickly and it is not fair to the last group to report) Put them on hold until that group is reporting The points written down will help you and the group remember issues that need to be referred to later. Try to give each group a similar amount of time to report and get the input from each of the group members. Sometimes even within groups perceptions vary and conflicts need to be presented by both sides.

Try to link what happened as much as possible to the course content preceding the simulation Check if new techniques and concepts were actually applied, experimented with and ask participants how they felt about this

You will find that participants have many things to say and the debriefing can probably go on for a long time, so watch the clock !

If you plan to use the simulation again, use this opportunity to ask for comments on the simulation and suggestions for improvements

Alternative debriefing scenario (B)

Initially, before everyone reconvenes for the plenary debriefing, all groups are asked to discuss for fifteen minutes the first question:

1 What was your situation and what did you do about it ?

Villagers Describe the initial case and day-in-the-life cards Has your situation changed ? If so, how ?

Other groups Describe the initial case and day-in-the-life cards How did you organize yourself internally ? Did you prioritize, and, if so, how ? What were your achievements ? What was left undone ?

Do you have any feedback, comments or questions for other individuals or groups ?

Groups then return to the main room and each group reports its answers to the previous questions The trainer then raises the following questions

2 Which organization and management concepts and techniques did you use ?

Did you use any of the techniques and concepts that were covered in the course (or will be covered next) ? If so, which ones ?

[Leadership, planning, organizing, staffing, directing, controlling, strategic planning, goal setting, financial management, public relations, coordination, formal problem solving processes, prioritizing, environmental analysis, force field analysis, training, supervision, reward systems, brainstorming, participative management, teamwork, delegation, communication, feedback, time management, management by objectives and results, situational leadership, etc]

If not ? Why not ?

3 How well did the various groups perform ?

How do you feel about your group's performance ? If you would do the simulation over again, would you do anything differently ? If so, what ?

4 What do you think of the simulation in general ?

What did you like about the simulation ?
What would you change about the simulation ?

APPENDIX III

CRISES

The following situations are examples of external crises that can be introduced in the simulation. It is advisable to wait until the exercise has been going for at least two hours and communication between groups has been firmly established. Introduce one crisis at a time and see how the system responds.

CRISIS # 1 - PANDORA COLLEGE OF PHYSICIANS (COP) OPPOSES INCREASING THE ROLE OF PARAMEDICS IN CLINICAL SERVICE DELIVERY

Suggestions for using this crisis

- 1 COP may encourage its members to strike (sample letter to be sent to all physicians at the three levels on next page)
- 2 COP president is very powerful (personal physician to the President of Pandora)
- 3 COP president forces a meeting with the MOH (interrupting the normal workday), or wants to hold lengthy meetings nobody has time for

CRISIS # 2 - DRIVERS OR MESSENGERS GO ON STRIKE !

CRISIS # 3 - VILLAGE WOMAN MISCARRIES AND HEMORRAGES SHE ARRIVES TOO LATE AT THE CLINIC GENERAL CONFUSION, PANIC, THE WOMAN DIES. VERY ANGRY PEOPLE ALL AROUND

CRISIS # 4 - A MECHANIC WHO HAS REPAIRED A MOH VEHICLE HAS NOT BEEN PAID AND HARASSES MOH OR RHO OFFICIALS WHILE THEY ARE TRYING TO MAKE A VISIT

CRISIS # 5 - STOLEN VEHICLES.

NATIONAL COLLEGE OF PHYSICIANS
Pandora City
Pandora

To the Honourable Minister of Health
Ministry of Health
Pandora City
Pandora

Honourable colleague

It is with great concern that we follow the latest developments concerning your Ministry's endeavours to entrust greater (medical) responsibilities to paramedics and non-physicians

As you know, it is our primary concern to see to it that the medical profession stays clear of elements that might compromise the high standards of professional and ethical behavior of our members. I therefore take it as my personal responsibility to review with you the potential repercussions of the policy that your Ministry seems to be pursuing so actively

Sincerely,

President,
Pandora College of Physicians

CALL TO ACTION !!!!!!!!

TO All members of the Pandora College of Physicians

FROM PCOP President

RE Anticipated expansion of non-physician's role in health care delivery

The Executive Board of the Pandora College of Physicians has, by unanimous vote, decided to oppose the Ministry of Health in its current search to expand the role of non-physicians in clinical service delivery. As President of the COP I therefore appeal to all members to join in the strike that has been called as of today. We consider the matter seriously enough to warrant a general strike, despite our moral objections against such political action. However, **THIS IS A SERIOUS THREAT TO THE HIGH STANDARDS MAINTAINED SO METICULOUSLY OVER THE LAST 50 YEARS IN OUR PROFESSION !**

THE PANDORA FAMILY PLANNING PROGRAM

SIMULATION

Participant Instruction Manual

by

Paula Caproni, Vincent David and Sylvia Vriesendorp
The Family Planning Management Training Project
Management Sciences for Health
Boston, Massachusetts, 1988

