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A Study on the Impact of the Workshop on Family Planning Conducted with the Traditional and Religious Leaders in Nasirnagar Thana by Save the Children/US

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FINAL

A STUDY ON THE IMPACT OF THE WORKSHOP ON FAMILY PLANNING CONDUCTED WITH THE TRADITIONAL AND RELIGIOUS LEADERS IN NASIRNAGAR THANA BY SAVE THE CHILDREN(USA)

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Preface

Although Bangladesh has achieved considerable success in its family planning program, despite considerable poverty and underdevelopment, there is no room for complacence. In order to achieve the national demographic goals, the program not only has to sustain the current users, but also and quite importantly, bring within its fold the never users and dropouts. Accordingly, there would be need to develop, implement, evaluate, and then replicate innovative IEC component of the program. The proposed study is a positive step toward understanding of the impact of an innovative IEC component, namely workshops on family planning participated by the traditional and religious leaders in a conservative area, Nasirnagar thana of Brahmanbaria District, of Bangladesh.

This report is the outcome of untiring efforts of a number of persons, directly and indirectly, involved in this study. I am extremely grateful to Mr. Thomas R. Krift and Mrs. Lisa L. Krift of SC (USA), Dhaka, for their encouragement, and support. I am most indebted to Dr. Afzal Hossain, Program Officer (Health), SC (USA), Dhaka, for his critical views at various stages of the study. I am indebted to Dr. Joe D. Wray for his valuable insights and comments on the draft report. I am grateful to Ms. Ruchira Tabassum, Management Information and Research Coordinator, SC (USA), BFO, Dhaka, for her useful comments and in-depth discussions on the draft report. Also, I gratefully acknowledge the support extended by the TFPO and ATFPO of Nasirnagar Thana, as well as by Mr. Kalimullah, the Impact Area Manager of SC (USA), Nasirnagar.

I am grateful to Mr. M. Rafiq-uz-Zaman, Director General, Directorate of Family Planning, for his valuable assistance at different stages of the study, particularly ensuring the cooperation and support of the district and thana family planning functionaries, which helped considerably in the process of field data collection.

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CONTENTS

LIST OF ABBREVIATIONS
EXECUTIVE SUMMARY
LIST OF TABLES

1. BACKGROUND....1
1.1. Rationale and Limitations of the Study....1
1.2. Objectives of the Study....3
1.3. The Workshop: Participants, Timing, and Contents....4

2. METHODOLOGY....7
2.1. Variables, Sources of Data, and Data Collection Instruments....7
2.2. Sample Size and Selection of Respondents....7

3. SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS....12
3.1. Religion....12
3.2. Age....12
3.3. Age at Marriage....14
3.4. Children: Alive and Dead....15
3.5. Pregnancy Wasted....17
3.6. Education....17
3.7. Land Ownership....17
3.8. Husband's Occupation....19
3.9. Client's Involvement in Income Generation Activities....19
3.10. Involvement in Community Organizations....21

4. KNOWLEDGE AND USE OF FP....22
4.1. Awareness of Modern FP Methods....22
4.2. Knowledge about person(s) Involved in FP Activities....22
4.3. Source(s) and Media of Knowledge....17
4.4. Use of FP Method(s) Before the Current Method....27

5. OUTCOME OF THE WORKSHOP: EFFECT AND PROCESS....30
5.1. Interaction with the Workshop Participants....30
5.2. Information disseminated by the participants and Levels of Satisfaction of the respondents....35
5.3. Workshop Participants' Role in Enhancing FP Acceptance: Gross and Net Effects....38
5.4. Multiplier Effect: Dissemination of Workshop Knowledge by the Clients....41

6. DISCUSSION AND RECOMMENDATIONS....44
6.1. Outcomes of the Workshop and its Replicability....44
6.2. Lessons for the Future....45

Annex A: Questionnaire

EXECUTIVE SUMMARY

1. BACKGROUND

Compared to the contraceptive acceptance rate (CAR) in Brahmanbaria District, the CAR in Nasirnagar Thana of the same district has shown an unprecedented rise during the last one year, with the CAR increasing from 35.4 percent in 1992 to 51 percent in 1993. The estimated growth rate in the CAR in Nasirnagar Thana during 1991-1992 was 8.25 percent, and the corresponding figure for 1992-93 was as high as 44 percent. Assuming the 1991-92 growth rate of CAR in 1992-1993, the 1992-93 CAR would have been 38.3 percent, instead of the actually recorded rate of 51 percent. Thus, assuming the steady-state scenario (i.e., the trend based on the 1991-92 rate), the real increase in the CAR during the last one year was 12.7 percentage points. Obviously, there would be some reasons behind this 12.7 percentage points increase in the CAR during the last one year.

There can be various reasons and factors, which can explain the unprecedented increase in the CAR in Nasirnagar Thana during the last one year. According to an official document, four factors accounted for the above change in the CAR, and these are: (a) intensive field supervision by the district level FP personnel; (b) activating local FP committees by the TFPO; (c) deployment of 7 FWVs in the vacant posts; and (d) raising of FP awareness as a result of the FP workshops conducted in each union by Save The Children (USA) in close collaboration with the local GOB FP personnel.

Since Save The Children (USA) was the initiator and implementor of the fourth factor, it was considered appropriate by Save The Children (USA) to commission a study to help explain the processes and mechanism by which the workshops may have contributed to such an unprecedented increase in contraceptive acceptance in a rural area of Bangladesh. Thus, this study was not planned to identify all the factors as well as the degree of contribution by individual factors; rather, it was planned to explain the contribution of the workshop as a process variable.

An important limitation of any study designed to assess the impact of an intervention such as a workshop is related to the problems of over-estimation or under-estimation of the impact of such an intervention. Such an impact is not easy to be measured for certain reasons such as: (a) the workshop is not the only medium from which the leaders receive information about family planning; (b) the leaders who are really motivated will be promoting the idea of FP for long time in the future, and therefore, the real extent of the impact is not easily discernible at a point in time; and (c) the workshop is not the only activity attributable to family planning performance (the problem of disaggregation of causal values).

2. OBJECTIVES OF THE STUDY

The main objective of this study was to document the impact of the FP workshops conducted with the traditional and religious leaders in Nasirnagar Thana by Save The Children (USA) on contraceptive acceptance in that thana. However, "impact", being the ultimate variable in the outcome continuum, cannot be measured for such a short-run activity as the FP workshop.

The specific objectives of the study were, therefore, to: (a) assess the trend in family planning performance before and after the workshop; (b) assess the effect of the workshop on the use of selected clinical methods of FP, namely, tubectomy, vasectomy, and injectables; and (c) document the process/mechanism by which the workshop has resulted in increased acceptance of the selected clinical FP methods.

3. METHODOLOGY

The methodology, with all its components, was designed in such a way that will satisfy the general as well as the specific objectives of the study.

Data on four broad types of variables were obtained. These include variables related to: (a) socio-economic and demographic characteristics of the sample MWRAs; (b) knowledge, sources of knowledge, and use of FP methods; (c) outcome of the workshop; and (d) changes in the CAR during the pre-and post workshop periods.

Both primary and secondary data collection instruments were used to generate relevant quantitative and qualitative information. Data collection instruments used include questionnaire for the sample MWRAs; FGD guidelines for the sample workshop participants; indepth interviewing checklists for the ATFPO and IAM; and secondary data compilation formats for the MIS Unit, and for the compilation of unionwise list of pre-and post workshop clients of tubectomy, vasectomy, and injectables.

All necessary data related to the variables under all broad groups, except group four, were collected by administering primary data collection instruments. Data related to pre-and-post workshop changes in the CAR, as well as those related to the number of pre-and-post workshop tubectomy, vasectomy, and injectable clients by unions were obtained, using secondary data compilation formats.

Initially, it was thought that in order to ascertain the effect of the workshop the eligible male samples would only be drawn, because most workshop participants were males and they are likely to interact with the males only. However, it was finally decided in the field to take the female samples instead of the initially planned males due to two main reasons: (a) compared to the pre-workshop period, the number of injectable clients (all females) in the post-workshop period increased by 6 times; and (b) in many cases, males were not available at their households, because the data were collected in July, being the lean period for males in Nasirnagar, when many males left for adjacent areas for temporary jobs.

The sample women (pre-and post workshop clients of tubectomy and injectables) were drawn from 11 out of the 13 unions in Nasirnagar. Two unions, namely, Kunda and Gokarna, were excluded, since they comprise the oldest SC program areas. The reference periods for the pre-workshop period were June 1991 to May 1992, and for post-workshop June 1992 to May 1993. The tubectomy, vasectomy, and injectable clients of these periods (pre- or post-workshop) in the 11 sample unions constitute the sample frame for the corresponding period.

The sampling technique used was 'probability proportionate to the size'. Considering the absolute size of the population, a 20 percent sample was drawn

from the pre-workshop sample frame and a 10 percent sample was drawn from the post-workshop sample frame. In drawing the samples, proportionate distributions of the population using permanent methods and injectables were ensured for both the periods (pre-and post-workshop). Also, proportions were considered in drawing samples from the unions.

Since ascertaining the process/mechanism of dissemination of knowledge acquired by the workshop participants was one of the major objectives of the study, it was considered appropriate to conduct focus group discussions (FGDs) with them. Thus, 7 FGDs were conducted:1 each with the FWAs, FPIs, elected chairman/members of the union councils, sarders/matbars, teachers, religious leaders, and village doctors. In each FGD, there were 6-7 participants.

The basic objectives of indepth interviewing were to obtain inferences regarding the mechanisms used by the workshop participants and changes which occurred in the area due to the workshop, as well as to cross-check the views of the GOB and NGO (SC) program managers regarding the possible contribution of the workshops. The ATFPO and the IAM of Save The Children were interviewed a number of times for the purpose.

4. FINDINGS AND IMPLICATIONS

4.1. Outcomes of the Workshop and its Replicability

The workshop has a positive net effect on the post-workshop contraceptive acceptance rate in Nasirnagar Thana of Brahmanbaria District. The positive effect is reflected from the extent of the workshop participants' involvement in the clients' decision-making process regarding acceptance of FP methods (mainly clinical methods). The gross effect of the workshop is discernible from the fact that 86 percent of the post-workshop clients, 81 percent of the post-workshop tubectomy clients, and 87 percent of the post-workshop injectable clients categorically stated that the "workshop participants" have "contributed most" in their decision-making process regarding acceptance of their current FP method. The positive contribution of the workshop, measured in terms of the net effect, which is a better indicator of the outcome of the workshop, is unquestionable. The overall contribution of the workshop in terms of the net-effect was 28.4 percent, being 13.9 percent for the increased use of tubectomy and 40.4 percent for the increased use of injectables. That is, out of the 12.7 percentage points increase in the CAR (actual CAR minus CAR due to steady-state situation), 3.61 percentage points was due to the net-effect of the workshop.

Besides the 'net effect' mentioned, there were other effects of the workshop (e.g., multiplier-effect, integrational effect, facilitating effect, 'kick-bag' effect, etc.). The multiplier effect has a long-term value. The immediate multiplier effect is discernible from the fact that about 86 percent of the post-workshop clients and about 70 percent of the pre-workshop clients who got FP knowledge from the workshop participants have subsequently disseminated the information to others (neighbors, friends, relatives). This effect is likely to continue for a quite long time, and according to the rule of interpersonal communication the effect will multiply.

The integrational effect has two aspects. First, the design of the workshop was collaborative in nature, with the GOB and the NGO participating in the selection

process of both the trainers and trainees, i.e., the selection process effort was a joint effort. Second, the selection of the workshop participants was done, using a "bottom-up" approach which ultimately added a significant component of the "community influentials". Thus, the integrational effect was instrumental in overcoming the factors responsible for lack of coordination among the various important actors who can promote FP in rural areas.

The **facilitating effect** of the workshop is multidimensional. First, the inclusion of the 'conservative' community influentials as workshop participants helped overcome their antagonistism after attending the workshop. After the workshop, these 'gatekeepers' opened their gates to the FP fieldworkers. As a result, the workers got supporters, the would-be users got workers, the FP movement got momentum, culminating into an unprecedented rise in the CAR. An indication of the impact of this factor is discernible from the fact that the Muslims constitute a much higher proportion of the post-workshop clients compared to the pre-workshop clients. Second, according to the GOB directives, the elected community leaders (chairmen/members of Union Councils) are supposed to work for family planning, and they are members of the local FP committees. These elected members, who participated in the workshop, reportedly took more active interest in the work of the family planning workers in their area during the post-workshop period. Third, FP is a sensitive topic and in the context of rural Bangladesh it is not an usual practice that the older community influentials discuss this topic with the younger members of the community. However, the workshop was able to break this norm to some extent, as reported by many of the participants who said that after the workshop the older community leaders discuss the topic with the younger members of the community. An indication of this can be found in the fact that while 21 percent of the pre-workshop tubectomy clients were in the age group of 20-29 years, it was about 39 percent in the case of the post-workshop tubectomy clients. Fourth, it is also not an usual practice that the male community leaders in rural Bangladesh discuss FP with the females. However, such male-female interactions were also reported by many respondents (females) as well as by some of the male workshop participants.

The **'kick-bag' effect**, though marginal in value, should be treated as an important outcome of the workshop. This effect goes beyond the target territory (in this case, Nasirnagar). For example, a participant travelling by train/bus enters into an interpersonal communication on FP with a co-passenger, and soon afterwards the "interpersonal communication" on FP turns into a lively "group discussion".

Thus, the FP workshop, as designed and implemented in Nasirnagar Thana by the SC, can be treated as a replicable means of increasing the contraceptive acceptance beyond the steady-state increase in other parts of rural Bangladesh.

4.2. Lessons for the Future

Since about 29 percent of the increased CAR during the post-workshop period was due to the 'net-effect' of the workshop, the remaining 81 percent was due to factors other than the workshop. These factors include, among others, the deployment of seven FWVs, increased activity of the local FP committees, increased supervision by the district level personnel, better supply situation, etc. However, due to the limitations of this study, the relative shares of these contributing factors could not be ascertained. **Thus, to be able to identify all the factors responsible for the increased CAR as well as to determine their relative shares, a**

more elaborate study should be undertaken. If the SC replicates this type of workshops in the future, there should be ample scopes for more indepth studies, incorporating all possible variables and indicators so that the relative contributions of all possible factors can be identified. In that respect, implementation of such workshop should be planned from the perspectives of Operations Research.

