



Community based Empirical study and Statistical Analysis about RH Cases with Canadian International Development Agency and Planned Parenthood Federation of Canada

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ABSTRACT

CBRHEP is an initiative of a package of service delivery at the community doorstep to meet the unmet needs and avoid the challenges of access to services and mobility of women, in particular. However it was observed that at certain locations, despite the service provision at a nominal cost, the preventive methodology acceptance is very low. The main source of this information is the reports received from the Project Locations regarding the preventive methodology use and clientele of RH services. The main question of the present study is to find out that, what are the factors that restrain people from availing the services, especially preventive methodology, while they are being provided at a nominal cost, or sometimes free of cost, at the community doorstep? This query can be answered by analyzing the views of the community members at the project locations from different angles, like socio-cultural, religious, economic, medical etc. It is also a very interesting inquiry regarding the operation of the project and existing gaps in its implementation.

The low acceptance of the preventive methodology has many dimensions and determinants; the discrepancy between stated fecundity preferences and reported preventive methodology behavior is often interpreted as indicative of latent demand for preventive methodology. Indeed, surveys carried out in many developing countries have shown that a discrepancy between productiveness preferences and behavior, commonly labeled "Unmet Need for FP," characterizes a sizable fraction of women of reproductive age in the developing societies. However the gap between the desired lushness and actual use not necessarily because of this unmet need; the social factors may be determinant of many behaviors and preventive methodology is one of them. According to Sathar et al (2001) "...what is remarkable about Pakistan is not the existence of this preference-use gap but rather its persistence at relatively high levels for decades without any significant change in prevalence and, accordingly, in period fecundity rates, which in the three decades leading up to the 1990s probably exceeded six births per woman."

KEYWORDS: Preventive methodologies, reproductive measures, empirical study, statistical analysis, significant differences

INTRODUCTION

In the past 50 years, the population of Pakistan has grown from 38 million people to more than 153 million people, making it the seventh most populous country in the world today. At the current growth rate of 1.9% per year the population will double in 37 years. The preventive methodology prevalence Rate is 36% with only 23.9% using a modern method, where as the unmet need is 33%.

The ICPD estimated that 350 million couples worldwide lack access "to the full range of modern FP methods" (UNFPA). It is estimated that 120-150 million married women worldwide wish either to have no more children or to delay their next birth at least two years but are not using any method of FP.

The causes of low contraceptive use are diverse; the socio-cultural milieu profoundly affects the preventive methodology uptake, like lack of proper information, prevalence of myths, affordability etc. Hence it is noteworthy, that in societies like Pakistan, where the family planning program launched long ago to fulfill the needs and control the alarmingly projected population, the high unmet need still persists.

This pilot project the Community Based RH Extension Project (CBRHEP) in a joint venture with Canadian International Development Agency (CIDA) and Planned Parenthood Federation of Canada (PPFC) to fulfill this long felt unmet need of the people of Pakistan. It was a unique project with a package of wide-ranging components of services providing at the doorstep of the community. The main services include: medicines for general health care, provision of contraceptives, safe motherhood and safe delivery kits, counseling on RH issues of adolescence

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and, first ever, Rights related to RH to meet the ICPD challenges and avoid all kind of violence, particularly against women. These services are being provided in the six districts of Pakistan, covering five locations in each district.

REVIEW OF RELEVANT LITERATURE

It is useful to review the existing researches before developing the research methodology for a study. An effort has been made to review the possible latest material relevant to the nature of present study.

AKIDA (2005) conducted a study “Awareness and Attitudes regarding FP & RH Rights at CBRHEP Locations in Test and Control Setting”, which was the assessment survey of the CBRHEP project where comparative analysis of CBRHEP operation areas was done with the areas with no intervention. The study concluded that the knowledge about the existence of FP methods was “remarkably higher in all target groups, with percentages having such knowledge being quite high for the basic methods and relatively lower for the advanced methods.” This study has close relevance with the present study; however the present study focuses on the factors restricting the preventive methodology acceptance, which was less emphasized in the study and broadly all components of the project were assessed.