INTRODUCTION

Welcome to the Pandora Family Planning Program simulation exercise. This simulation has been developed for the Family Planning Management Training Project for senior managers responsible for family planning programs. It has been tested in a variety of training programs and revised based on suggestions made by trainers and participants. The simulation is used as one of many training methods in the courses developed and organized by the Family Planning Management Training Project, a project that is implemented by Management Sciences for Health in collaboration with the Pathfinder Fund, CEDPA and LASPAU. The goal of this simulation is to recreate a day in the life of a national family planning program and to provide you with an opportunity to put into practice the skills and concepts that have proven useful to managers of family planning programs. This simulated real life experience allows you to use your particular expertise and experience, to advise and learn from your colleagues, to experiment with new behaviors and to see the consequences of your behavior and decisions.

You will soon be entering into the national health system of a fictitious, small developing country, named Pandora. Five groups are represented in this simulation.

Pandora Ministry of Health - MCH/FP Division which is responsible for planning, organizing, motivating, and controlling all family planning services in the country.

Highlands Regional Health Office - Office of the family planning coordinator which is responsible for effectively and efficiently implementing family planning services in Highlands, one of the ten regions (provinces) of Pandora.

Peoples' General Hospital - family planning clinic, established within a large hospital located in the provincial capital (Provincetown), which is responsible for providing a wide range of family planning services directly to the population of Highlands Region.

Longview District Health Center, a large district health center with 24 beds, located in a remote area in the Highlands region, which is responsible for providing basic health services to the rural population, and which is about to embark on an integrated FP/MCH services program.

Villagers of Noncosia, inhabitants of a village located within the District Health Center's area, who want to be healthy and responsible wives, husbands, and members of their community.

You will be assigned to one of these groups. Along with the other members of your group, you will encounter a number of problems, opportunities, and constraints that reflect your position in the health system. Together you will apply your skills and experience toward identifying key issues and resolving major problems.

This simulated environment, of course, is not as complex as the real world in which you work. However, we have made this simulation as realistic as possible by including many of the issues, problems and decisions you face every day. Because this is meant to be a simple model of the real world, you will need to use your experience, imagination, and creativity to fill in the gaps. As in the real world, there is seldom only one best solution. There are no right answers. What is important is that you get involved and try to come up with solutions that work. The success of the simulation depends upon your effort and enthusiasm, so relax, be creative, take risks, and enjoy.

HOW THE SIMULATION WORKS

The design of the simulation is quite simple. There are four phases.

Phase 1 - On the day before the simulation, the trainer will assign you to one of the five groups - the Ministry of Health, the Regional Health Office, the Peoples' General Hospital, the District Health Center or the villagers. You will read the case for that group and the rules of the simulation to familiarize yourself with the setting in which you must work.

Phase 2 - On the day of the simulation, the trainer will introduce you to the simulation by

- o Reviewing the setting
- o Distributing a simulation folder to each group in which you will find
 - a participant's manual
 - the goals of the National Family Planning Program (*)
 - the case for your group
 - day-in-the-life cards
 - idea cards (*)
 - communication vouchers
 - travel vouchers
 - miscellaneous items, depending on the group (*)

(*) The villagers will not receive the items marked with (*)

- o Reviewing the rules of the simulation
- o Explaining the role of the trainer(s)
- o Presenting the time schedule
- o Answering your questions
- o Directing you to your work area

After the introduction, the trainer(s) will play a minimal role and the simulation will become yours. Until the end of the exercise and the beginning of the debriefing, the trainers' only role will be to deliver your communication vouchers, serve as drivers and, if so requested (and if available), to serve as consultants on technical, management or process issues.

For example your group may ask one of the trainers to briefly take on a role not represented in your or any other group, such as a representative from a governmental or private donor agency, another Ministry, an external consultant, etc. Be aware however, that the trainer may decide at any time to end his or her role or to decline the invitation

Phase 3 - The simulation will begin as soon as you arrive in your work area. Together with your group, you will review the day-in-the-life cards and idea cards, determine the main issues and problems, and develop and undertake a plan of action. You may not have all the information you need, so you will have to find it, and, if it is not available, create it based on your own experience

Phase 4 - The simulation will end at a predetermined time, and all participants will meet, as a group, with the trainers for a total group debriefing

RULES OF THE SIMULATION

1 You are to act as though you have become a citizen of Pandora, either working at some level in the health system, or a potential beneficiary of the health system. Try to get into your role as fast as possible and stay in that role throughout the day

For example. If you are assigned a villager, try to become that villager for the day. Make his/her problems, fears, superstitions and concerns yours. If you are assigned to the Ministry of Health, take on the role and all the responsibilities, challenges, concerns and worries that come with that role. If you work in the family planning clinic, imagine yourself in that situation, etc

Be a creative roleplayer and make up the missing information (for example about the person's character, personality, etc.) relying on your life experience to make the person you are playing as realistic as possible. You may wish to model your character after a real person you know back home.