A well designed workshop is always characterized by certain essential components, namely, the selection f participants and trainers, timing, placement, contents, follow-up mechanisms, etc. All these components should be designed in accordance with the "main objective" of the workshop. The quantitative and qualitative aspects pertaining to the impact of the workshop analyzed in this study show that the workshop was not adequately designed, especially with respect to the "follow-up mechanisms". In reality, the participants were given an assignment to direct their motivational efforts, especially toward those families which have five or six children, and the participants were also requested to motivate at least ten would-be users from each village. However, there was no built-in mechanism to ascertain the extent to which these assignments and requests were carried out by the participants. Also, it was reported by the participants, as well as by the ATFPO, that the workshop was treated as a 'one short' action. Thus, while planning for such workshops in the future, objective follow-up plans as well as follow-up mechanisms should be built-in components of the overall workshop plan.

It was reported by the workshop participants themselves as well as by some of the sample clients that there were some participants who were less motivated and less convinced about FP compared to the others. These 'hard core' participants should not be ignored, because if after participating at the workshop someone does not contribute to the FP motivational work in the community, the resources directed toward that participant should be considered as "wastage". Thus, to minimize waste of workshop resources in the future, this category of participants should be identified first, and then, re-motivated as a special target group.

FP is a dynamic subject-matter. Also, it should not be expected that the community influentials will know everything about FP by attending a two-day workshop. Thus, to maximize the information base of the community influentials, there should be provisions for refresher-workshops/follow-up workshops. Such workshops should deal with the issues identified by the previous-participants as problems faced by them in motivating the target groups.

Since the workshop has a positive effect on the acceptance of FP and since one of the ways of interaction was "client visiting participant's home", the participants can be considered as an "information distribution point". The effectiveness of this information distribution point would depend largely on the efficiency of the information disseminator. Thus, to be able to raise the effectiveness of the information dissemination points, the satisfied clients, among others, should be considered while selecting the workshops participants.

LIST OF TABLES

TABLE 1.1: CONTRACEPTIVE ACCEPTANCE RATES IN BRAHMANBARIA DISTRICT AND IN NASIRNAGAR THANA: 1991-1993.....1

TABLE 1.2: DISTRIBUTION OF THE WORKSHOP PARTICIPANTS BY CATEGORIES.....6

TABLE 2.1: VARIABLES AND INDICATORS BY DATA SOURCE(S) AND DATA COLLECTION INSTRUMENT(S).....8

TABLE 2.2: SAMPLE SIZE OF PRE- AND POST-WORKSHOP CLIENTS OF STERILIZATION AND INJECTABLES.....11

TABLE 3.1: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY RELIGION...13

TABLE 3.2: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY THEIR AGE AND AGE OF THEIR HUSBANDS.....13

TABLE 3.3: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY THEIR AGE AT MARRIAGE.....14

TABLE 3.4: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY LIVING SONS, AND BY MEAN NUMBERS OF LIVING CHILDREN BY GENDER.....15

TABLE 3.5: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY THE AGE OF THEIR YOUNGEST LIVING CHILD.....16

TABLE 3.6: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY NUMBER OF CHILDREN DIED.....16

TABLE 3.7: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY PREGNANCY WASTED.....17

TABLE 3.8: PERCENTAGE DISTRIBUTION OF RESPONDENTS AND THEIR HUSBANDS BY LEVELS OF EDUCATION.....18

TABLE 3.9: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY HOUSEHOLD LANDOWNERSHIP.....19

TABLE 3.10: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY THEIR HUSBAND'S PRIMARY OCCUPATION.....20

TABLE 3.11: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY THEIR INVOLVEMENT IN INCOME GENERATION ACTIVITIES (OTHER THAN NORMAL HOUSEHOLD WORK).....20

TABLE 3.12: PERCENTAGE DISTRIBUTION OF RESPONDENTS AND THEIR HUSBANDS BY MEMBERSHIP IN ANY COMMUNITY ORGANIZATIONS.....21

TABLE 4.1: PERCENTAGE DISTRIBUTION OF RESPONDENTS HAVING AWARENESS OF SPECIFIC MODERN FP METHOD.....23

TABLE 4.2: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY THEIR OPINION ABOUT WHO AMONG VARIOUS CATEGORIES OF PERSONS ARE INVOLVED IN FP IN THE LOCALITY.....24

TABLE 4.3: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY SOURCE(S) FROM WHERE THEY FIRST LEARN ABOUT FP METHOD CURRENTLY USING.....25

TABLE 4.4: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY WHETHER THEY KNOW ANY COMMUNITY LEADERS WHO IS INVOLVED IN FP ACTIVITIES OF THE LOCALITY.....26

TABLE 4.5: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY EVER USE OF ANY MODERN FP METHOD BEFORE THE CURRENT METHOD (STERILIZATION OR INJECTABLE), AND THE NUMBER(S) OF MODERN METHODS EVER USED (EXCLUDING THE CURRENT METHOD).....28

TABLE 4.6: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY USE OF SPECIFIC FP METHODS BEFORE THE CURRENT METHOD (STERILIZATION OR INJECTABLES).....29

TABLE 5.1: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY WHETHER HAD FP-RELATED DISCUSSIONS WITH THE WORKSHOP PARTICIPANTS DURING THE LAST ONE YEAR.....31

TABLE 5.2: PERCENTAGE DISTRIBUTION OF RESPONDENTS WHO HAD FP DISCUSSIONS WITH THE WORKSHOP PARTICIPANTS DURING THE LAST ONE YEAR BY NUMBER OF PARTICIPANTS WITH WHOM SUCH DISCUSSIONS WERE HELD.....32

TABLE 5.3: PERCENTAGE DISTRIBUTION OF RESPONDENTS WHO MENTIONED HAVING STERILIZATION/INJECTABLE RELATED DISCUSSIONS WITH THE WORKSHOP PARTICIPANTS DURING THE LAST ONE YEAR BY TYPES OF PARTICIPANTS.....33

TABLE 5.4: PERCENTAGE DISTRIBUTION OF RESPONDENTS WHO MENTIONED INTERACTIONS WITH THE WORKSHOP PARTICIPANTS BY THEIR OPINION ABOUT WHO WAS THE MOST ACTIVE PERSON IN TERMS OF DISSEMINATION OF KNOWLEDGE ABOUT FP.....34

TABLE 5.5: MEAN NUMBER(S) OF FP-RELATED INTERACTIONS/MEETINGS OF THE RESPONDENTS WITH THE WORKSHOP PARTICIPANTS DURING THE POST-WORKSHOP PERIOD (LAST OF YEAR) BY NATURE OF SUCH MEETINGS.....36

TABLE 5.6: PERCENTAGE DISTRIBUTION OF RESPONDENTS HAVING INTERACTIONS WITH THE WORKSHOP PARTICIPANTS BY TYPES OF INFORMATION ABOUT STERILIZATION AND INJECTABLES GIVEN TO THE RESPONDENTS BY THE PARTICIPANTS.....37

TABLE 5.7: PERCENTAGE DISTRIBUTION OF RESPONDENTS HAVING FP-RELATED DISCUSSIONS WITH THE WORKSHOP PARTICIPANTS BY REPORTED LEVELS OF SATISFACTION WITH THE VOLUME OF SUCH INFORMATION.....38

TABLE 5.8: PERCENTAGE DISTRIBUTION OF RESPONDENTS ACCORDING TO THEIR OPINION ABOUT WHO HELPED THEM IN THEIR DECISION MAKING REGARDING ACCEPTANCE OF THE CURRENT METHOD.....40

TABLE 5.9: PERCENTAGE DISTRIBUTION OF RESPONDENTS ACCORDING TO THEIR OPINION ABOUT THE TYPE OF THE PERSON WHO CONTRIBUTED MOST IN THEIR DECISION MAKING REGARDING ACCEPTANCE OF THE CURRENT FP METHOD.....40

TABLE 5.10: PERCENTAGE DISTRIBUTION OF RESPONDENTS WHO HAD DISCUSSION WITH WORKSHOP PARTICIPANTS BY WHETHER DISSEMINATED FP INFORMATION TO OTHERS.....42

TABLE 5.11: PERCENTAGE DISTRIBUTION OF RESPONDENTS WHO HAVE DISSEMINATED KNOWLEDGE ABOUT STERILIZATION/ INJECTABLE BY WHO DID THEY DISSEMINATE AND WHAT MESSAGE DID THEY CONVEYED TO THEM.....43

FIGURE

FIGURE 1.1: PRE AND POST-WORKSHOP CHANGES IN CONTRACEPTIVE ACCEPTANCE RATE IN NASIRNAGAR: STEADY-STATE AND ACTUAL.....2

FIGURE 1.2: MODEL SHOWING EXPECTED OUTCOME OF A FP WORKSHOP ALONG THE STAGES OF OUTCOME CONTINUUM.....3

FIGURE 1.3: LOGICAL RELATIONSHIPS OF THE SUBJECT MATTERS PRESENTED AT THE WORKSHOPS.....5

FIGURE 5.1: GROSS AND NET CONTRIBUTION OF THE WORKSHOP IN THE INCREASED CAR OF NASIRNAGAR THANA DURING THE LAST YEAR.....41

LIST OF ABBREVIATIONS

ATFPO	: Assistant Thana Family Planning Officer
CAR	: Contraceptive Acceptance Rate
CDC	: Community Development Coordinator
CPR	: Contraceptive Prevalence Rate
DDFP	: Deputy Director, Family Planning
DFP	: Directorate of Family Planning
ELCO	: Eligible Couple
FGD	: Focus Group Discussion
FP	: Family Planning
FPAB	: Family Planning Association of Bangladesh
FPI	: Family Planning Inspector
FWA	: Family Welfare Assistant
FWC	: Family Welfare Centre
FWV	: Family Welfare Visitor
GOB	: Government of Bangladesh
IAM	: Impact Area Manager
IEC	: Information Education Communication
TNO	: Thana Nirbahi Officer
IUD	: Intra Uterine Device
MIS	: Management Information System
MR	: Menstrual Regulation
MWRA	: Married Women of Reproductive Age
NGO	: Non-government Organization
SAVE	: Save the Children (USA)
SC	: Save the Children(USA)
SD	: Standard Deviation
TFPO	: Thana Family Planning Officer
TV	: Television
UC	: Union Council
UP	: Union Parishad
URC(B)	: University Research Corporation (Bangladesh)
VDP	: Village Development Party

1. BACKGROUND

1.1. Rationale and Limitations of the Study

Compared to the contraceptive acceptance rate (CAR) in Brahmanbaria District, the CAR in Nasirnagar Thana of the same district has shown a dramatic rise during the last one year (Table 1.1).

In Nasirnagar Thana, the CAR has increased from 35.4 percent in 1992 to 51 percent in 1993, i.e., an unprecedented increase of 15.6 percentage points within a period of one year. During 1991-1992, the estimated growth rate in the CAR in Nasirnagar was 8.25 percent, and the corresponding figure for 1992-93 was as high as 44 percent. Assuming the 1991-92 growth rate of CAR in 1992-1993, the CAR in 1992-93 would have been 38.3 percent, instead of the actually achievement rate of 51 percent. Thus, assuming the steady-state scenario (i.e., the trend using the 1991-92 rate) the real increase in the CAR during the last one year was 12.7 percentage points (Figure 1.1). Obviously, there would be some reasons behind this 12.7 percentage points increase in the CAR during the last one year.

TABLE 1.1: CONTRACEPTIVE ACCEPTANCE RATES IN BRAHMANBARIA DISTRICT AND IN NASIRNAGAR THANA: 1991-1993

District/Thana	1991	1992	1993	Growth rate between (1992-1993) (%)
Brahmanbaria District Nasirnagar Thana	39.4 32.7	43.0 35.4	51.2 51.0	19.6 44.1
Nasirnagar Thana as % of Brahmanbaria District	83.0	82.3	99.6	-

Source: Estimated by the authors, based on information obtained from MIS Unit, Directorate of Family Planning, Dhaka.

Theoretically, there can be multidimensional reasons and factors which can explain the high increase in the contraceptive use rates in Nasirnagar Thana during the last one year. According to a letter of DDFP, Brahmanbaria to the Directorate of Family Planning, four factors have been identified as reasons for the above changes in CAR (see: DDFP, Brahmanbaria, 16.5.93). Those factors are:

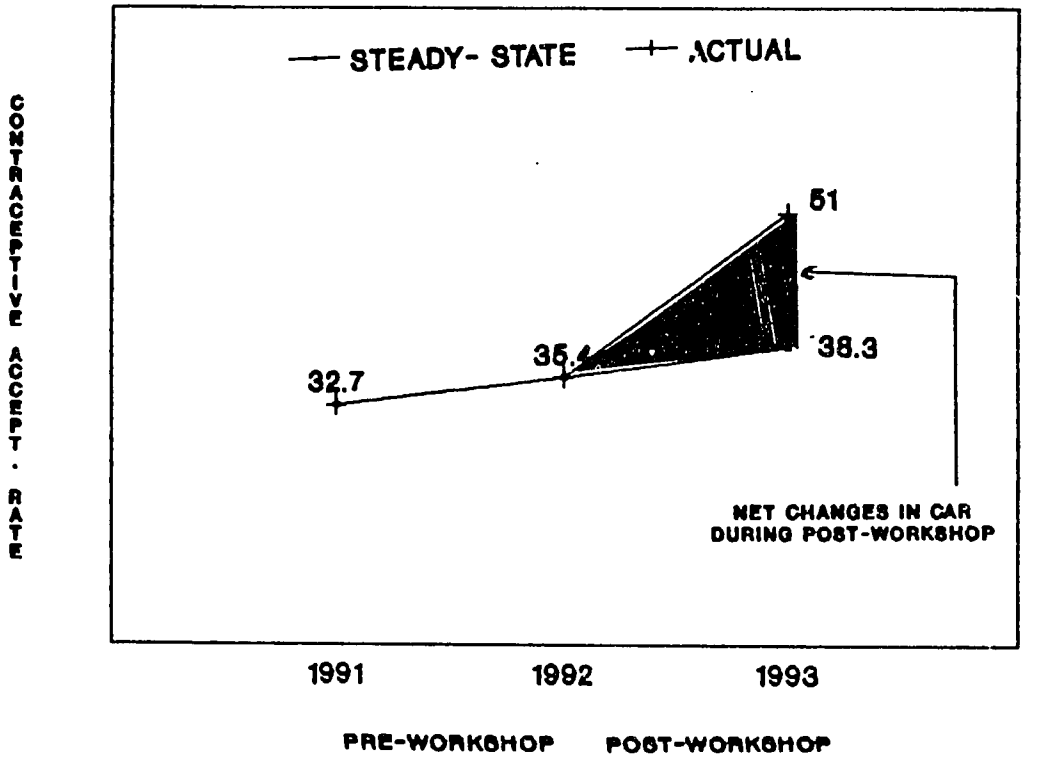
(a) intensive field supervision by the district level FP personnel,

(b) activating local FP committees by the TFPO,

(c) deployment of 7 FWVs in the vacant posts, and

(d) raising of FP awareness as a result of the FP workshops conducted in each union by the Save The Children (USA).