According to UNFPA (2005) the preventive methodology can widely be affected by the socio-cultural and economic factors and also the factors impeding access on the part of following service providers:

- Wrong information on the part of provider or client;
- Service system biases favoring particular methods;
- Limited choice of methods;
- Inadequate attention to the client's experience;
- Inadequate discussion
- Myths about the preventive methodology

Since the present study also analyses the role of the service providers of CBRHEP, the UNFPA report gave a good view of obstructions and behaviors on the part of service providers.

Anwar (1987) conducted a very important study on “The Users’ Perspective”, which is quite relevant to the present study and it is useful to mention here. The main objective of the study was to delineate the perception about FP availability, choice and preference of user, in their particular socio-cultural milieu, in the operation areas of FPAP (respondents from the FPAP centers, who visited and utilized the services). The study analyzed the various issues regarding perceptions, attitudes and use of the preventive measures; the main barriers found in the FP use were availability, affordability and common myths about the side effects. The study found very useful in outlining the indicators and also offered sensible issues to explore in a way of Cohort analysis to compare the results over a long time.

In a study, Sathar et al (2001) have identified the following assumptions influencing on the fecundity behavior and preventive methodologies use of the women:

- The strength of attachment to the desire to terminate childbearing or postpone the next demand clearly varies among women. Some women who indicate a desire to avoid needs are relatively unconcerned about becoming needy.
- Many potential informational barriers exist to preventive measure use. Women must be aware of the methods available, must know where supplies of these methods can be obtained and how much they cost (with the exception of non-supply methods such as withdrawal and periodic abstinence), and they must know how to use the method they choose.
- Empirical research conducted during the 1990s makes evident that women’s perception that their husbands oppose FP is a dominant factor discouraging preventive measure practice in a wide variety of settings
- Costs of preventive measure may also influence its uptake
- In previous research conducted in Pakistan, the social, cultural, and religious unacceptability of preventive measure repeatedly emerged as an important obstacle to using a method.
- The same empirical studies carried out in diverse settings that highlight the determining role of women’s perceptions that their husbands oppose preventive measure also reveal that a set of related health concerns constitutes a powerful obstacle to using a method.

The above mentioned studies, though, in some way analyze the issue of low preventive methodologies acceptance; however, the present study primarily aims at analyzing the problem stated above from different dimensions. The literature review gave a good idea about the issue and helped in outlining and specifying the study objectives.

Significance of the Study:

The present study is important from many aspects. The analysis will not only give a extensive and up-to-date profile of the factors affecting acceptance of contraceptives, but also a precise set of recommendations evolved on the basis of scientific evidence. The project goals of increasing clientage and contraceptive use for the year VI (i.e. April 2005-March 2006) can be achieved after addressing the causes explored in the light of the present Study. The study will also bring to light some issues for the long-term implications for the FPAP strategy regarding BCC, FP promotion and service delivery. As the nature of present study particularly focuses on the communities where Services are provided in Mobile Setting, the empirical data from the present study will specifically suggest important suggestions for such Setting to adopt Pilot project in to National level full-fledged project.

Objectives of the Study:

The main objective of the present study is to find out the factors influencing the preventive methodologies use among the people of the project locations. This broad objective can specifically be seen from different perspectives. Specifically the present study intends to explore:

1. The basic demographics of the respondents
2. Reproductive behavior of the respondents
3. Knowledge about various preventive methodologies methods
4. Socio-cultural, biological and economic obstacles in the preventive methodologies use
5. Attitude towards the women’s reproductive rights
6. Attitude and Utilization of services offered by CBRHEP

Since the study conducted by AKIDA (2005) [2] presents a comprehensive analysis about the awareness and attitudes towards the Reproductive Rights, the present study will try to explore only the attitude of men about few rights that can impede the access of women to the FP/RH services.