2 You will receive the following materials:

* **Case** - The case describes your group's position in the system, and gives you some background information about Pandora, the family planning system, its culture, and other facts that are considered important. Each group has a different case.

* **Day-in-the-life cards** - The day-in-the-life cards are designed to represent typical problems, constraints, and opportunities in the day-to-day life of your group. The cards require action and decisions, and they alert you to problems that need to be dealt with. You will find that there are too many problems and issues to deal with in just one day. You will therefore have to prioritize, and/or delegate. Each group receives a different set of day-in-the-life cards. Do not show any of these to members of other groups

* **Idea cards** - The idea cards are designed to present management and organizational concepts, ideas and hints which you may find useful. All groups, except the villagers, have an identical set of idea cards.

* **Communication vouchers** - You will receive a set of twenty communication vouchers. These vouchers are used to communicate with other groups (levels) - for example, to request information, to propose a meeting, to answer questions, etc. You may use as many communication vouchers as you like and may obtain additional vouchers from the trainers. All written communication between groups must (1) be written on a communication voucher; and (2) be delivered through one of the trainers.

* **Travel vouchers** - Each group will receive between 1 and 10 travel vouchers, depending on the level (the Ministry receives 10, the Regional Office 5, the health facilities 3 each, and the villagers 1). These vouchers serve as vehicles that can take up to four passengers. After each trip the vehicle breaks down. There are no spare parts for repairs. Therefore, a travel voucher can only be used for one round trip to one other group. You may travel to another group only by going to the trainer and handing over one travel voucher. The supply of travel vouchers for each group is fixed. There are no extra vouchers. You do not have to use your travel vouchers when bringing your communication vouchers to the trainer, when going for lunch or to the bathroom.

3. You are free to meet as often as you like within your own group. As long as you respect the guidelines for the communication vouchers and travel vouchers, you are free to meet with members of other groups throughout the simulation.

4. You are free to use any resources (books, notes, handouts, etc.) that you feel might be useful. The idea cards can be used any time to refresh your memory about management and organizational principles and techniques.

5. There is no one best solution to any problem. Do not worry about the right answer. Be creative and try to come up with something that works.

GETTING STARTED

You are now ready to get started For all groups except the villagers, we suggest that you

- 1) Review the setting in which you work (your group's case)
- 2) Read through your day-in-the-life cards and idea cards
- 3) Place group members in appropriate positions (staffing)
- 4) Prioritize
- 5) Develop your plan of action
- 6) Implement your plan of action
- 6) Evaluate your performance throughout the simulation
- 7) Enjoy yourselves '

For the villagers, we suggest that you

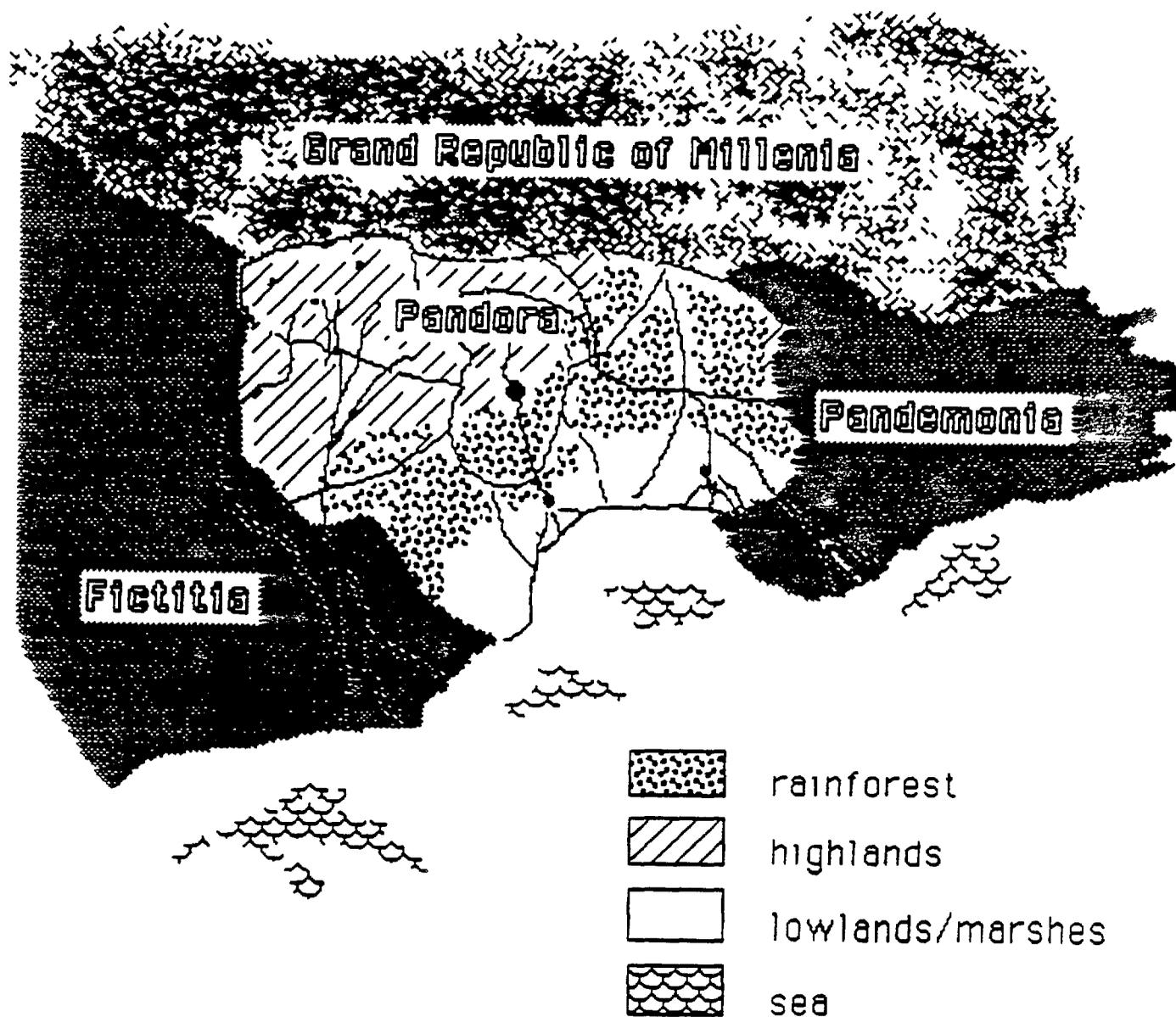
- 1) Assign the various roles (pregnant woman, chief, PHCW, TBA, husband, etc)
- 2) In your assigned role, discuss your experiences with the modern and traditional health systems, your worries, fears and concerns, your hopes and expectations
- 3) Wait to see what happens, and enjoy yourselves '