FIGURE 1.1: PRE AND POST-WORKSHOP CHANGES IN CONTRACEPTIVE ACCEPTANCE RATE IN NASIRNAGAR : STEADY-STATE AND ACTUAL



Note : Authors estimates based on information in Table 1.1. Net changes in CAR =(ACTUAL - STEADY STATE) CAR.

Since Save The Children (USA) * was the initiator and implementor of the fourth factor (mentioned in the DDFP's letter referred to above), it was considered appropriate by the SC to undertake a study, which would explain the processes and mechanism as to how the workshops contributed to such an unprecedented change in contraceptive acceptance in a rural area of Bangladesh. Thus, this study was not planned to identify all the factors as well as the degree of contribution by individual factors; rather, it was planned to explain the contribution of the workshop conducted by the SC viewed as a process variable.

*. *Henceforth, Save The Children (USA) will be abbreviated as SC.*

Another important limitation of any study designed to assess the impact of such an intervention as a workshop is related to the inherent possibilities of over-estimation or under-estimation of the impact of such an intervention. Such an impact is not easy to be measured for certain reasons:

(a) workshop is not the only medium from which the leaders receive information about family planning;

(b) leaders who are really motivated will be promoting the idea of FP for long time in the future, and therefore, the real extent of the impact is not easily discernible at a point in time; and

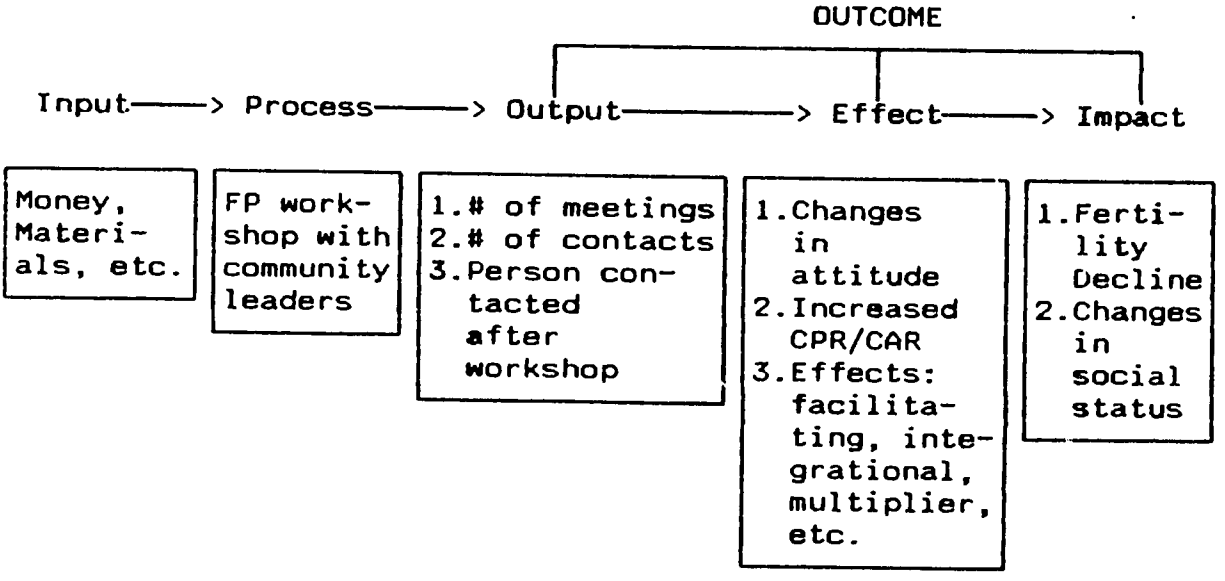
(c) workshop is not the only activity attributable to family planning performance (the problem of disaggregation of causal values).

1.2. Objectives of the Study

The main objective of this study was to document the impact of the workshop on family planning conducted with the traditional and religious leaders in Nasirnagar Thana by the SC on contraceptive acceptance in that thana.

It should be noted that "impact", being the ultimate variable in the outcome continuum, cannot be measured for such a short-run activity as the FP workshop with the traditional and religious leaders. As shown in Figure 1.2, "effect" should be the maximum level for which outcome of the workshop can be measured.

FIGURE 1.2: MODEL SHOWING EXPECTED OUTCOME OF A FP WORKSHOP ALONG THE STAGES OF OUTCOME CONTINUUM



The specific objectives of the proposed study were therefore to:

(a) assess the trend of family planning performance before and after the workshop;

(b) assess the effect of the workshop on the use of selected clinical methods of FP, namely, tubectomy, vasectomy, and injectables; and

(c) document the process/mechanism by which the workshop has resulted in the increased use of the selected clinical methods of FP.

1.3. The Workshop: Participants, Timing, and Contents

During 1992-1993, the SC conducted workshops on "Family Planning from the view points of religion, economy, and health" in 23 batches, 1 batch each in each of the 3 unions and 2 batches each in rest of the 10 unions under Nasirnagar Thana. Each workshop continued for 2 days.

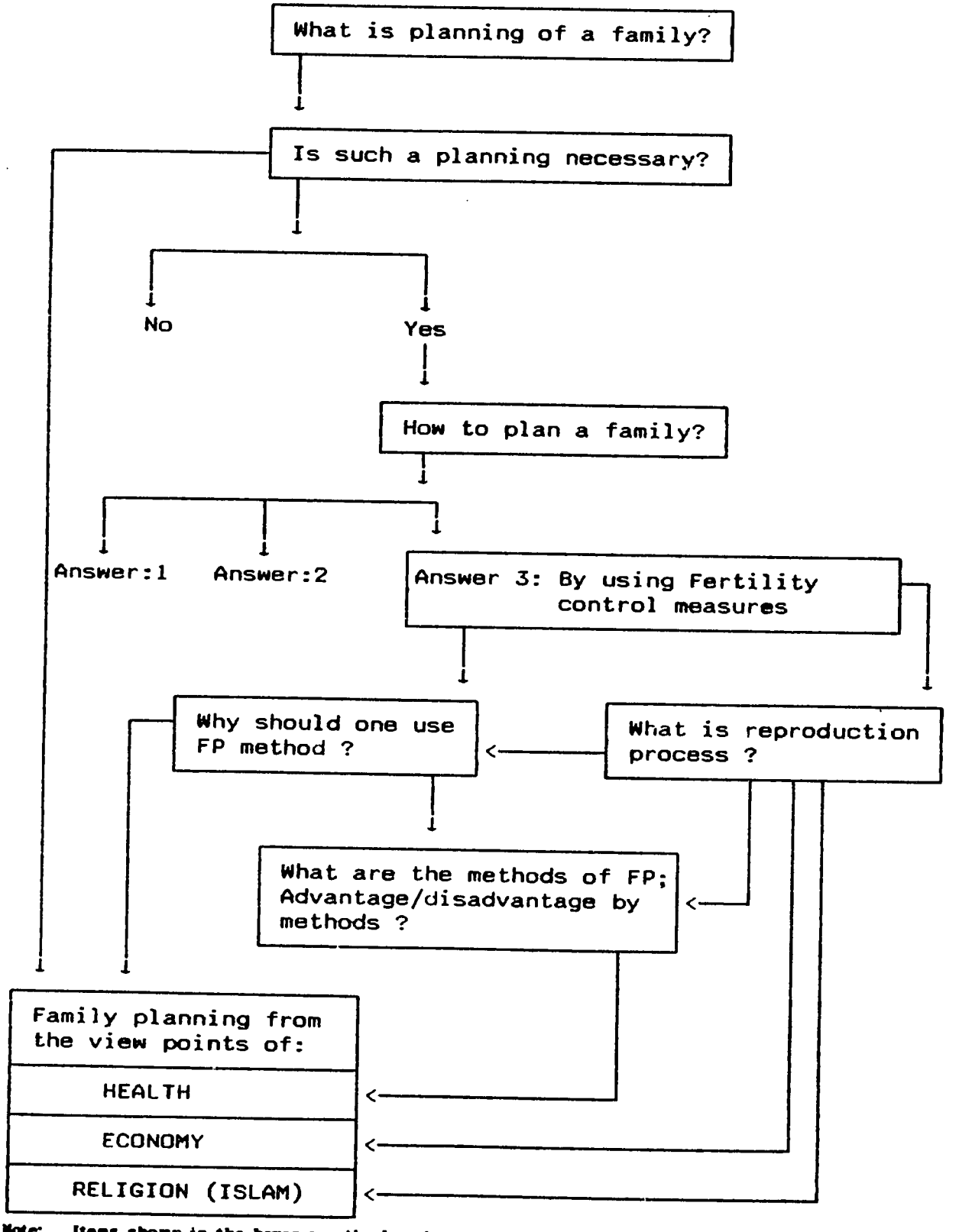
The subject matters discussed in the workshops were carefully thought out. The basic aim was to conscientize the participants regarding the fundamental issues of population growth and family planning. The subjects were designed in such a way, that after returning from the workshops the participants could contribute to the FP program as IEC actors. The logical chain of the discussion materials presented in the workshop is shown in Figure 1.3.

In total, 725 persons participated in the workshops. The profile of the participants by types of community influentials, shown in Table 1.2, is indicative of the fact that careful thoughts have been given in selecting them. More than 90 percent of the participants were drawn from those who are not family planning workers. The majority of the participants comprise those community influentials, who enjoy prestige and power and have potential roles in moulding opinion in the community.

The "bottom-up" approach in the selection of the workshop participants should be treated as one of the major distinctive features of the overall design of the workshop. The family planning grass-root workers were asked to prepare a list of would-be participants. In preparing the lists of the participants, the fieldworkers gave considerations to the following: those who matter in the decision-making at locality level (example 'para' level); among them those who are antagonistic toward family planning (examples, some of the non-elected/elected leaders, religious leaders, etc); and those who can promote family planning, etc. Thus, the underlying idea was to neutralize those who are antagonistic to the idea of family planning, activate those who are neutral toward family planning, and boost up those who do some IEC activities on family planning.

Another strong aspect of the design of the workshop was related to the selection of the workshop trainers/discussants. In this regard, local resources of the Government and the NGOs were maximally utilized. This integration of GOB and NGO personnel has generated a sense of ownership, and increased the credibility of the workshop. Among the trainers, the prominents included the Thana Nirbahi Officer, the GOB Medical Officers (Health and FP personnel), the GOB family planning personnel at the thana level (TFPO, FPI), Community Development Coordinators, and IAM of SC, and a trainer of FPAB (an expert on religion).

FIGURE 1.3: LOGICAL RELATIONSHIPS OF THE SUBJECT MATTERS PRESENTED AT THE WORKSHOPS



Note: Items shown in the boxes are the broad areas of subject matters discussed in the workshops.

TABLE 1.2: DISTRIBUTION OF THE WORKSHOP PARTICIPANTS BY CATEGORIES

Categories of community influentials/leaders	Distribution	
	Number	% of total
1. Elected leader: Chairman/Member of Union Council	170	23.4
2. Non-elected leader:Matbar/Sardar	188	25.9
3. Religious leader: Imam	32	4.4
4. Farmers	78	10.8
5. Social Worker	47	6.5
6. Service Holder	41	5.7
7. Teacher	30	4.1
8. Family Planning workers	69	9.5
9. Village Doctor	45	6.2
10. Others*	25	3.4
TOTAL	725	100

Source: Estimates, based on information provided by the Impact Area Manager, SC, Brahmanbaria.

* *Others include: VDP/Ansar, Student, etc.*

2. METHODOLOGY

The methodology, with all its components, was designed in such a way which will satisfy the general as well as the specific objectives of the study.

2.1. Variables, Sources of Data, and Data Collection Instruments

Data on four broad type of variables were obtained. These include variables related to:

(i) socio-economic and demographic characteristics of the sample MWRAs;

(ii) knowledge, sources of knowledge, and use of FP methods of the sample MWRAs';

(iii) outcome of the workshop; and

(iv) changes in the CAR in Nasirnagar Thana during the pre-and post workshop periods.

The detail breakdown of the above four groups of variables by indicators, sources of data, and instruments used for data collection, is shown in Table 2.1. As can be seen from Table 2.1, both primary and secondary data collection instruments were used to generate relevant quantitative and qualitative information. Data collection instruments used include: questionnaire for the sample MWRAs; FGD guidelines for the sample workshop participants; indepth interviewing checklists for the ATFPO and IAM; and secondary data compilation formats for the MIS Unit, and for the compilation of unionwise list of pre-and post workshop clients of tubectomy, vasectomy, and injectables.

2.2. Sample Size and Selection of Respondents

All necessary data related to the variables under all broad groups, except group four, were collected by administering primary data collection instruments (Questionnaire is presented in Annex A)). Data related to pre-and-post workshop changes in the CAR. as well as those related to the number of pre-and-post workshop tubectomy, vasectomy, and injectable clients by unions were obtained, using secondary data compilation formats.

Pre-and-post workshop user sample:

Initially, it was thought that in order to ascertain the effect of the workshop the eligible male samples (irrespective of tubectomy or vasectomy clients) only would be drawn, using the sample frame comprising pre-and-post workshop sterilized clients (see: URC,B, proposal, 1993, p.3). This was planned, because most workshop participants are males and they are likely to interact with the males only. However, in the actual field it was decided to take the female samples instead of the initially planned males. The decision was taken due to two main reasons:

TABLE 2.1: VARIABLES AND INDICATORS BY DATA SOURCE(S) AND DATA COLLECTION INSTRUMENT(S)

Variable(s) and Indicator(s)	Data Source(s)	Data Collection Instrument(s)
1. SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS	MWRA	Questionnaire
1.1. Age (wife, husband)		
1.2. Age at marriage		
1.3. Religion		
1.4. Living children		
1.5. Pregnancy wasted		
1.6. Education (wife husband)		
1.7. Land ownership		
1.8. Husbands' primary occupation		
1.9. Respondents' involvement in income-generation activities		
1.10. Membership in community organization (wife, husband)		
2. KNOWLEDGE, SOURCES OF KNOWLEDGE AND USE OF FP METHODS	MWRA	Questionnaire
2.1. Current knowledge about FP methods		
2.2. Knowledge about FP methods before acceptance of the current method		
2.3. Source(s) of knowledge about the current method		

contd...