Table 1: Indicators for Measurement

Sr. No.	Objective	Indicators
1.	Demographics of the respondents	<ul style="list-style-type: none"> • Age, education, occupation, monthly HH income, persons living in HH • Education & occupation of spouse, family structure • No. of sons & daughters
2.	Reproductive behavior	<ul style="list-style-type: none"> • Respondent’s and spouse’s age at marriage • Had infant death, use any FP method/ intended to use • Ideal No. of children and male child preference
3.	Socio-cultural, Medical and economic obstacles	<ul style="list-style-type: none"> • Personal and community attitude towards FP; Discussion on FP use • Obstacles/Problem faced in FP • Affordability • Myths about side effects
4.	Attitude and Utilization of services offered by CBRHEP	<ul style="list-style-type: none"> • Knowledge and utilization of CBRHEP services • Affordability and access to services by CBRHEP • Counseling and whether faced any misbehavior

Validation Procedure and Results

METHODOLOGY

For the present study, Triangulation approach was incorporated for validity of data, in which both qualitative and quantitative methods were used. For quantitative analysis, cross-sectional survey method was used for statistical analysis. Face to face interviews with 317 respondents were conducted by the Operations Research Officer and the project Counselors. For qualitative assessment, Focus Group Discussions (FGDs) were conducted and Thematic Analysis was done [3]. Due to time constrains, the researcher decided to conduct one FGD of men and one of women, from each district. There were, on the average six to eight participants in each FGD.

Universe:

The universe for the present study consisted of the married men & women in the operational areas of CBRHE Project.

Questionnaires:

Two modules of pre-coded questionnaire, for men & women, were developed to collect data from both sex groups. The indicators are drawn to measure the objectives, on the basis of review of the existing studies (see Table of Indicators). The parameters used for developing the tool were

- Reproductive Behavior
- Role of CBRHEP
- Knowledge & Use of FP
- Medical Aspect & Perceived/ Observed Side Effects

For additional information and exploring some issues in-depth, some open-ended questions were also included, which gave a comprehensive picture of the user and non-user’s perspective. For conducting Focus Group Discussions, an FGD Guideline was also developed.

Pre-testing of the Tools:

The questionnaires was pre-tested and improved in the light of the feedback received during the pre-testing procedure; 20 respondents, 10 men and 10 women were interviewed for the pre-testing of the tool. These interviews were not included for the data analysis [6]. Since most of the respondents were illiterate, the questionnaires were used, as Interview Schedule and question were described for the respondents in the local language.

Sampling Technique:

For the present study, multi stage sampling technique was used. Since it was a community based survey, respondents were interview from their houses, rather than those who visited the mobile clinic. A scientific sample of 317 respondents was drawn to have generalize-able results. The researcher actually decided to interview 30 men and 30 women from each project FAP/Region, however due to time constrains, only 317 respondents were interviewed. Three locations from each district were selected for interview (except Karachi and Lahore, where only two locations were visited). The detail of the data collected region wise is as under:

Table 2: Detail of the Data Collection

Region/FAP	Men	Women	Total
Faisalabad	28	27	55
Islamabad	30	30	60
Kohat	27	28	55
Lahore	24	26	50
Quetta	24	26	50
Karachi	23	24	47
Total	156	161	317

The data was then entered in the computer program SPSS for analysis and statistical calculations. The tables/ graphs were generated using Microsoft Excel.