Good luck '

PANDORA MAP AND COUNTRY DESCRIPTION

THE PANDORA FAMILY PLANNING PROGRAM SIMULATION

Country background information



THE PANDORA FAMILY PLANNING PROGRAM SIMULATION

Description of the country

Pandora is a tropical country with a population of 15 million people. The annual per capita income is US\$420. The country is predominately rural with 28% of the population living in towns larger than 5,000 people. Farming is the main occupation, including subsistence farming and cultivation of coffee, tobacco and cotton for export. Some industries have been developed around the main towns, contributing to a slow but steady migration from the countryside. Pandora's main river provides a quarter of the electricity needs, a small oil field another quarter, the remaining half is supplied by imported oil. In many of the rural areas, wood is still the predominant energy source.

The latest population statistics show a crude birth rate (CBR) of 51, a crude death rate (CDR) of 20 and thus a rate of natural increase of 3.1 percent. The average life expectancy is 50 years (up from 37 years in the 1960's). The average number of children per woman is six. The growth rate is roughly the same as the influence of in- and out-migration is insignificant. With a growth rate of 3.1%, the population will double in about 23 years. Over 46% of the population is under the age of fifteen.

Maternal mortality is high: official statistics - which only count the women who have been in contact with the formal health system - report as many as 480 deaths per 100,000 live births. The major causes of maternal mortality are reportedly haemorrhage, infection (some proportion of which is post-abortum) and obstructed labor.

The Infant Mortality Rate (IMR) has been brought down from 157 per thousand 10 years ago to 115 per thousand, partly due to the country's socio-economic development and partly due to successful child survival interventions. These included the promotion of ORT through media and health facilities, and a large scale immunization campaign that raised the level of coverage for DPT-Polio-3 and measles among children under 3 to 65%. From the incoming reports it is estimated that 60% of this infant mortality is due to deaths occurring during the first month of life. The causes reported for the age group "less than one year" are: prematurity, delivery problems, respiratory infections and diarrhea (national level statistics do not differentiate between causes of neonatal and infant mortality).

The contraceptive prevalence rate in Pandora is estimated to be 3%. In Highlands Region, a survey was recently undertaken showing that the prevalence was even lower (1%). The same survey revealed that approximately 10% of the villagers had heard of family planning services through IEC efforts, another 40% had heard of family planning services from other villagers or, less frequently, from personnel at health clinics. Initial acceptance rates for family planning services have increased slightly in the past five years. Continuation rates are alarmingly low. Only a small portion of the women who begin family planning services continue after their first visit.

CASES

THE PANDORA FAMILY PLANNING PROGRAM

The Ministry of Health - Family Planning Division

Concerned about the effects of rapid population growth (3.3% per year) on family welfare and the country's socioeconomic development, the Government of Pandora initiated a National Family Planning Program in 1975. The Ministry of Health was given the overall responsibility for determining the family planning needs of the country, developing the policies and organizational systems which would lead toward the promotion and provision of family planning services, and implementing, monitoring, and evaluating the program. At the inception of the Program, the Family Planning Division developed the following mission statement:

"All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so. The Pandora Family Planning Program's mission is to ensure this basic right and provide the resources necessary to exercise this right."