Table 2.1: (contd.)

Variable(s) and Indicator(s)	Data Source(s)	Data Collection Instrument(s)
2.4. Knowledge about persons involved in FP activities		
2.5. Knowledge about the community leaders involved in FP activities		
2.6. Knowledge about the participants of the workshop		
2.7. FP method(s) used before the current method		
3. OUTCOME OF THE WORKSHOP		
3.1. Frequency of interaction with the workshop participants	MWRA, Workshop participants	Questionnaire, FGD guidelines
3.2. Places and nature of such interactions	MWRA, Workshop participants	Questionnaire, FGD guidelines
3.3. Messages disseminated by the participants	MWRA, Workshop participants	Questionnaire, FGD, guidelines
3.4. Proportion of the workshop participants who are most active in FP information dissemination	MWRA	Questionnaire
3.5. Process and mechanisms of dissemination of FP knowledge by the participants of the workshop	MWRA, Workshop participant, TFPO, IAM	Questionnaire, FGD guidelines, Indepth interviewing checklist

contd...

Table 2.1: (contd.)

Variable(s) and Indicator(s)	Data Source(s)	Data Collection Instrument(s)
3.6. Decision making process of the current users: role of the workshop participants	MWRA	Questionnaire
3.7. Dissemination of information about FP gathered from the workshop participants by the respondents (Multiplier effect)	MWRA, Workshop participants, ATFPO, IAM	Questionnaire, FGD guidelines, Indepth interviewing checklist
3.8. Design of the workshop	MWRA	Questionnaire
4. CHANGES IN THE CONTRACEPTIVE ACCEPTANCE RATE DURING THE LAST THREE YEARS IN NASIRNAGAR THANA. PRE-POST-WORKSHOP CAR.	Workshop participants, ATFPO, IAM, ATFPO, MIS unit/DFP	FGD guidelines, Indepth interviewing checklists, indepth interviewing, secondary data compilation format

Note: "MWRA" refers to the sample MWRAs (pre-and-post workshop tubectomy and injectable clients). 'Workshop participants' refers to those who have participated in the FGDs.

(a) compared to the pre-workshop period, the number of injectable clients (all females) in the post-workshop period increased dramatically by 6 times, 2,253 during the post-workshop period and 377 during the pre-workshop period. During these two periods, the number of clients who had undergone sterilization were 331 and 252, respectively. This information became available from TFPO, Nasirnagar immediately before starting data collection. Thus, in consultation with the SC (USA) designated personnel for the study, it was decided to include the injectable clients in addition to the sterilized clients in the sample.

(b) in many cases, males were not available at their households, because the time for data collection (the month of July, which is part of the rainy season) coincided with lean period for males in Nasirnagar, thus, forcing many males to leave for adjacent areas (examples tea gardens at Sylhet, fishing at the haors, etc.) for temporary jobs.

The sample women (pre-and post workshop clients of tubectomy and injectables) were drawn from 11 out of the 13 unions in Nasirnagar. Two unions, namely, Kunda and Gokarna, were excluded, since they comprise the oldest SC program areas. A point to note is that the reference periods for the pre-workshop period were June 1991 to May 1992 and for post-workshop June 1992 to May 1993. The

tubectomy, vasectomy, and injectable clients of these periods (pre or post workshop) in the 11 sample unions constitute the sample frame for the corresponding period. Relevant information for the sample frame were collected by the URC(B) Field Investigators from the TFPO office and the FWCs in the corresponding unions.

The sampling technique used was 'probability proportionate to the size'. Considering the absolute size of the population, a 20 percent sample were drawn from the pre-workshop sample frame and a 10 percent sample was drawn from the post-workshop sample frame. In drawing the samples, proportionate distribution of the population using permanent methods and injectables was ensured for both the periods (pre-and post-workshop). Also, proportions were considered in drawing samples from the unions. The pre-and post-workshop clients' samples are presented in Table 2.2.

Samples for Focus Group Discussions

Since ascertaining the process/mechanism of dissemination of knowledge acquired by the workshop participants was one of the major objectives of the study and since those participants are 725 in numbers, Focus Group Discussions (FGDs) were conducted. In order to obtain qualitative information, 7 FGDs were conducted-1 with the FWAs, 1 with the FPIs, and 5 with such categories of the workshop participants as elected chairman/members of the union councils, sarder/matbars, teachers, religious leaders, and village doctors. In each FGDs, there were 6-7 participants.

Samples for Indepth Interviews

The basic objective of indepth interviewing were to obtain inferences regarding the mechanisms used by the workshop participants, changes which occurred in the area due to the workshop, and to cross-check views of the GOB and NGO (SC) program managers regarding the possible contribution of the workshop, etc. Thus, in doing so, the AFTFPO (because TFPO was not in place during the time of data collection) and the IAM of SC were interviewed multiple times.

TABLE 2.2: SAMPLE SIZE OF PRE- AND POST-WORKSHOP CLIENTS OF STERILIZATION AND INJECTABLES

Periods	Tubectomy/ Vasectomy	Injectables	Total
Pre-workshop	51	43	94
Post-workshop	36	168	204

3. SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS

This section presents socio-economic and demographic characteristics of the pre- and post-workshop clients (users of permanent methods and injectables) residing in the sample unions of Nasirnagar thana. The socio-economic characteristics discussed are: religion, educational attainment (both the respondent and her husband), land ownership, occupation, involvement in income generation activities, and membership in community organizations. Demographic indicators discussed include: age (both of the respondent and her husband), age at marriage, number of living children and children who died (by gender), and status of pregnancy wasted. These variables were considered in the study, because it is likely that these are the important independent variables which affect decisions regarding the use/non-use of clinical methods (permanent or temporary) of contraception.

3.1. Religion

Both in the pre-and post-workshop periods, the predominant proportion of the clients were Muslims. However, as shown in Table 3.1, the Muslims constituted a much higher proportion in the post-workshop sample (82%) than in the pre-workshop sample (73%), and the major changes were attributable to the injectable clients (not to the tubectomy clients). It is difficult to ascertain whether the post-workshop increase in the relative share of the Muslims among the clients was due to the workshops or not. However, the changes in the religious composition of the clients indicates the presence of relatively stronger IEC during the post-workshop period than before the workshop. This can be substantiated by the fact that the workshop was, to a great extent, successful in neutralizing those religious leaders who were antagonistic to FP, as one of the participant religious leaders said "Allah has created soul (Ruh) once and for all. Therefore, one cannot destroy what is destined to come. Hence, it cannot be said that family planning is capable of destroying souls or Ruhs created by the Almighty. Thus, it can't be said that family planning is against the will of Allah". Another imam-participant of the FGDs said "since there are references in the Holy Quran about 'Zahadul Bala' and since 'Azal' was practised in the days of the Prophet Mohammad, the concept of family planning should not be treated as anti-islamic".

3.2. Age

The distribution of the respondents and their husbands by age is presented in Table 3.2. A declining trend has been observed in the post-workshop respondents than the pre-workshop. The mean age of the post-workshop clients (29 years) was about 2 years less than the pre-workshop clients, (31 years), and this was also true of their husbands (post-workshop 38 years and pre-workshop 40 years). An important finding to note is that while about 22 percent of the tubectomy clients during the pre-workshop period was in the age group of 20-29 years, it was about 39 percent during the post-workshop period.

TABLE 3.1: PERCENTAGE DISTRIBUTION OF RESPONDENTS* BY RELIGION

Religion	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
Islam	68.6	79.1	73.4	69.4	84.5	81.9
Hinduism	31.4	20.9	26.6	30.6	15.5	18.1
Total	100	100	100	100	100	100
N	51	43	94	36	168	204

* *Respondents included users of injectables and tubectomy during the pre-and post-workshop periods. In the post-workshop sample, there was only one vasectomy case which was included throughout the report as the post-workshop tubectomy sample.*

TABLE 3.2: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY THEIR AGE AND AGE OF THEIR HUSBANDS

Age (in years)	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
RESPONDENT(WIFE)						
<20	-	2.3	1.1	-	1.2	1.0
20-29	21.6	48.8	34.0	38.8	50.0	48.0
30-39	68.6	44.2	57.5	55.6	45.2	47.1
40-49	9.8	4.7	7.4	5.6	3.6	3.9
Total	100	100	100	100	100	100
Mean	32.3	29.4	31.0	30.4	28.9	29.2
SD	4.6	5.6	5.2	4.5	5.2	5.1
HUSBAND						
<20	-	-	-	-	-	-
20-29	2.0	7.0	4.3	5.6	8.3	7.8
30-39	35.3	53.5	43.6	44.4	52.4	51.0
40-49	52.9	37.2	45.7	41.7	29.8	31.9
50+	9.8	2.3	6.4	8.3	9.5	9.3
Total	100	100	100	100	100	100
Mean	41.1	37.9	39.6	39.5	37.6	37.9
SD	6.5	6.5	6.7	7.7	7.2	7.3
N	51	43	94	36	168	204

Thus, during the post-workshop period, more emphasis was given on acceptance of permanent clinical methods among clients in the lower age group. It is difficult to quantify the extent to which the workshop participants gave emphasis on the lower age groups while disseminating their FP knowledge. However, in a FGD with the community influentials, some said "we discuss FP not only with the people of our age group, but also with those who are younger. We feel that preaching and practising of FP should be a joint responsibility of all to us".

3.3. Age at Marriage

The mean age at marriage of the pre-workshop respondents (16) was 2 years higher than that of the post-workshop respondents (14 years) (Table 3.3). Thus, the post-workshop clients married earlier than the pre-workshop clients. However, the correct interpretation of the data on age at marriage would be that the post-workshop program efforts in Nasirnagar thana has gave more emphasis on the promotion of tubectomy and injectables than in the pre-workshop period. This is also evident from the fact that while the proportion married before the age of 11 years was 9.8 percent among the pre-workshop tubectomy clients it was 33.2 percent for the post-workshop tubectomy clients (Table 3.3).

TABLE 3.3: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY THEIR AGE AT MARRIAGE

Age at Marriage (in years)	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
<11	9.8	32.4	20.2	33.2	36.3	35.7
11	-	4.7	2.1	-	3.6	2.9
12	5.9	9.3	7.4	2.8	6.5	5.9
13	5.9	7.0	6.4	2.8	7.1	6.4
14	15.7	-	8.5	5.6	4.8	4.9
15	7.8	7.0	7.4	11.1	7.1	7.8
16	7.8	-	4.3	13.9	5.4	6.9
17	-	2.3	1.1	2.8	2.4	2.5
18+	47.1	37.2	42.6	27.8	26.8	27.0
Total	100	100	100	100	100	100
Mean	17.5	14.1	15.9	14.6	13.3	13.6
SD	5.8	6.1	6.1	5.6	6.3	6.2
N	51	43	94	36	168	204

3.4. Children: Alive and Dead

All the respondents, irrespective of pre-and post-workshop clients of tubectomy or injectables, had living children. The mean number of living children reported was slightly lower among the post-workshop clients (3.8) than among the pre-workshop clients (4.0). Almost all the post and pre-workshop clients have living sons, and the mean number of living sons among both the groups was 2.1 (Table 3.4). As presented in Table 3.5, the mean age of the youngest child of the post workshop clients (2.4 years) was 1 year lower than that of the pre-workshop clients (1.3 years).

About one-half of both the pre-and post workshop clients reported to have children who died (Table 3.6). About one-tenth of the pre- and post workshop clients reported deaths of 3 or more children.

TABLE 3.4: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY LIVING SONS, AND BY MEAN NUMBERS OF LIVING CHILDREN BY GENDER

Living Children by Gender	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
1. Percentage Having living sons	100.0	93.0	96.8	97.2	94.0	94.6
2. Mean number of living children	4.3	3.7	4.0	4.0	3.7	3.8
3. Mean number of living son	2.3	1.9	2.1	2.1	2.1	2.1
4. Mean number of living daughter	2.0	1.8	1.9	1.9	1.6	1.7
N	51	43	94	36	168	204

TABLE 3.5: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY THE AGE OF THEIR YOUNGEST LIVING CHILD

Age (in years)	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
< 1	2.0	2.3	2.1	11.1	7.7	8.3
1-2	7.8	7.0	7.4	41.6	26.2	28.9
2-3	29.5	27.9	28.7	25.0	31.0	29.9
3-4	23.5	37.2	29.8	5.6	22.0	19.2
4-5	13.7	7.0	10.6	5.6	8.3	7.8
5+	23.5	18.6	21.4	11.1	4.8	5.9
Total	100	100	100	100	100	100
Mean	3.7	3.4	3.6	2.2	2.4	2.4
N	51	43	94	36	168	204

TABLE 3.6: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY NUMBER OF CHILDREN DIED

Number of Children Died	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
0	52.9	60.4	56.5	41.7	59.4	56.3
1	19.7	25.6	22.3	36.1	17.9	21.1
2	11.8	9.3	10.6	8.3	14.9	13.7
3	7.8	4.7	6.4	5.6	4.2	4.4
4	3.9	-	2.1	8.3	1.2	2.5
5+	3.9	-	2.1	-	2.4	2.0
Total	100	100	100	100	100	100
Mean	1.0	.6	.8	1.0	0.8	0.8
Mean: Boys died	.4	.3	.4	.6	.4	.8
Mean: Girls died	.6	.3	.5	.5	.4	.4
SD: Boys died	.7	.5	.7	.9	.8	.8
SD: Girls died	1.0	.5	.9	.9	.7	.8
N	51	43	94	36	168	204

3.5. Pregnancy Wasted

The proportion reporting pregnancy wasted was 7.4 percent among the post-workshop respondents and 10.6 percent among the pre-workshop respondents (Table 3.7). However, the mean number of pregnancy wasted was 0.1 for both the pre- and post-workshop clients.