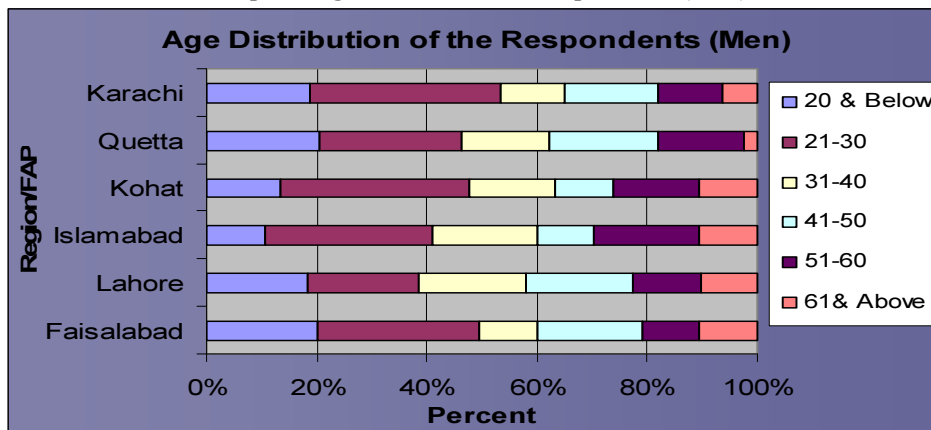
Field Work & Data Collection:

For the quality and reliability of data, the Operations Research Officer collected data from the male respondents, while the Counselor interviewed the female respondents. The Operations Research Officer conducted the FGD of men with the help of the male doctors and Counselor conducted female FGD with the assistance from the female doctor, *in toto* 2 FGDs from each district were conducted.

Findings:

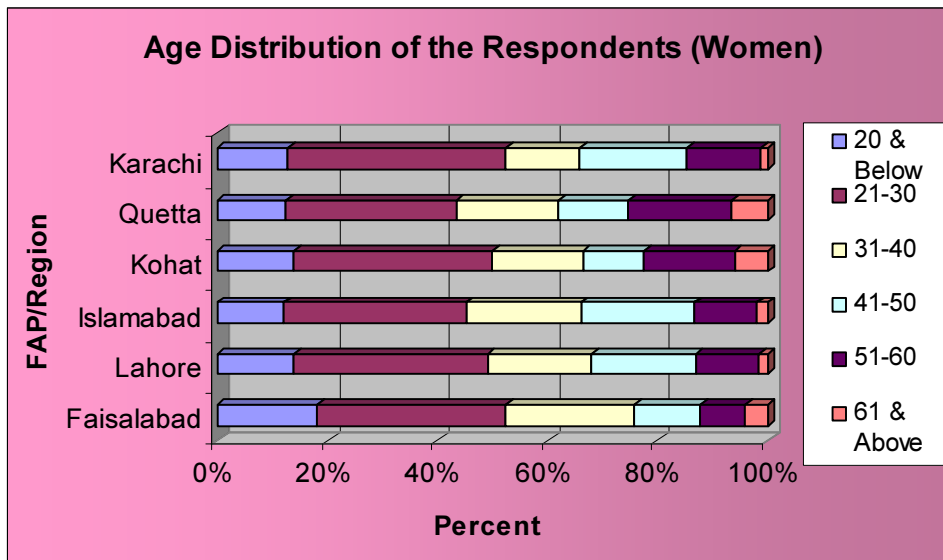
Section I: Demographic Data

Graph 1: Age Distribution of Respondents (Men)



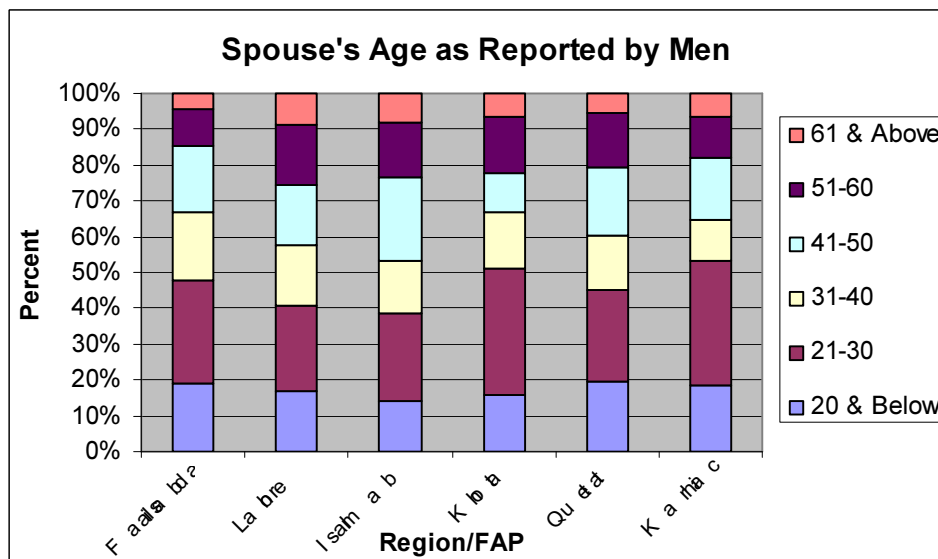
The graph 1 described the location wise age distribution of the male respondents. Since the universe of the study consisted of the married people of CBRHEP location, whether they were in their reproductive span or not, some respondents above the age of sixty were also interviewed, as it was assumed that they had more knowledge about community and their perspective is important as well. However majority of the respondents were in their reproductive age.