The overall goal of the National Family Planning Program is:

To incorporate family planning services, including child spacing, contraception, and the treatment of infertility and sexually transmitted diseases, into existing maternal and child health (MCH) programs so as to promote and maintain the health of the people, especially mothers and children and to ensure a reasonably manageable population growth and well-being in Pandora.

Delicate Issues and Resistance to Family Planning. The Family Planning Program raises delicate moral and political issues, as it is being implemented in the context of long-standing cultural values emphasizing fatalism, fertility and large families, polygamy, and tribalism. In addition, practical problems are raised by the diversity and multiplicity of ethnic groups, languages, and religious beliefs, as well as the high illiteracy rate, and the fact that most of the population lives in small rural communities dispersed throughout the countryside.

The Family Planning System. In spite of all these complications, the Pandora Family Planning Program has come a long way since it was instituted in 1975. An operational three-level organizational system is in place, consisting of the MCH/FP Division within the Ministry of Health, 10 Regional Health Offices, which each have a family planning coordinator and the various family planning service delivery points.

The unit responsible for family planning within the Ministry is the MCH/FP Division. The head of this division, a physician who used to be the Chief of the OB/GYN department at the Lowlands Regional Hospital, has been given the responsibility to determine the country's needs in terms of maternal and child health, which includes family planning, and to develop the plans, policies and management systems which would lead to the promotion and provision of these services. The MCH/FP Division is also responsible for monitoring and evaluating the implementation of all MCH/FP programs (the actual implementation is decentralized, and in the hands of the Regional Health Offices). Decisions concerning resource allocation among the regions are made at the Ministry level. Finally, all communication with the donor community regarding MCH and FP is handled by this division.

Service Delivery Family planning services are offered through hospital-based family planning clinics, health centers, through some dispensaries and by trained TBAs. Hospital-based family planning clinics have been established over the last few years in 7 of the 11 major hospitals in the country (Two of these hospitals are in Pandora City and one in each of the nine other regions). These clinics are usually staffed separately from the hospital with specially trained nurse/midwives and nurses. They have access to the hospital's OB/GYN specialists at fixed times during the day.

The family planning services provided by the district health centers tend to be integrated with their other MCH services. These health centers are staffed by at least one physician, one nurse and one nurse/midwife. Not all staff is trained in family planning. Most of the district health centers are very clinically oriented, with few or no outreach activities (including family planning IEC).

Family planning services, including the distribution of condoms, diaphragms, contraceptive pills, and IUDs are provided free of charge. There is a fee (amounting to 1/10 of an average village family's monthly income) for lab work which is required before obtaining the pill. Only married women have access to family planning services. In some areas, women must have permission from their husbands to obtain contraceptives.

Finally, several hundred traditional birth attendants (TBAs) have been trained in safe delivery techniques and basic family planning services. Most of this training is done by the staff of the various (government) family planning clinics with support from UNICEF, although some private initiatives are supplementing these efforts. The trained TBAs are to be supervised and periodically resupplied by health personnel in their district. As no evaluation has been done yet, it is not known what their coverage is. Neither are there any data on the quality of their work. An unknown number of TBAs work without having received any formal training.

The first doctors trained by the National University of Medicine have finished their training three years ago, but there is still a shortage of physicians, especially in the mountain areas. Yet, the National College of Physicians is quite reluctant to agree to suggestions by the MOH and donors that paramedics be trained to insert IUDs and prescribe oral contraceptives.

The Budget The health budget this year is roughly equal (after correction for inflation) to that of last year and is likely to remain so in the next few years, though it is hoped that the production of additional oil-derived energy will allow to allocate more resources to the health sector. Indeed, the Prime Minister has assured the Minister of Health that additional funds for the Family Planning Program would be made available in next year's budget. Meanwhile, the Program would have to do with the present allocation and with any other funding they could come up with.

Coordination There are plans to create a National Family Planning Coordination Board (NFPCB) consisting of representatives from the Ministries of Health, Education and Agriculture, Information, Economic Planning and Finance, and Works, the National University of Medicine, Pandora Planned Parenthood Federation (PPPF), the National Council of Women Society; the Pandora Christian Pilgrims Welfare Association, the Pandora Muslim Brotherhood, and the Pandora College of Physicians. The exact role of the NFPCB is still to be developed, but it is hoped that by bringing together all available experience and expertise, the planning and smooth implementation of family planning programs, projects, and services will benefit. It is also expected that this move will reduce some of the anticipated resistance from religious groups.