TABLE 3.7: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY PREGNANCY WASTED

Pregnancy Wasted Status	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
Wasted	9.8	11.6	10.6	5.6	7.7	7.4
Not wasted	90.2	88.4	89.4	94.4	92.3	92.6
Total	100	100	100	100	100	100
Mean	0.1	0.1	0.1	0.1	0.1	0.1
N	51	43	94	36	168	204

3.6. Education

The literacy rates as well as the mean years of schooling of the post-workshop clients were lower than the pre-workshop clients, and this is true of both the tubectomy and injectable clients (Table 3.8). This suggests that the FP program in the sample areas was able to attract relatively more of illiterate women during the post-workshop period than the pre-workshop period.

3.7. Land Ownership

Land ownership is the most important economic indicator in the context of rural Bangladesh. More than four-fifths of the post-workshop clients and two-thirds of the pre-workshop clients reported possessing own land (Table 3.9). The difference is statistically significant. Thus, compared to the pre-workshop period, the post-workshop program, specially the tubectomy program, was more directed toward the relatively higher economic status group.

TABLE 3.8: PERCENTAGE DISTRIBUTION OF RESPONDENTS AND THEIR HUSBANDS BY LEVELS OF EDUCATION

Education	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
I. Respondents education						
Illiterate	66.6	48.8	58.6	72.2	67.3	68.1
Primary	21.6	23.3	22.3	13.9	23.8	22.1
Secondary and above	11.8	27.9	19.1	13.9	8.9	9.8
Total	100	100	100	100	100	100
Mean	1.8	3.4	2.5	1.6	1.7	1.7
SD	3.1	3.9	3.5	3.1	2.8	2.8
II. Husbands' education						
Illiterate	51.0	37.2	44.6	55.6	44.6	46.5
Primary	19.6	11.6	16.0	16.6	27.4	25.5
Secondary and above	29.4	51.2	39.4	27.8	28.0	28.0
Total	100	100	100	100	100	100
Mean	3.5	5.0	4.2	3.3	3.9	3.8
SD	4.1	4.3	4.2	4.5	4.2	4.3
N	51	43	94	36	168	204

TABLE 3.9: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY HOUSEHOLD LANDOWNERSHIP

Landownership	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
Own land	54.9	86.0	69.1	63.9	84.5	80.9
Does not own land	45.1	14.0	30.9	36.1	15.5	19.1
Total	100	100	100	100	100	100
N	51	43	94	36	168	204

Note: df=1, x^2=10.6

3.8. Husband's Occupation

The post-workshop clients reported a relatively higher proportion of their husbands engaged in 'farming' and "petty business" than the pre-workshop clients (Table 3.10). However, the reverse was true in the case of "wage labor" (both agricultural and non-agricultural). These findings are in line with the land ownership status of the two groups of clients.

3.9. Client's Involvement in Income Generation Activities

Though not statistically significant, the post-workshop clients reported a higher degree of their involvement in income generation activities (58%) than the pre-workshop clients (48%). The differences were more prominent among the injectable clients (Table 3.11). Irrespective of pre-and post-workshop clients, about one-half were involved in income generation activities.

TABLE 3.10: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY THEIR HUSBAND'S PRIMARY OCCUPATION

Husband's Primary Occupation	Pre-Workshop Clients			Post-Workshop Clients		
	Tubectomy	Injectables	Both	Tubectomy	Injectables	Both
Farming	35.4	58.1	45.8	41.7	64.9	60.8
Agricultural wage labor	17.6	2.3	10.6	19.4	6.5	8.8
Non-agricultural wage labor	19.6	9.3	14.9	8.3	5.4	5.9
Petty business	13.7	7.0	10.6	13.6	11.9	12.2
Trading (static business)	3.9	9.3	6.4	5.6	3.6	3.9
Service	9.8	14.0	11.7	8.3	7.1	7.4
Others	-	-	-	2.8	.6	1.0
Total	100	100	100	100	100	100
N	51	43	94	36	168	204

TABLE 3.11: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY THEIR INVOLVEMENT IN INCOME GENERATION ACTIVITIES (OTHER THAN NORMAL HOUSEHOLD WORK)

Involvement in income generation activities	Pre-Workshop Clients			Post-Workshop Clients		
	Tubectomy	Injectables	Both	Tubectomy	Injectables	Both
Involved	51.0	44.2	47.9	52.8	59.5	58.3
Not involved	49.0	55.8	52.1	47.2	40.5	41.7
Total	100	100	100	100	100	100
N	51	43	94	36	168	204

3.10. Involvement in Community Organizations

Slightly over five percent of the clients, both pre-and post-workshop, and slightly less than 10 percent of their husbands were reported to be members of any community organization (Table 3.12). Thus, membership of a community organization should not be treated as a determinant of use of tubectomy or injectables, for both the pre- and post-workshop clients.

TABLE 3.12: PERCENTAGE DISTRIBUTION OF RESPONDENTS AND THEIR HUSBANDS BY MEMBERSHIP IN ANY COMMUNITY ORGANIZATIONS

Membership status in community organization/types of NGOs	Pre-Workshop Clients			Post-Workshop Clients		
	Tubectomy	Injectables	Both	Tubectomy	Injectables	Both
I. Respondent (Wife)						
Non-member	94.1	95.3	94.7	97.2	94.0	94.6
Member:of which	5.9	4.7	5.3	2.8	6.0	5.4
National level NGO	2.0	4.7	4.3	2.8	3.0	2.5
Local level NGO	3.9	-	2.1	-	3.0	2.5
Total	100	100	100	100	100	100
II. Husband						
Non-member	90.2	90.7	90.4	97.2	89.9	91.2
Member:of which	9.8	9.3	9.6	2.8	10.1	8.8
National level NGO	7.8	9.3	8.5	-	5.4	4.4
Local level NGO	2.0	-	1.1	2.8	4.8	4.4
Total	100	100	100	100	100	100
N	51	43	94	36	168	204

4. KNOWLEDGE AND USE OF FP

This chapter discusses awareness of FP methods, knowledge about persons involved in FP activities, source(s) of knowledge about FP, and use of FP before the current method among the sample respondents. Knowledge about FP methods as well as knowledge about the persons involved in FP activities are important indications of the quality of care aspect of a FP program. Informed choice is a function of such knowledge.

4.1. Awareness of Modern FP Methods

In general, the post-workshop clients were reported to be more aware of modern FP methods than the pre-workshop clients. While the mean numbers of modern FP methods known by the post-workshop clients was 4.8, it was 4.3 for the pre-workshop clients (Table 4.1). Thus, the degree of informed choice was relatively higher for the post-workshop clients than the pre-workshop clients.

4.2. Knowledge about person(s) Involved in FP Activities

The sample respondents were asked to name person(s) involved in FP activities in the locality. Irrespective of pre and post-workshop clients and irrespective of tubectomy or injectable clients, the variety 'FWA' was mentioned by almost all the respondents (Table 4.2). However, the involvement of religious leaders, teachers, and elected chairman/members in FP activities was reported by a higher proportion of the post-workshop than the pre-workshop clients (Table 4.2). This clearly indicate that the community leaders' involvement in the FP program of the locality got intensified during the post-than the pre-workshop period. This is also reflected in the fact that a higher proportion of the post-workshop clients first learned about FP from the community leaders compared to their pre-workshop counterparts (Table 4.3).

The respondents were asked to say whether they knew any chairman/member/teacher/matbar/sardar/imam (i.e., anyone other than the FP program personnel) who is involved in FP activities. About three-fifths of the post-workshop clients and two-fifths of the pre-workshop clients answered in the affirmative (Table 4.4) Among these community leaders, the teachers and chairman/members were mentioned more frequently than the other categories (Table 4.4). A significant finding to note is that, irrespective of the pre- and post-workshop clients 90 percent of those mentioned happened to be the workshop participants (Table 4.4). The finding reflects two dimensions: the selection of the participants for the workshop was appropriate, and the participants were likely to be active in the process of dissemination of FP information in the locality.

TABLE 4.1: PERCENTAGE DISTRIBUTION OF RESPONDENTS HAVING AWARENESS OF SPECIFIC MODERN FP METHOD

(Multiple answers)

FP Methods	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
Condom	68.6	93.0	79.8	77.8	95.2	92.2
Oral pill	96.1	90.7	93.6	97.2	95.2	95.6
IUD	29.4	39.5	34.0	38.9	45.2	44.1
Injection	54.9	100.0	75.5	72.2	100.0	95.1
Vaginal method	11.8	7.0	9.6	22.2	8.9	11.3
Tubectomy	100.0	69.8	86.2	100.0	89.3	91.2
Vasectomy	47.1	39.5	43.6	47.2	44.0	44.6
Induced abortion/MR	7.8	7.0	7.4	8.3	7.7	7.8
Mean number known	4.2	4.5	4.3	4.6	4.9	4.8
N	51	43	94	36	168	204

TABLE 4.2: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY THEIR OPINION ABOUT WHO AMONG VARIOUS CATEGORIES OF PERSONS ARE INVOLVED IN FP IN THE LOCALITY

(Multiple answers)

Person(s) Involved in FP	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
Government workers:						
FWA	98.0	100.0	98.9	100.0	98.8	99.0
Others	17.6	14.0	16.0	19.4	23.2	22.5
NGO workers:						
SC	45.1	16.3	31.9	58.3	25.0	30.9
Others	2.0	4.7	3.2	2.8	3.0	2.9
Religius leaders /Imams	3.9	7.0	5.3	16.7	7.7	9.3
Teachers	5.9	7.0	6.4	16.7	16.1	23.5
Matbars	13.7	25.6	19.1	25.0	23.2	23.5
Chairman/member	29.4	27.9	28.7	41.7	45.2	44.6
Village Doctor	11.8	25.6	18.1	27.8	29.8	29.4
Others	7.8	7.0	7.4	16.7	12.5	13.2
N	51	43	94	36	168	204

TABLE 4.3: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY SOURCE(S) FROM WHERE THEY FIRST LEARN ABOUT FP METHOD CURRENTLY USING

(Multiple answers)

Source(s) and Media	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
Mass Media						
Radio	45.1	62.8	53.2	41.7	38.7	39.2
TV	5.9	11.6	8.5	5.6	6.0	5.9
Poster	11.8	4.7	8.5	-	4.2	3.4
Leaflet	3.9	2.3	3.2	5.6	4.2	4.4
Billboard	-	2.3	1.1	2.8	2.4	2.5
Interpersonal Media						
GOB Fieldworker:						
FWA	86.3	95.3	90.4	86.1	86.9	86.8
Others	5.9	9.3	7.4	8.3	6.5	6.9
NGO workers:						
SC	5.9	-	3.2	2.8	6.0	5.4
Others	-	-	-	-	2.4	2.0
Husband/Relative /Neighbor	9.8	4.7	7.4	16.7	7.7	9.3
Community leader	5.9	2.3	4.3	8.3	10.1	9.8
Others	2.0	-	1.1	6.0	4.9	4.9
N	51	43	94	36	168	204

TABLE 4.4: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY WHETHER THEY KNOW ANY COMMUNITY LEADERS WHO IS INVOLVED IN FP ACTIVITIES OF THE LOCALITY

Whether know anyone/types of community leaders mentioned	Pre-Workshop Clients			Post-Workshop Clients		
	Tubectomy	Injectables	Both	Tubectomy	Injectables	Both
I. Whether know anyone						
No	64.7	55.8	60.6	50.0	41.1	42.6
Yes	35.3	44.2	39.4	50.0	58.9	57.4
Total	100	100	100	100	100	100
N	51	43	94	36	168	204
II. Types of community leaders mentioned (Multiple answers)						
Chairman/members	33.3	31.6	32.4	50.0	36.4	38.5
Teacher	61.1	57.9	59.5	72.2	54.5	57.3
Matbar/Sardar	11.1	5.3	8.1	16.7	19.2	18.8
Imam	11.1	26.3	18.9	16.7	23.2	22.2
Village Doctors	16.7	21.1	18.9	16.7	10.1	11.1
Social worker/ NGO worker	22.2	10.5	16.2	5.6	10.0	9.3
N	18	19	37	18	99	117
III. Whether community leaders mentioned are participant of SAVE (USA) workshop:						
Participant	88.9	89.5	89.2	94.4	89.9	90.6
Non-participant	11.1	10.5	10.8	5.6	10.1	9.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	18	19	37	18	99	117

4.3. Source(s) and Media of Knowledge

It is interesting to note that the role of the "mass media" (radio, TV, poster, leaflet, Billboard) as source of 'first learning' about the current method was less prominent for the post than the pre-workshop clients (Table 4.3). On the other hand, the role of interpersonal communication through community leader, relative/neighbor, and NGO workers was higher during the post- than pre-workshop period. Such changes, reflected in the increased role of the interpersonal communication agents, can be an outcome of the workshop. However, at this stage, it is difficult to give an accurate estimate of the workshop's contribution toward that change.

4.4. Use of FP Method(s) Before the Current Method

As shown in Table 4.5, there were no differences between the pre- and post-workshop clients regarding the proportions using any modern FP method before the current method as well as the mean number of modern FP methods used. About 70 percent of the pre- and post-workshop clients each, used at least one modern method before the current method, and the mean number of modern methods used before the current method was slightly over one method. Also, there were no appreciable differences by number of modern methods used. Thus, regarding the past behavior of the pre- and post-workshop clients, measured in terms of ever use of any modern FP method as well as mean number of method(s) used in the past (before the use of the current method), the two groups (pre- and post) are similar. For both the groups, it was observed that the proportion using any modern method in the past was higher among the injectable clients than the tubectomy clients (Table 4.5); and oral pill was most popular ever used method, followed by condom (Table 4.6).