Graph 2: Age Distribution of Respondents (Women)



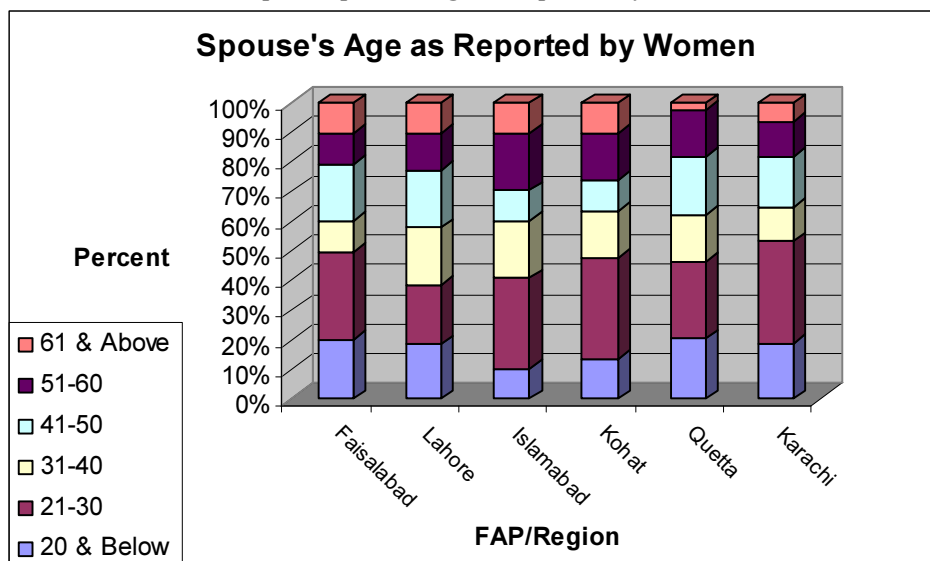
Graph 2 depicted the age distribution of the female respondents. The proportion of sixty plus female respondents is comparatively low as compared with men. A most of the women were between the ages of 20-40.