THE PANDORA FAMILY PLANNING PROGRAM

Highlands Regional Health Office - Office of the Family Planning Coordinator

Highlands is one of the country's ten regions. It is divided into 17 districts and counts around 950,000 people, of which 1/3 live in the main city, Provincetown. Apart from the main road leading to the capital city, there are very few asphalted roads and transportation is a major problem. The altitude ranges from 4,900 to 9,000 feet and the region has a rather cool climate, explaining that, in some areas, wood is used for heating as well as for cooking, and deforestation is going on at an increasing rate. The population includes a number of migrant workers leaving the area every year to find seasonal employment in the coffee or cotton plantations in the lower regions, where malaria is still prevalent.

The health structure in the Highlands region includes the main regional hospital in Provincetown, with its 260 beds, including Ob/Gyn and pediatrics departments, two district-level large health centers with beds in the remotest parts of the region, 13 health centers, each staffed by a physician (4 of them expatriates) and a nurse.

The Director General is quite aware of the problems created by high population growth in the region. The pressures on scarce resources within the Regional Health Office are increasing noticeably. In addition, the high maternal mortality rate also calls for action. Family planning has become an important political and public health issue. However, it has also raised delicate moral and political issues, as it is being implemented in the context of long-standing cultural values emphasizing fatalism, fertility and large families, polygamy, and tribalism. In addition, practical problems are raised by the diversity and multiplicity of ethnic groups, languages, and religious beliefs, as well as the high illiteracy rate, and the fact that most of the population lives in small rural communities dispersed throughout the countryside.

The Family Planning System. In spite of all these complications, the Pandora Family Planning Program has come a long way since it was instituted in 1975. An operational three-level organizational system is in place, consisting of the MCH/FP Division within the Ministry of Health, 10 Regional Health Offices, and the various family planning service delivery points.

The unit responsible for family planning within the Regional Health Office is the Family Planning Coordinator. His (her) main responsibilities are to coordinate all family planning services in Highlands Region. This includes ordering commodities for the region, ensuring that all commodities get distributed, overseeing all family planning programs and special projects/campaigns, training and supervision of staff, monitoring and evaluation of activities, and data collection and analysis.

Service Delivery Family planning services are offered through a hospital-based family planning clinic, (district) health centers, through some dispensaries and by trained TBAs. Highlands Region has one hospital-based family planning clinic, established three years ago in the Peoples' General Hospital in Provincetown. It is operated and staffed separately from the hospital, with a full-time nurse midwife and general nurse, and a part-time nurse educator. Furthermore, it has access to all OB/GYN services in the hospital, and the hospital's OB/GYN specialists work part-time in the family planning clinic.

The family planning services provided by the district health centers tend to be integrated with their other MCH services. The health centers are staffed by at least one physician, one nurse and one nurse/midwife. (The Longview DHC has two physicians, four nurses and a lab assistant, and has recently added a nurse midwife and nurse educator to its staff who are trained in family planning.) Not all staff is trained in family planning. Most of the district health centers are very clinically oriented, with few or no outreach activities (including family planning IEC).

Family planning services, including the distribution of condoms, diaphragms, contraceptive pills, and IUDs are provided free of charge. There is a fee (amounting to 1/10 of an average village family's monthly income) for lab work which is required before obtaining the pill. Only married women have access to family planning services. In some areas, women must have permission from their husbands to obtain contraceptives. Pandora has 7 hospital-based family planning clinics.

Finally, some hundred traditional birth attendants (TBAs) have been trained in safe delivery techniques and basic family planning services. Most of this training is done by the staff of the various (government) family planning clinics with support from UNICEF, although some private initiatives are supplementing these efforts. The trained TBAs are to be supervised and periodically resupplied by health personnel in their district. As no evaluation has been done yet, it is not known what their coverage is. Neither are there any data on the quality of their work. An unknown number of TBAs work without having received any formal training.

The first doctors trained by the National University of Medicine have finished their training three years ago, but there is still a shortage of physicians, especially in the mountain areas. Yet, the National College of Physicians is quite reluctant to agree to suggestions by the MCH and donors that paramedics be trained to insert IUDs and prescribe oral contraceptives.

The Budget. The health budget this year is roughly equal (after correction for inflation) to that of last year and is likely to remain so in the next few years, though it is hoped that the production of additional oil-derived energy will allow to allocate more resources to the health sector. Indeed, the Prime Minister has assured the Minister of Health that additional funds for the Family Planning Program would be made available in next year's budget.

THE PANDORA FAMILY PLANNING PROGRAM SIMULATION

The Longview District Health Center

Farway is a small town of 10,000 people, located near the northern border of Pandora, in Longview District, Highlands Region. The road to Provincetown, the region's main city with its People's Regional Hospital, is asphalted only on the first half of its 120 miles, and the trip requires a good four hours by car. In addition to the town's population, the District Health Center (DHC) serves a rural catchment area - the district - whose population is estimated around 40,000, distributed among several small villages with difficult access, especially during the rainy season.