TABLE 4.5: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY EVER USE OF ANY MODERN FP METHOD BEFORE THE CURRENT METHOD (STERILIZATION OR INJECTABLE), AND THE NUMBER(S) OF MODERN METHODS EVER USED (EXCLUDING THE CURRENT METHOD)

Ever use of modern method before the current method/number of modern method ever used	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
1. Percentages ever used any modern method before the current method	60.8	79.1	69.1	50.0	74.4	69.8
2. Number of modern methods ever used before the current method:						
0	39.2	20.9	30.9	50.0	25.6	29.9
1	37.3	30.2	34.0	16.7	34.5	31.4
2	17.6	45.5	30.9	25.0	35.7	33.8
3+	5.9	2.3	4.3	8.4	4.2	4.9
Mean	0.9	1.3	1.1	1.0	1.2	1.2
N	51	43	94	36	168	205

TABLE 4.6: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY USE OF SPECIFIC FP METHODS BEFORE THE CURRENT METHOD (STERILIZATION OR INJECTABLES)

(Multiple answers)

FP Methods	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
Condom	23.5	53.5	37.2	25.0	36.9	34.8
Oral pill	52.9	72.1	61.7	50.0	71.4	67.6
IUD	3.9	4.7	4.3	5.6	6.0	5.9
Injectable	3.9	2.3	3.2	13.9	1.8	3.9
Vaginal method (Foam/emko/ jelly)	5.9	-	3.2	5.6	1.8	2.5
Induced Abortion/MR	-	-	-	-	1.2	1.0
Safe period	13.7	14.0	13.8	5.6	10.7	9.8
Withdrawal	-	4.7	2.1	-	1.2	1.0
Abstinence	2.0	4.7	3.2	-	1.8	1.5
N	51	43	94	36	168	204

5. OUTCOME OF THE WORKSHOP:EFFECT AND PROCESS

The basic objective of the workshops was to train the opinion leaders, so that they could subsequently contribute to the promotion of ideas related to FP in the community. However, as already mentioned in Sections 1.1 and 1.2, accurate quantitative measurement of the impact of the workshops would be difficult for various reasons, including:

(a) the increased FP use during the post-workshop period cannot be attributable to a single factor, namely the "workshop";

(b) with the deployment of seven FWVs in the study area, additional programmatic efforts were undertaken, activating the local FP committees;

(c) unless all possible factors determining the changes occurred are known, the real cause-effect relationships cannot be established; and finally;

(d) the "impact" of such an activity as "workshop with the religious and community leaders" cannot be established, considering the short time lag between the action (workshop) and the outcome of the action.

Thus, considering all the limitations mentioned above, it should be logically sound to assess the effect of the workshop in terms of the various dimensions of interaction of the target population with the workshop participants regarding FP issues. Those dimensions could be as follows: type and number of interactions, contents of those interactions (messages disseminated), clients' level of satisfaction with the information disseminated by the workshop participants, proportion of the post-workshop clients who were motivated to use tubectomy/injectables mainly due to the participants' efforts, multiplier effect of the workshop, etc. Also, it was thought logical to document the process and mechanism by which the workshop has resulted in increased use of the selected clinical methods of FP during the post-workshop period. Moreover, in order to determine the degree of interactions of the participants (most of whom are males; about 90%) with the males, a total of 40 male members of the sample households were also interviewed.

5.1. Interaction with the Workshop Participants

In this study, interactions of the target population with the workshop participants was assessed in terms of the proportion of the sample respondents (by types) who reported having FP-related discussions with the workshop participants during the last one year, mean number of participants who had such discussions with the respondents, modes of such interactions and frequencies by modes, degrees of active involvements by types of participants, etc.

Almost all (96%) the post-workshop clients and three-quarters of the pre-workshop clients reported having FP-related discussions with at least one workshop participant during the last one year (Table 5.1). Thus, the workshop participants were able to reach almost all the post-workshop clients. Also, they disseminated knowledge even to those who started using permanent methods before the workshop. This means that dissemination of FP knowledge by the workshop

participants was not limited to a specific segment (post-workshop clients), but it covered others as well. Furthermore, almost all the sample male members interviewed said that they had FP-related discussions with at least one workshop participant during the last one year.

On average, there were 5-6 persons from each village who participated at the SC workshop. The respondents were asked to name the participants who interacted with the respondents during the last one year, and the number of times such interactions took place. The mean number of workshop participants who had such interactions with the respondents was 2.4 person for the post-workshop clients and 2.2 person for pre-workshop clients (Table 5.2). The mean number of participants who had such interactions with the male members of the sample households was 2.4 persons. Thus, at least about half of the workshop participants were active in disseminating FP information after the workshop. An indication of relatively higher concentration of participants' motivational activities toward the post-workshop clients can be obtained from the fact that while discussions with four or more participants during the last one year was reported by 4.3 percent of the pre-workshop clients the corresponding figure was over 20 percent among the post-workshop clients (Table 5.2). Among these four or more participants, at least three do not belong to the regular FP program. Thus, the workshop participants, who in most cases are not FP workers, were turned into active promoters of FP during the post-workshop period.

The distribution of the workshop participants who had relevant interactions with the respondents show that the workshop has done a positive service to the program by rejuvenating the regular workers of the FP program. This is reflected in the fact that while 53 percent of the pre-workshop clients mentioned the name of FP workers it was mentioned by 88 percent of the post-workshop clients (Table 5.3). Moreover, in reply to a question regarding who among the workshop participants was "the most active" person in terms of dissemination of FP, about two-fifths of the post-workshop clients compared to half of the pre-workshop clients gave their opinion in favour of the FP workers (Table 5.4). Thus, the workshop has accentuated the demand for FP motivational activities to be undertaken by the FP fieldworkers.

TABLE 5.1: PERCENTAGE DISTRIBUTION OF RESPONDENTS BY WHETHER HAD FP-RELATED DISCUSSIONS WITH THE WORKSHOP PARTICIPANTS DURING THE LAST ONE YEAR

Status of discussion	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
Discussed	66.7	83.7	74.5	91.7	96.4	95.6
Not discussed	33.3	16.3	25.5	8.3	3.6	4.4
Total	100	100	100	100	100	100
N	51	43	94	36	168	204

TABLE 5.2: PERCENTAGE DISTRIBUTION OF RESPONDENTS WHO HAD FP DISCUSSIONS WITH THE WORKSHOP PARTICIPANTS DURING THE LAST ONE YEAR BY NUMBER OF PARTICIPANTS WITH WHOM SUCH DISCUSSIONS WERE HELD

Number of Participants	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
1	14.7	38.9	27.1	36.4	34.6	34.9
2	67.6	25.0	45.7	15.2	19.8	19.0
3	17.6	27.8	22.9	24.2	25.9	25.6
4	-	2.8	1.4	9.1	13.6	12.8
5+	-	5.6	2.9	15.2	6.2	7.7
Total	100	100	100	100	100	100
Mean number of participants mentioned by those having such discussion	2.0	2.4	2.2	2.6	2.4	2.4
N	34	36	70	33	162	195
Mean number of participants per sample respondent	1.3	2.0	1.6	2.4	2.3	2.3
N	51	43	94	36	168	204

TABLE 5.3: PERCENTAGE DISTRIBUTION OF RESPONDENTS WHO MENTIONED HAVING STERILIZATION/INJECTABLE RELATED DISCUSSIONS WITH THE WORKSHOP PARTICIPANTS DURING THE LAST ONE YEAR BY TYPES OF PARTICIPANTS

Types of workshop participants	Pre-Workshop Clients			Post-Workshop Clients		
	Tubectomy	Injectables	Both	Tubectomy	Injectables	Both
Religious leader	22.4	-	14.3	9.1	8.6	8.7
Elected leader	82.4	27.8	54.3	42.4	45.7	45.1
Sardar/Matbar	50.0	22.2	35.7	30.3	22.8	24.1
Rural Health Practitioner	11.8	22.2	17.1	36.4	33.3	33.8
Social Worker	8.8	19.4	14.3	12.1	12.4	12.4
Family Planning Worker	8.8	94.4	52.9	93.9	87.0	88.2
Teacher	14.7	2.8	8.6	6.1	13.0	11.9
Others (Service/ Business)	-	11.1	5.7	24.2	16.1	17.5
N	34	36	70	33	162	195

TABLE 5.4: PERCENTAGE DISTRIBUTION OF RESPONDENTS WHO MENTIONED INTERACTIONS WITH THE WORKSHOP PARTICIPANTS BY THEIR OPINION ABOUT WHO WAS THE MOST ACTIVE PERSON IN TERMS OF DISSEMINATION OF KNOWLEDGE ABOUT FP

The most active disseminator of FP knowledge	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
Religious leader	-	2.8	1.4	-	11.1	9.2
Elected leader	50.0	-	24.3	12.1	5.6	6.7
Sardar/Matbar	26.5	2.8	14.3	9.1	1.9	3.1
Rural Health Practitioner	-	-	-	-	3.1	2.6
Social Worker	5.9	-	2.9	-	1.2	1.0
Family Planning Worker	17.6	94.4	57.1	78.8	75.3	75.9
Teacher	-	-	-	-	1.9	1.5
Total	100	100	100	100	100	100
N	34	36	70	33	162	195

Among the various categories of the community leaders who participated in the workshop, the most frequently mentioned, in terms of their interactions with the respondents, the elected leaders, i.e., chairman/members of Union Councils, followed by sardar/mathars (non-elected), rural health practitioners, social workers, etc. (Table 5.3). A similar pattern was discernible from the responses of the sample male respondents. However, when the respondents were asked to say who among the community leaders mentioned by them they believe to be "the most active person" disseminating FP, the "religious leaders" were mentioned as the most active by the post-workshop clients; and "elected leaders", followed by sardar/matabars by the pre-workshop clients (Table 5.4). Thus, at least three categories of the workshop participants -- religious leaders, elected leaders, and sardar/matbars emerged as the most prominent types of community leaders being distinctly active after the workshop. Activating the religious leaders in FP activities should be treated as a positive contribution of the workshop. This argument is further substantiated by the fact that about 10 percent of the post-workshop clients said that the "religious leaders" were most active in respect of dissemination of FP, while the religious leaders comprised only 4.4 percent of the total number of workshop participants (Table 1.2).

Ideally, there can be three ways of dissemination of FP knowledge by the workshop participants, namely, participant's visit to the respondent, respondent's visit to the participant, and both the participant and the respondent meet in a FP

meeting. Among these three modes/ways, the most frequent was the participant's visit to the respondent's house, followed by the respondent's visit to the participant's house, and the least frequent was "FP meeting" (Table 5.5). The mean number of visits by the participant to the respondent's home during the last one year was 7.1 in case of the post-workshop clients and 3.8 in case of the pre-workshop clients. The number of visits were higher among injectable clients than tubectomy clients. The frequency of interaction of the participants with the male members of the sample households was reported to be higher than the participants' interaction with the female respondents. In this respect, the male members representing post-workshop clients have reported 8.2 home visits and those representing pre-workshop clients reported 4.8 home visits during the last one year.

The above findings regarding the modes of interaction of the workshop participants with the clientele population was also evident from the FGDs with the community leaders. For example, some of the participants said "out of our sense of ownership with program efforts, we discuss FP almost everywhere and with everyone". "We discuss this either in formal or in informal meetings". A participant, who is an ex-UP member, said "let's cite an example. When I pass through a mahalla or para, as usual I also chat with the womenfolk and enquire their state of affairs. At the end of my discussion, I stress that the main issue is to control the rate of population growth by using family planning method". Another participant claimed, "we tell people that this (FP) can be done in these ways or in these manners for these benefits. As a result of our motivational efforts, there are many people who have said that they will accept a method".

Spatially, the dissemination of FP-related information by the participants was not only limited to Nasirnagar. It went beyond Nasirnagar. One of the participants, described an interesting story, observed: "I was going to Noakhali District by train. I had with me the workshop bag. The inscription in the bag drew the attention of co-passengers and one of them asked me what was the inscription about. Then, I explained, what I learned from the workshop, and we got into a lively discussion about religion and family planning. I think that there were many who got interested and learnt a lot from our discussions".

5.2 Information disseminated by the participants and Levels of Satisfaction of the respondents

As mentioned earlier (Section 1.3), the basic objective of the workshop was to enhance FP knowledge among the participants, with special emphasis on "FP from the view of religion, health and economy". The participants were given information on advantages and disadvantages of various modern methods of FP, particularly about the clinical methods of contraceptions. It was expected that the participants, after the workshop, would disseminate the knowledge/information among the community members.

This has been clearly reported by those pre and post-workshop clients (respondents), who had FP-related interactions with the participants during the last one year. For example, more than 80 percent of both the pre and post-workshop clients said that they were told by the participants that the clinical methods are good for health; about three-fifths were told that the clinical methods are good for family welfare; about half told that clinical methods have relatively less side-effects; etc. (Table 5.6).

TABLE 5.5: MEAN NUMBER(s) OF FP-RELATED INTERACTIONS/MEETINGS OF THE RESPONDENTS WITH THE WORKSHOP PARTICIPANTS DURING THE POST-WORKSHOP PERIOD (LAST OF YEAR) BY NATURE OF SUCH MEETINGS

Nature of interactions/meetings	Pre-Workshop Clients			Post-Workshop Clients		
	Tubectomy	Injectables	Both	Tubectomy	Injectables	Both
1. Workshop participant visited the respondent	3.1	4.7	3.8	6.3	7.2	7.1
2. Respondent went to the participant for discussion	0.8	1.6	1.2	2.0	2.1	2.1
3. Meet in a FP meeting	0.3	0.1	0.2	0.2	0.2	0.2
N	51	43	94	36	168	204

TABLE 5.6: PERCENTAGE DISTRIBUTION OF RESPONDENTS HAVING INTERACTIONS WITH THE WORKSHOP PARTICIPANTS BY TYPES OF INFORMATION ABOUT STERILIZATION AND INJECTABLES GIVEN TO THE RESPONDENTS BY THE PARTICIPANTS

(Multiple answer)

Type(s) of sterilization and injectable related information disseminated by workshop participants	Pre-Workshop Clients			Post-Workshop Clients		
	Tubectomy	Injectables	Both	Tubectomy	Injectables	Both
The method is good for you and your health	79.4	86.1	82.9	81.3	85.2	84.5
You can stop use/ switch to another method if you wish	-	36.1	-	-	30.2	-
The method is good for the well being of your family	67.6	66.7	67.1	62.5	58.6	59.3
Using FP is good for the country	32.4	33.3	32.9	37.5	30.2	31.4
Once you take the method, the issue is over for life	67.6	16.7	41.4	75.0	-	12.4
The method has less side-effects	44.1	58.3	51.4	37.5	50.6	48.5
It's not like pill that should be take everyday	29.4	77.8	54.3	53.1	74.1	70.6
N	34	36	70	33	162	195

In general, both the pre- and post-workshop and their husbands clients having FP- related discussions with the workshop participants were reported to be satisfied with the quantum of information received from the participants. In both the groups, at least 70 percent of the respondents were "satisfied" and the rest "somewhat satisfied" (Table 5.7). The response "somewhat satisfied" should be interpreted with caution, because "somewhat satisfied" imply that there are people who are actually "not satisfied" but were merely being polite to the interviewer. Also, one cannot expect that everybody with be satisfied with the amount of information received through such an intervention.