Graph 3: Spouse's Age as Reported by Men



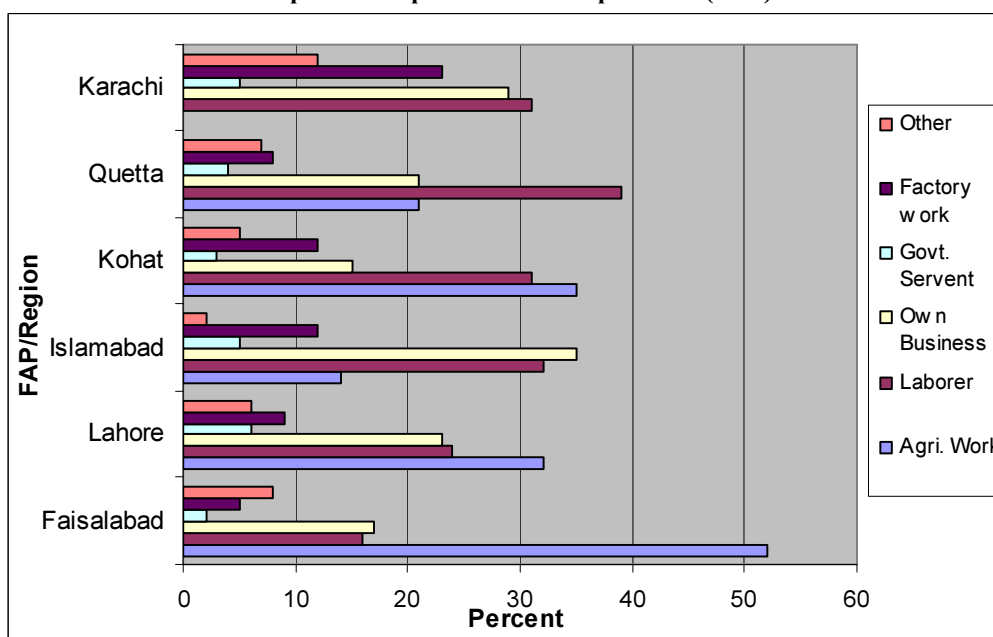
Graph 3 showed the age of the wives described by the male respondents. The difference between the age of husband and wife still exist in Pakistani society due to cultural norm.

Graph 4: Spouse's Age as Reported by Women



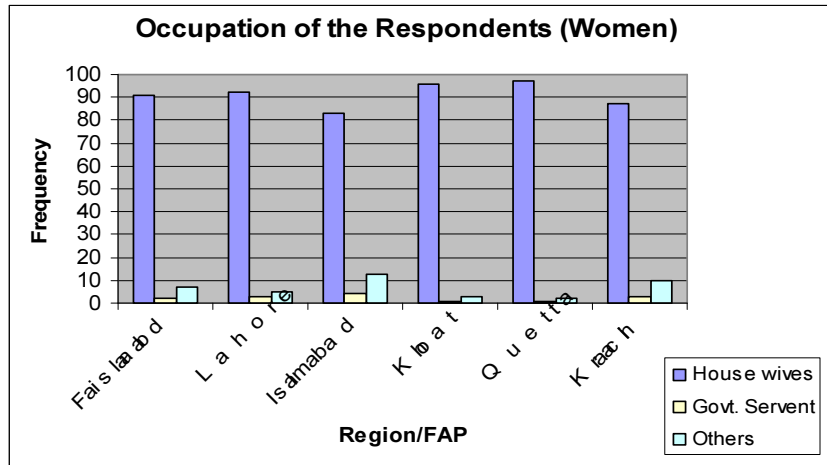
The graph 4 [6] described the ages of the husbands as reported by the female respondents; the graph showed that the husbands were relatively aged as compared with their wives.

Graph 5: Occupation of the Respondents (Men)