Most of these villages are inhabited by farmers practicing subsistence farming and growing a little corn and vegetables for sale. Farway has a market twice a week and a few general stores. At the beginning of the cotton and coffee harvesting season, men from the surrounding villages gather in Farway to meet the recruiters who will transport them to the Lowlands and the Hills Regions.

The Longview DHC has been built ten years ago thanks to a grant from an international health foundation. It is operated by the government. It comprises two consultation rooms, a small operating theater, a dressing/injection room, two in-patients rooms (one for males, one for females) with 12 beds each, a basic laboratory (malaria, urine and stool examination, blood cells count, ESR) plus an additional room for storage, and a smaller one for the duty personnel. The staff includes two physicians (including a surgical resident) sent by the government as part of their civil service, four nurses, a laboratory assistant and two cleaners.

Until recently Longview DHC did not offer family planning as part of its MCH services because none of its staff was trained in family planning. Last month, two new staff arrived, a nurse/midwife and a part-time nurse educator, both trained in family planning. The new goal of the DHC is now to integrate family planning services into the existing health care program so that it may effectively and efficiently promote and provide family planning services to the villages it serves. Family planning services that will be offered include education/information and counseling, IUD insertion, distribution of oral contraceptives and barrier methods, diagnosis and treatment of sexually transmitted diseases, treatment of infertility, and counseling and referral for sterilization. In order to develop the family planning services component, the DHC will need resources. The addition of the new staff is a great step in the right direction. The DHC will also receive equipment and medical supplies to provide family planning services. Rumor has it that Longview DHC may be able to share a vehicle with three of the other health centers in the area, one of which is already providing family planning services.

Longview DHC is open for all services Monday through Friday from 8:00 - 12:00 in the morning and again from 1:00 - 5:00 in the afternoon. The nurses are at the health center all day and the physicians rotate shifts. Their availability for family planning is limited due to their many other responsibilities (including surgery)

Organizationally, the DHC is responsible to and supervised by the PHC unit within the Regional Health Office in Provincetown. Supervision of the family planning services rests with the Office of the Family Planning Coordinator (also at the Regional Health Office)

Well over half the people seen at the Longview DHC are mothers and children. Aside from the common problems of diarrhea, malnutrition, respiratory infections and pregnancy related problems, there is an increasing occurrence of sexually transmitted diseases. The staff estimates that less than half of the women who come to the clinic have heard of family planning services. Rarely do the nurses get requests for information and contraceptives, and until a month ago, they usually could not provide the information nor the contraceptives.

The Longview DHC staff is aware of the Government's concern about rapid population growth, but it is not clear to them how this rapid growth affects the current and future daily life of the people they serve. They are actually quite divided about the issue. For example, although the nurse feels it is about time family planning is offered, one of the physicians is keenly aware of the delicate moral and political issues that family planning seems to bring up wherever it is introduced. There are long-standing cultural values emphasizing fatalism, fertility and large families, polygamy, and tribalism in the community. The diversity of ethnic groups and languages poses additional, practical problems.

THE PANDORA FAMILY PLANNING PROGRAM

Peoples' General Hospital - Family Planning Clinic

The People's General Hospital is located in Provincetown, the main agglomeration in the Highlands Region, a town of 300,000 inhabitants. It has been built eight years ago and receives patients from the town itself as well as from the whole region. It has several medical and surgical wards, including a pediatric section for each. It also has a maternity ward, coupled with a four-bed delivery room, receiving on average 25 deliveries per day. It has an obstetrician on call day and night and, since last year, a few interns have been sent by the University for their last year of practical training. The Family Planning Clinic is situated on the premises of the Peoples' General Hospital, and has been in existence for three years. It serves the people from Provincetown and surrounding towns and villages. Its goal is to effectively and efficiently promote and provide family planning services to all men and women who are interested in planning their families.

Services offered by the clinic include family planning education, gynecological exams, IUD insertion, prescription of oral contraceptives, periodical check-ups of pill and IUD users, distribution of condoms, foam and jelly Norplant has recently become available, and sterilization requesters are counseled and then referred to the OB/GYN department of the hospital. Clinic staff is also trained in diagnosis and treatment of sexually transmitted diseases, and infertility counseling.

Well over half the people they see at the clinic are mothers and children. The married women who use the clinic have an average of seven children each. Knowledge of modern family planning methods is on the increase, although practice is still very low, according to a recent survey in Highlands region.

The clinic staff is aware of the government's concern about rapid population growth in Pandora, but is not clear about how this rapid growth affects the current and future daily life of the people they serve. They are, however, aware of the delicate moral and political issues raised by the family planning program. There are long-standing cultural values emphasizing fatalism, fertility and large families, polygamy, and tribalism in the community. The diversity of ethnic groups, languages, and religious beliefs doesn't make things easier. In addition, the high illiteracy rate complicates matters even more.