TABLE 5.7: PERCENTAGE DISTRIBUTION OF RESPONDENTS HAVING FP-RELATED DISCUSSIONS WITH THE WORKSHOP PARTICIPANTS BY REPORTED LEVELS OF SATISFACTION WITH THE VOLUME OF SUCH INFORMATION

Levels of satisfactions	Pre-Workshop Clients			Post-Workshop Clients Clients		
	Tubectomy	Injectables	Both	Tubectomy	Injectables	Both
Satisfied	76.5	63.9	70.0	70.6	72.2	71.9
Somewhat satisfied	23.5	36.1	30.0	29.4	27.2	27.6
Not satisfied	-	-	-	-	0.6	0.5
N	34	36	70	33	162	195

Also, it appeared from the FGDs that the participants do not have the same amount and quality of information about various methods of FP. Moreover, there was no feedback from the participants, and no scope for refresher workshop/follow-up workshops, etc.

5.3 Workshop Participants' Role in Enhancing FP Acceptance: Gross and Net Effects

The relative contribution of the workshop participants in enhancing FP acceptance in Nasirnagar, as noted already, is a difficult question to be answered, because FP acceptance is a complex matrix and function of multidimensional factors, "workshop" being one of those dimensions which has been recognized in the official document of the GOB. However, in order to ascertain the relative contributions of the participants in enhancing the acceptance of clinical methods (permanent method and injectables) two questions were asked to the respondents:

(a) "Who helped you in your decision-making regarding the acceptance of the FP method you are currently using"?

(b) "Among those mentioned, who contributed most in your decision-making regarding the acceptance of the FP method you are currently using"?

Before presenting any meaningful analysis of this crucial issue, it should be remembered that the questions asked cannot directly answer the point of investigation: however, meaningful inferences can be drawn. While the first question gives multiple answers which is important in order to identify all those which matter in the decision-making process of the clients, the second question enables singling out the most important decision-making agent from among the many.

As to who are those who helped in the decision-making process, the predominant answer, irrespective of pre or post-workshop clients, was "GOB fieldworker" (Table 5.8). However, half of the post-workshop clients and about one-fifth of the pre-workshop clients said that the workshop participants (other than the GOB field workers) have helped them in their decisions to accept the current method. How could the workshop participants help the pre-workshop clients? The only plausible explanation is that some of the community influentials who participated in the workshop were actively involved in FP activities even before the workshop. This is again an indication of proper selection of workshop participants.

The effect of the post-workshop activities of the participants is discernible from the fact that 86 percent of the post-workshop clients, 81 percent of the post-workshop tubectomy clients, and 87 percent of the post-workshop injectable clients said that the "workshop participants" (irrespective of FP worker or community influentials) contributed most in their decision-making process (Table 5.9). This can be treated as a gross effect of the workshop.

What would be the net effect of the workshop? Considering the limitations of the study, some indirect estimations can be derived. What should be subtracted from the gross effect in order to arrive at a logical value for the net effect? The contributing factors which should be subtracted partially or fully from the value of the gross effect are: values contributed by the participant FWAs and the values contributed by those participant community leaders who were active in the local FP program even before the workshops. Again deducting those values "fully" would mean that the workshops did not contribute in the activities of the above two groups. This, of course, would not represent reality. However, at the same time, it is not possible to determine the "workshop's share" of the increased activity of those two groups. Thus, the "minimum" net effect of the workshop can be derived by subtracting the value of two gross effects due to the participants, i.e., percentages of participants mentioned as "most contributor" by the post workshop clients (85.8 percent) and by the pre-worshop clients (57.4 percent). Thus, it can be said that the workshop's overall contribution in terms of the net effect would be 28.4 percent. The net effect on account of increased tubectomy use would be 14 percent, and that for injectable 40 percent. Perhaps, the rest of the net effect would be attributable to other factors such as deployment of 7 FWVs, enhanced supervision by the district level FP officials, and active performance of FP committees and other unknown factors.

If one assumes that the above gross and net effects are applicable to all modern FP methods, which, in reality may be valid to a certain degree not known to us, out of the 12.7 percentage points increase in the CAR in Nasirnagar Thana during the last one year-10.9 percentage points (86 percent) was due to the gross effect of the workshop, and 3.6 percentage points (28.4 percent) was due to the net effect of the workshop (Figure 5.1).

TABLE 5.8: PERCENTAGE DISTRIBUTION OF RESPONDENTS ACCORDING TO THEIR OPINION ABOUT WHO HELPED THEM IN THEIR DECISION MAKING REGARDING ACCEPTANCE OF THE CURRENT METHOD

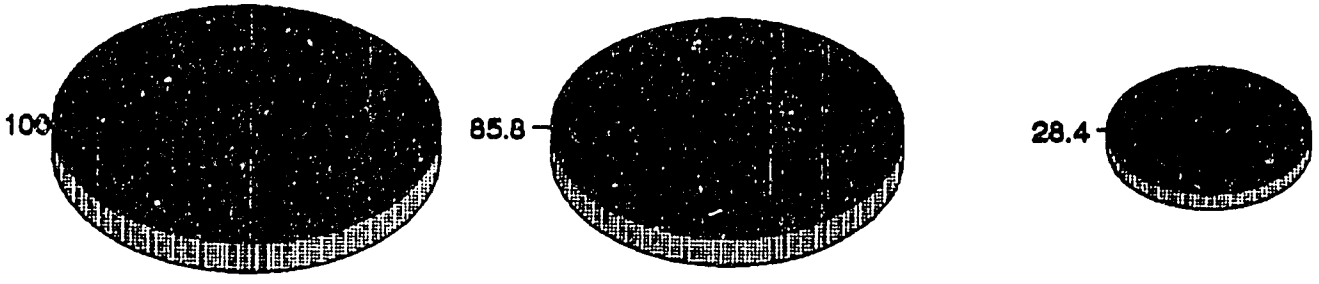
(Multiple answer)

Person(s) who helped in decision making	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
GOB fieldworker	94.1	86.0	90.4	97.2	93.5	94.1
NGO fieldworker	3.9	4.7	4.3	-	2.4	2.0
Friend/Neighbor/ Relative	17.6	9.3	13.8	16.7	10.7	11.8
Workshop participant (other than GOB workers)	13.7	23.3	18.1	41.7	51.8	50.0
Others	11.8	11.6	11.7	16.7	13.1	13.7
N	51	43	94	36	168	204

TABLE 5.9: PERCENTAGE DISTRIBUTION OF RESPONDENTS ACCORDING TO THEIR OPINION ABOUT THE TYPE OF THE PERSON WHO CONTRIBUTED MOST IN THEIR DECISION MAKING REGARDING ACCEPTANCE OF THE CURRENT FP METHOD

Main contributor influencing decision making	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
Participants	66.7	46.5	57.4	80.6	86.9	85.8
Not participants	33.3	53.5	42.6	19.4	13.1	14.2
Total	100	100	100	100	100	100
N	51	43	94	36	168	204

FIGURE 5.1 : GROSS AND NET CONTRIBUTION OF THE WORKSHOP IN THE INCREASED CAR OF NASIRNAGAR THANA DURING THE LAST YEAR



POST-WORKSHOP INCREASED CAR: 12.7 % POINTS

GROSS EFFECT : 10.9 % POINTS

NET EFFECT : 3.61 % POINTS

5.4. Multiplier Effect: Dissemination of Workshop Knowledge by the Clients

Multiplier effect, measured in terms of dissemination of workshop knowledge not by the participants but by those who interacted with the participants, is a major chain effect of the workshop. This should be treated as a major effect of the workshop, value of which cannot be measured at a given point in time, because this chain will multiply as long as the clients continue to disseminate those information obtained from the first party (the participants), and subsequently the second party (the client 'x') becomes the first party, and so on.

The immediate multiplier effect is discernible from the fact that 86 percent of those post-workshop clients who had interactions with the workshop participants subsequently disseminated the information to others. For the pre-workshop clients, the corresponding figure was 70 percent (Table 5.10). These groups have disseminated workshop knowledge among their neighbors, friends and relatives (Table 5.11). The main messages disseminated to others by the clients including safety of clinical methods, FP use is a wise decision, method (injectables) is reversible, etc. (Table 5.12).

TABLE 5.10: PERCENTAGE DISTRIBUTION OF RESPONDENTS WHO HAD DISCUSSION WITH WORKSHOP PARTICIPANTS BY WHETHER DISSEMINATED FP INFORMATION TO OTHERS

Whether disseminated knowledge among others	Pre-Workshop Clients			Post-Workshop Clients		
	Tubec-tomy	Injec-tables	Both	Tubec-tomy	Injec-tables	Both
Disseminated	85.3	55.6	70.0	87.9	85.2	85.6
Not-disseminated	14.7	44.4	30.0	12.1	14.8	14.4
Total	100	100	100	100	100	100
N	34	36	70	33	162	195

TABLE 5.11: PERCENTAGE DISTRIBUTION OF RESPONDENTS WHO HAVE DISSEMINATED KNOWLEDGE ABOUT STERILIZATION/ INJECTABLE BY WHO DID THEY DISSEMINATE AND WHAT MESSAGE DID THEY CONVEYED TO THEM

Who did they disseminated and what message(s) they conveyed	Pre-Workshop Clients			Post-Workshop Clients		
	Tubectomy	Injectables	Both	Tubectomy	Injectables	Both
I. WHO:						
Neighbor/Friends	89.7	90.0	89.8	89.7	78.8	80.7
Relatives	62.1	70.0	65.3	75.9	73.9	74.3
Total	100	100	100	100	100	100
II. WHAT MESSAGE(S) CONVEYED (Multiple responses)						
The method is safe/ their is no side-effect	72.4	65.0	69.4	79.3	72.5	73.7
Using the method ensures a small family which is a wise decision	58.6	40.0	51.0	62.1	39.9	43.7
It's not like pills that should be taken everyday	17.2	20.0	18.4	13.8	22.5	21.0
You can stop use/ switch to any other method if you wish	-	40.0	16.3	-	56.5	46.7
Others	-	5.0	2.0	3.4	8.0	7.2
N	29	20	49	29	138	167

6. DISCUSSION AND RECOMMENDATIONS

6.1. Outcomes of the Workshop and its Replicability

The workshop has a positive net effect on the post-workshop contraceptive acceptance rate in Nasirnagar Thana of Brahmanbaria District. The positive effect is reflected from the extent of the workshop participants' involvement in the clients' decision-making process regarding acceptance of FP methods (mainly clinical methods). The gross effect of the workshop is discernible from the fact that 86 percent of the post-workshop clients, 81 percent of the post-workshop tubectomy clients, and 87 percent of the post-workshop injectable clients categorically stated that the "workshop participants" have "contributed most" in their decision-making process regarding acceptance of their current FP method. The positive contribution of the workshop, measured in terms of the net effect, which is a better indicator of the outcome of the workshop, is unquestionable. The overall contribution of the workshop in terms of the net-effect was 28.4 percent, being 13.9 percent for the increased use of tubectomy and 40.4 percent for the increased use of injectables. That is, out of the 12.7 percentage points increase in the CAR (actual CAR minus CAR due to steady-state situation), 3.61 percentage points was due to the net-effect of the workshop.

Besides the 'net effect' mentioned, there were other effects of the workshop (e.g., multiplier-effect, integrational effect, facilitating effect, 'kick-bag' effect, etc.). The multiplier effect has a long-term value. The immediate multiplier effect is discernible from the fact that about 86 percent of the post-workshop clients and about 70 percent of the pre-workshop clients who got FP knowledge from the workshop participants have subsequently disseminated the information to others (neighbors, friends, relatives). This effect is likely to continue for a quite long time, and according to the rule of interpersonal communication the effect will multiply.

The integrational effect has two aspects. First, the design of the workshop was collaborative in nature, with the GOB and the NGO participating in the selection process of both the trainers and trainees, i.e., the selection process effort was a joint effort. Second, the selection of the workshop participants was done, using a "bottom-up" approach which ultimately added a significant component of the "community influentials". Thus, the integrational effect was instrumental in overcoming the factors responsible for lack of coordination among the various important actors who can promote FP in rural areas.

The facilitating effect of the workshop is multidimensional. First, the inclusion of the 'conservative' community influentials as workshop participants helped overcome their antagonistism after attending the workshop. After the workshop, these 'gatekeepers' opened their gates to the FP fieldworkers. As a result, the workers got supporters, the would-be users got workers, the FP movement got momentum, culminating into an unprecedented rise in the CAR. An indication of the impact of this factor is discernible from the fact that the Muslims constitute a much higher proportion of the post-workshop clients compared to the pre-workshop clients. Second, according to the GOB directives, the elected community leaders (chairmen/members of Union Councils) are supposed to work for family planning, and they are members of the local FP committees. These elected members, who participated in the workshop, reportedly took more active interest in the work of the family planning workers in their area during the post-workshop period.

Third, FP is a sensitive topic and in the context of rural Bangladesh it is not an usual practice that the older community influentials discuss this topic with the younger members of the community. However, the workshop was able to break this norm to some extent, as reported by many of the participants who said that after the workshop the older community leaders discuss the topic with the younger members of the community. An indication of this can be found in the fact that while 21 percent of the pre-workshop tubectomy clients were in the age group of 20-29 years, it was about 39 percent in the case of the post-workshop tubectomy clients. Fourth, it is also not an usual practice that the male community leaders in rural Bangladesh discuss FP with the females. However, such male-female interactions were also reported by many respondents (females) as well as by some of the male workshop participants.

The 'kick-bag' effect, though marginal in value, should be treated as an important outcome of the workshop. This effect goes beyond the target territory (in this case, Nasirnagar). For example, a participant travelling by train/bus enters into an interpersonal communication on FP with a co-passenger, and soon afterwards the "interpersonal communication" on FP turns into a lively "group discussion".

Thus, the FP workshop, as designed and implemented in Nasirnagar Thana by the SC, can be treated as a replicable means of increasing the contraceptive acceptance beyond the steady-state increase in other parts of rural Bangladesh.