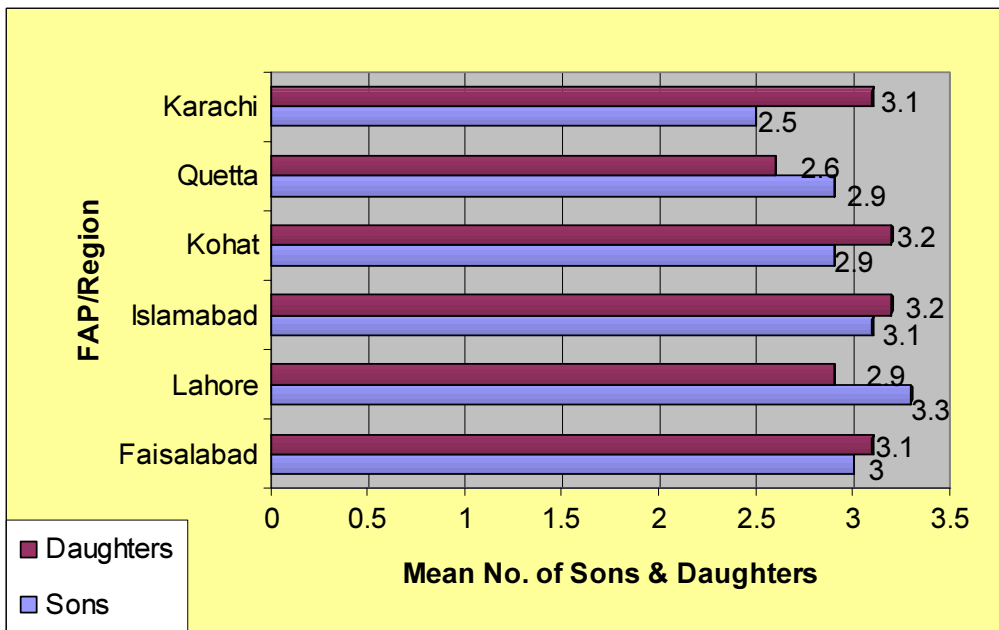
Graph 5 described the occupation of the male respondents; it is clear that in Faisalabad, Lahore and Kohat most of the respondent were related to agriculture work, where as in Karachi, Islamabad and Quetta the proportion of people related to agriculture is relatively low. The occupation distribution of the respondents somehow described the economic status of the respondents; in the regions like Karachi and Islamabad, where people were either workers or running their own business were having relatively higher monthly income.

Graph 6: Occupation of Respondents (Women)



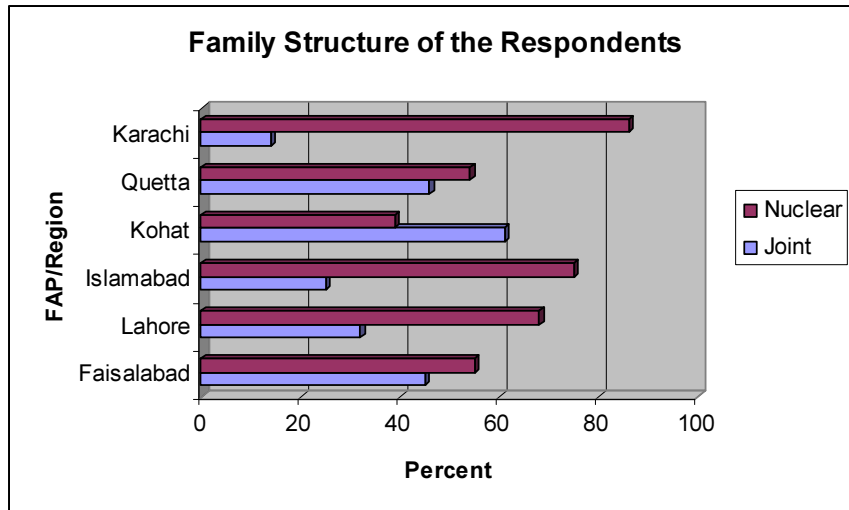
Graph 6 showed that a majority of female respondents were housewives; only a few respondents (mainly from Islamabad and Karachi) were doing some kind of work. The phenomenon is also rooted in the culture, where women are restricted to do any work other than the household chores.

Graph 7: Mean Number of Children of the Respondents



Graph 7 described the mean number of sons and daughters as reported by the respondents in each region/FAP. Though a gradual change is observed in the fertility behavior of the community members, where CBRHEP is working; however, reproduction and fertility of the people is very complex phenomenon that is spread over a long period of time and immediate results cannot be seen. Nevertheless, it is obvious that rural and peri-urban communities where average number of children used to be 7 or 8 plus, now adopting the FP methods.

Graph 8: Family Structure of the Respondents



Graph 8 showed that most of respondents were living in the nuclear family system, except Kohat where more than half of the respondents reported that they live in the joint family structure. It is important to note that those who live in the joint family system, with mother and father in law and other close relatives, may face some kind of opposition or their fertility behavior may be influenced by the others.