Service Delivery The clinic has been operational for three years now (the hospital itself is eight years old). The clinic staff works independently of the hospital, with the exception of the physicians. The hospital's OB/GYN specialists divide their day between the hospital and the clinic on a rotating basis (from 10.00 - 12.00 in the morning and 2.00 - 4.00 in the afternoon). The physicians are the only ones who are authorized to conduct gynecological exams. The clinic is staffed by a full-time trained midwife and a general nurse, and a part-time nurse educator.

The midwife is responsible for the administration of all family planning services, including the organization of client flow, the completion of all reports, the ordering of supplies and equipment, distribution of contraceptives, insertion of IUDs, and the supervision of the general nurse and educator nurse. The general nurse is responsible for assisting the midwife in her responsibilities and assisting the physicians during gynecological exams. The educator nurse is responsible for outreach and education. There are no job descriptions.

The clinic is open Monday through Friday from 8 00 - 12 00 in the morning and again from 1 00 - 5 00 in the afternoon. The midwife and the general nurse are at the clinic all day and the educator nurse is there in the morning. They cover for each during absences. Organizationally, the clinic is responsible to and supervised by the Office of the Family Planning Coordinator at the Regional Health Office in Provincetown.

The daily routine typically proceeds as follows: When a woman first comes to the family planning clinic, she meets with the midwife who opens a file for the woman and obtains information from her. The woman then meets with the educator nurse who (1) talks with her either individually or in a group about the physiology of reproduction, child spacing, and contraceptive usage; (2) explains that the process for obtaining contraceptives includes a gynecological exam, initial lab tests for which the woman must pay (approximately 10% of one month's family income), and a meeting with the midwife to determine the most appropriate contraceptive, (3) explains that all contraceptives are distributed free of charge, (4) explains that the woman must get permission from her husband to obtain contraceptives. Only married women are seen by the family planning clinic. The woman is then seen by the physician for a pelvic exam (obligatory for each first visit, independent of the type of contraceptive requested). Her final stop is with the nurse midwife or general nurse who provide her with the contraceptive of her choice.

Depending on the type of contraceptive, an appointment is set up for the next visit: pills are distributed in two month supplies; IUDs, once inserted, must be checked once within the first two weeks, then again at one month, three months, six months, and one year, followed by yearly visits to the clinic; condoms are distributed in packages of twelve, along with 3 strips of foam tablets (12 tablets in total). Sterilizations can be done, but are rarely requested.

Initial acceptance rates for family planning services have increased in the past three years, but to a lesser degree than had been hoped for. Continuation rates are alarmingly low. Only a small portion of the women who begin family planning services continue after their first visit.

THE PANDORA FAMILY PLANNING PROGRAM

The Villagers

The village of Noncosia is located in the mountains, about two and a half hours walk from the Longview District Health Center in Farway. It actually is a group of five hamlets whose total population is around 2,500. The villagers grow corn and vegetables, and some have a few sheep and goats. There is no electricity installed but some of the village people have generators. All use wood for cooking and parafine oil for light. Women and children are doing a large part of the agricultural work, in addition to the water and wood gathering. A number of men find employment on a seasonal basis in the coffee plantations or the small factories near the capital, and thus are absent from the village for long periods of time. The average annual income is around \$170, excluding resources in kind.

The village is located in a predominantly Christian area, but there is a noticeable minority of Muslims. The illiteracy rate is high, with 55% of the men and 75% of the women unable to read or write. In the extended family, a man is usually at the helm of affairs. His authority is hardly challengeable by other members of the family. His decisions, more often than not, are final. The Chief of Noncosia has final authority on all matters that affect the community. He is humbly respected by all inhabitants of the village.

The culture of the village values fertility and large families and is skeptical of outside influences. Children are considered divine gifts and are valued as a sign of status in the village. They are also valued for the labor they provide and the security they offer in their parents' old age. Polygamy is practiced by approximately 15% of the men. The average age of marriage for women is fifteen. Traditional contraceptive practices, such as abstinence, prolonged breastfeeding and return of the mother and baby to the paternal village, are disappearing at an increasing rate. Modern family planning methods are barely known and generally viewed with suspicion. Nevertheless, in reaction to the many maternal deaths that have occurred in the village, a few courageous women in the village have gone to the Longview District Health Center and asked about family planning.

For years, the village has had three TBAs to take care of all the "female needs" and that has been considered sufficient by everybody, including the elders council, without whom no major decision is taken in the village. These old women are well versed in the practice of traditional medicine (including traditional methods of child spacing). Two of them even participated in a course given last year by the midwife and received a certificate and a box for deliveries given by UNICEF. Of course, there has been some mishappenings; nearly every family has its own story to tell about having lost a woman, often a young one, during pregnancy, delivery or following an abortion. But this is the way things have been going on for ages.

Things are changing, though! Everybody in the village has listened to the speeches on the radio. They all heard the Prime Minister say that it is better to have small families, and that family planning and birth spacing is better for the health of women and children.