6.2. Lessons for the Future

Since 30 percent of the increased CAR during the post-workshop period was due to the 'net-effect' of the workshop, the remaining 70 percent was due to factors other than the workshop. These factors include, among others, the deployment of seven FWVs, increased activity of the local FP committees, increased supervision by the district level personnel, better supply situation, etc. However, due to the limitations of this study, the relative shares of these contributing factors could not be ascertained. **Thus, to be able to identify all the factors responsible for the increased CAR as well as to determine their relative shares, a more elaborate study should be undertaken. If the SC replicates this type of workshops in the future, there should be ample scopes for more indepth studies, incorporating all possible variables and indicators so that the relative contributions of all possible factors can be identified. In that respect, implementation of such workshop should be planned from the perspectives of Operations Research.**

A well designed workshop is always characterized by certain essential components, namely, the selection of participants and trainers, timing, placement, contents, follow-up mechanisms, etc. All these components should be designed in accordance with the "main objective" of the workshop. The quantitative and qualitative aspects pertaining to the impact of the workshop analyzed in this study show that the workshop was not adequately designed, especially with respect to the "follow-up mechanisms". In reality, the participants were given an assignment to direct their motivational efforts, especially toward those families which have five or six children, and the participants were also requested to motivate at least ten would-be users from each village. However, there was no built-in mechanism to ascertain the extent to which these assignments and requests were carried out by the participants. Also, it was reported by the participants, as well as by the ATFPO, that the workshop was treated as a 'one short' action. **Thus, while**

planning for such workshops in the future, objective follow-up plans as well as follow-up mechanisms should be built-in components of the overall workshop plan.

It was reported by the workshop participants themselves as well as by some of the sample clients that there were some participants who were less motivated and less convinced about FP compared to the others. These 'hard core' participants should not be ignored, because if after participating at the workshop someone does not contribute to the FP motivational work in the community, the resources directed toward that participant should be considered as "wastage". Thus, to minimize waste of workshop resources in the future, this category of participants should be identified first, and then, re-motivated as a special target group.

FP is a dynamic subject-matter. Also, it should not be expected that the community influentials will know everything about FP by attending a two-day workshop. Thus, to maximize the information base of the community influentials, there should be provisions for refresher-workshops/follow-up workshops. Such workshops should deal with the issues identified by the previous-participants as problems faced by them in motivating the target groups.

Since the workshop has a positive effect on the acceptance of FP and since one of the ways of interaction was "client visiting participant's home", the participants can be considered as an "information distribution point". The effectiveness of this information distribution point would depend largely on the efficiency of the information disseminator. Thus, to be able to raise the effectiveness of the information dissemination points, the satisfied clients, among others, should be considered while selecting the workshops participants.

Annex A

Questionnaire

A STUDY ON THE IMPACT OF THE WORKSHOP ON FAMILY PLANNING WITH TRADITIONAL AND RELIGIOUS LEADERS CONDUCTED BY SAVE THE CHILDREN (USA) IN NASIRNAGAR THANA

SAMPLE IDENTIFICATION

Sample No. [ ][ ][ ][ ]* Time Started _____

Name of the respondent: _____

Thana: Nasirnagar Union: _____

Village: _____

Tubectomy(1)/Vasectomy case(2)/Injection(3)

When performed tubectomy/vasectomy: Month _____

Year _____

(_____ Months back from June, 1993)

Interview Information:

Interview Call	1	2	3
Date			
Result Code**			

**Result Code: Completed=1, Respondent not available=2, Deferred=3, Refused=4, Dwelling vacant=5, Address not found=6
Others_____7
(Specify)

Supervisor Scrutinized [ ]

Date: _____

Reinterviewed or spot checked by Quality Control Officer [ ]

Date: _____

* *First box for pre(1)/ post(2) workshop sterilization/injectable cases, and the next three boxes for sample numbers.*

BATCH NO._____

SECTION I

BACKGROUND INFORMATION

101. How old is your husband ?

_____ (in completed years)

102. How old are you ?

_____ (in completed years)

103. Which year did you get married ?

19_____ year (from 1993 _____ years back)

104. What was the highest class your husband passed ?

_____ class

If no class, write '00'

105. What was the highest class you passed ?

_____ class

If no class, write '00'

106. What is your religion ?

1 Islam

2 Hindu

3 Christian

4 Buddhism

5 Others _____ (Specify)

107. Does your family own any agricultural land ?

[1] Yes [2] No

108. What is your husbands' principal occupation ?

[1] Farming
[2] Agricultural wage labor
[3] Non-agricultural wage labor
[4] Petty business
[5] Trading (static business)
[6] Service
[7] Others_____
(Specify)

109. Aside from doing normal household work, are your engaged in any other work (for cash or kind) on a regular basis (such as agriculture work, making things for sale etc.) ?

[1] Yes [2] No

110. Is your husband member of any community organization(s) ?

[1] Yes [2] No

(Name of the organizations: [National NGO=1, Local NGO=2]

_____

_____

111. Are you member of any community organization(s) ?

[1] Yes [2] No

(Name of the organizations: [National NGO=1, Local NGO=2]

_____

_____

112. Now I would like to ask you some questions regarding number of living children, children who died, and pregnancy wasted.

	Total	B.	G.
Living children _____ Boy(s) _____ Girl(s) _____			
Children who died_____ Boy(s) _____ Girl(s) _____			
Pregnancy wasted			

113. INTERVIEWER: Check Q.112 and tick appropriate box

[1] Has living child [2] Other (SKIP TO 201)

114. What is the age of your youngest living child ?

Year _____ Month _____

Months

[1] Aged 5 years or below [2] Aged above 5 years

SECTION II

KNOWLEDGE ABOUT FAMILY PLANNING METHODS, WORKSHOPS, PARTICIPANTS, AND DISSEMINATION OF KNOWLEDGE BY THE PARTICIPANTS.

201. What method(s) of family planning do you know about ?

		Know=1; Do not know=2		
a.	Condom	1	2	
b.	Oral pill	1	2	
c.	IUD	1	2	
d.	Injection	1	2	
e.	Vaginal method (Foam/Jelly/ Emko)	1	2	
f.	Tubectomy	1	2	
g.	Vasectomy	1	2	
h.	Induced abortion/MR	1	2	
i.	Safe period	1	2	
j.	Withdrawal	1	2	
k.	Abstinence	1	2	

202. How many of the following methods of Family Planning you knew before using the current method ?

		Knew=1; Did not know=2		
a.	Condom	1	2	
b.	Oral pill	1	2	
c.	IUD	1	2	
d.	Injection	1	2	
e.	Vaginal method (Foam/Jelly/ Fmko)	1	2	
f.	Tubectomy	1	2	
g.	Vasectomy	1	2	
h.	Induced abortion/MR	1	2	
i.	Safe period	1	2	
j.	Withdrawal	1	2	
k.	Abstinence	1	2	

203. In your opinion, who are involved in family planning ?

			Yes	No	
a.	Government:	FWA	1	2	
		Other	1	2	
b.	NGO :	SAVE	1	2	
		Other	1	2	

c.	Imams	1	2	
d.	Teachers	1	2	
e.	Matbars	1	2	
f.	Chairman/member	1	2	
g.	Village Doctor	1	2	
h.	Others_____ (Specify)			

204. Where did you first learn about the FP method you are using now ?
[INTERVIEWER: Ask for sterilization if respondent is using the method, or ask for injectable if using injectable].

		Yes	No	
a.	Radio	1	2	
b.	TV	1	2	
c.	Poster	1	2	
d.	Leaflet	1	2	
e.	Billboard	1	2	
f.	GOB Fieldworker: FWA	1	2	
	Other	1	2	
g.	NGO Fieldworker: SAVE	1	2	
	Other	1	2	

h. Husband/Relative/Neighbor	1	2	
i. Community Leaders	1	2	
j. Others _____ (Specify)			

205. Do you know any chairman/member/teacher/matbar/sardar/imam (i.e., anyone other than the FP program personnel) who is involved in FP activities ?

1 Yes

2 No (SKIP TO 208)

206. Who is/are that/those person(s) ? (Status)

	Yes	No	
a. Chairman (elected)	1	2	
b. Member (elected)	1	2	
c. Teacher	1	2	
d. Matbar/Sardar (non-elected)	1	2	
e. Imam	1	2	
f. Village Doctor	1	2	
g. Social worker/NGO worker	1	2	

INTERVIEWER: Check, using the list with you, whether anyone of those persons were participants in the workshop.

1 Participant

2 Not participants

207. Whether that/those person(s) ever told you anything about Family Planning/Sterilization/Injectables ?

	Yes	No	
a. Family Planning:	1	2	
b. Sterilization:	1	2	
c. Injectables :	1	2	

208. INTERVIEWER: Using the list of workshop participants for the relevant union, ascertain the answers of the following questions.

209. (Readout the list containing the names of the workshop participants of this village and then ask): Who in the list interacted with you/your wife and discussed about sterilization/injectables during the last one year ?

INTERVIEWER: Put tick mark against all names mentioned by the respondent, using the list of participant for the village of the respondent.

a. Number of person(s)/name(s) in the list _____ mentioned _____

If no name mentioned write 9,99 - upto Q.213

b. Categories mentioned:

	Yes	No	
1. Religious leader	1	2	
2. Elected leader	1	2	
3. Sardar/Matbar	1	2	

4. Rural health practitioner	1	2	
5. Social worker	1	2	
6. Family planning worker	1	2	
7. Teacher	1	2	
8. Others (Service/ business)	1	2	

210. Who, according to you, among the name(s) mentioned was most active in terms of dissemination of knowledge about FP ?

_____ (Name) _____ (Status category) (use codes of 209.b)

211. Where and how many times during the last one year (June 1992-May 1993:Jaishta 1399-Baishak 1400) did you interact with them regarding Family Planning/Sterilization/Injectables ?

a. He/they called on	1	_____ times.	
b. I called on	2	_____ times.	
c. We met at a meeting convened on family planning	3	_____ times	

212. What did he/they say about the FP method you/your husband is using now ? (Tick: currently using: Vasectomy [1], Tubectomy [2], Injectables [3] (Multiple responses possible).

	Yes	No	
a. It is good for you	1	2	
b. Can stop use/switch to other methods	1	2	

c. Good for the family	1	2	
d. Good for the country	1	2	
e. Once done, the issue is over for life	1	2	
f. No side-effects	1	2	
g. It's not like pills that should be taken everyday	1	2	

213. Were you satisfied with the volume of information that he/they provided ?

Satisfied [1] Somewhat satisfied [2] Not satisfied [3] [ ]

214. After getting information about sterilization/injectables, what did you do next ?

	Yes	No	
1. Discuss with Husband	1	2	
2. Discuss with relatives/neighbors	1	2	
3. Discuss with FWA/FWV/FPI	1	2	
4. Discuss with FP users	1	2	
5. Others _____ (Specify)	1	2	

215. After getting information about sterilization/injectables, did you disseminated knowledge among others ?

[1] Yes [2] No (SKIP TO 301) [ ]

216. Who did you disseminate knowledge and what did you tell them ?

		Yes	No	
WHO:	1. Neighbor/Friends	1	2	
	2. Relatives	1	2	
WHAT:	1. No side-effects/method safe	1	2	
	2. It ensure small family which is a wise decision	1	2	
	3. It's not like pills that should be taken everyday	1	2	
	4. Can stop/switch to other methods (easily)	1	2	
	5. Others	1	2	

SECTION III

ACCEPTANCE OF STERILIZATION/INJECTABLES AND RELATED ISSUES

301. Before accepting the current FP method, which of the following methods did you/your husband use? (Don't prompt)

	Yes	No	
Condom	1	2	
Oral pill	1	2	
IUD	1	2	
Injectable	1	2	
Foam/Emko/Jelly	1	2	
Induced Abortion/MR	1	2	
Safe period	1	2	
Withdrawal	1	2	
Abstinence	1	2	

302. Will you please tell me who helped you in your decision making regarding sterilization (vasectomy and tubectomy)/acceptance of injectables ? (Multiple answers possible).

INTERVIEWER: Probe: Whether the respondents' decision of accepting sterilization or injectables was influenced by someone who participated in the workshop conducted by the SAVE(USA). If so, collect the following information and also try to find out whether the respondent was motivated by a person who in someway is related to the participant of the workshop. In that case, identify the person as well as his relationship with the participant.

		Yes	No	
a.	GOB Fieldworker (Give tick mark:FWA/FWV/FPI/ Sr. FWV/TFPO)	1	2	
b.	NGO Fieldworker	1	2	
c.	Friends/Neighbors/Relatives	1	2	
d.	Participant of the workshop_____ (Specify status)	1	2	
e.	Others_____ (Specify)	1	2	

303. Among those mentioned above who contributed most in your decision making regarding acceptance of sterilization/injectables ? Was he/she a participant of the workshop ?

1 Participant 2 Non-participant

304. Did your husband play positive role in decision making for sterilization/injectables ?

1 Yes 2 No

(SKIP TO 306)

305. What role did he play ?

INTERVIEWER: Probe to establish a chain of interactions of her husband with others regarding FP, sterilization, injectables.

	Yes	No	
1. Husband discuss about FP with FWA	1	2	
2. Husband discussed the matter with FPI	1	2	
3. Husband discussed the matter with elders in the family	1	2	
4. Husband discussed the matter with community leaders	1	2	
5. Husband discussed the matter with Rural Doctor	1	2	

306. What are the three main reasons that influenced your decision regarding acceptance of sterilizations/ injectables ?

	Yes	No	
1. Economic prosperity (ensures child education, food security, etc.)	1	2	
2. No side-effect/better for health	1	2	
3. Not desire anymore children, because small family is happy family	1	2	
4. Not like pills that should be taken everyday	1	2	
5. Stop use/switching is possible, when necessary	1	2	

307. Was there anybody who accompanied you/your husband to the clinic for sterilization/injectable ?

Accompanied [1] No company [2] (SKIP TO 309)

308. Who accompanied you/your husband to the clinic ?

	Yes	No	
1. FWA	1	2	
2. Husband	1	2	
3. Relative/Neighbor	1	2	
4. None	1	2	

309. Did you face any problem from religious point of view before accepting any method ?

1 Yes

2 No (INTERVIEW END)

310. How did you overcome the problem ? (Who did you talk to etc.).

_____

_____

_____

_____

_____

INTERVIEWER: Please check and recheck that all relevant questions are asked and all 'SKIP' instructions are correctly followed, 'THANK' the respondent for her time and cooperation.

INTERVIEWERS NAME: _____ TIME END: _____

INTERVIEWER CODE