Table 3: Level of Education of the Respondents (Men)

Region	Level of Education (Men)						Total
	No-Schooling	Primary	Middle	Matric	Inter	BA & above	
Karachi	1	3	5	9	3	2	23
Quetta	8	2	5	6	3	0	24
Kohat	9	3	4	9	1	1	27
Islamabad	1	2	9	5	11	2	30
Lahore	2	8	3	6	4	1	24
Faisalabad	5	6	4	7	3	3	28
Total	26	24	30	42	25	9	156

Education, which remains a big hurdle in success of any project, does influence the work of CBRHE Project, especially for advocacy of rights and motivating people for FP use. It is relatively easy to convince the educated people for FP use or any other behavioral change than the uneducated ones. Table 3 described that majority of the respondents had low level of education and only 34 out of 317 respondents were having intermediate or above level of education.

Table 4: Level of Education of Respondents (Women)

Region/ FAP	Level of Education (Women)						Total
	No-Schooling	Primary	Middle	Matric	Inter	BA & above	
Karachi	2	5	4	9	3	1	24
Quetta	14	4	4	2	2	0	26
Kohat	12	3	3	8	1	1	28
Islamabad	3	4	8	6	7	2	30
Lahore	4	9	4	4	3	2	26
Faisalabad	7	3	7	4	4	2	27
Total	42	28	30	33	20	8	161

Table 4 [6] depicted that number of female respondents with no schooling is about double than that of the male respondents. Women's education level is important factor in their autonomy, decision making and adopting some behavior consequently. However, due to cultural norm, girls' education often sacrificed to the boys' education. Nevertheless, recent programs, including incentive offering, for promoting girl education showed encouraging results.

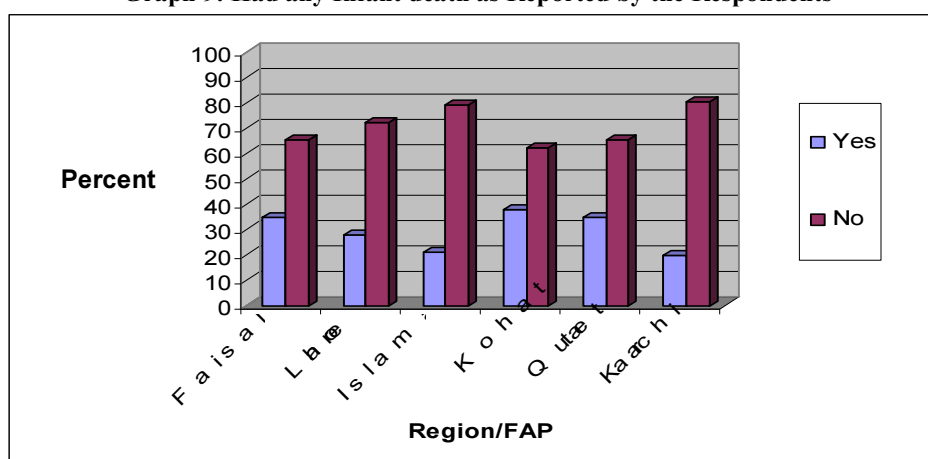
Table 5: Average Monthly Household Income of the Respondents

Region/FAP	Monthly Household Income of the Respondents (Rs)				Total
	Below 3000	3000-5000	5001-8000	8001 or above	
Karachi	13	20	8	6	47
Quetta	22	23	3	2	50
Kohat	18	21	10	6	55
Islamabad	10	31	10	9	60
Lahore	8	23	12	7	50
Faisalabad	14	23	7	8	55
Total	85	141	50	38	317

Table 5 described the monthly household income distribution of the respondents; it is obvious that the project is working in the locations with poor and marginalized people, who have least opportunities for basic health services. A majority of the respondents reported that their monthly household income below 5000 Rs., which shows their living standard below the poverty line, as if we divide this income to the household members, is less than a dollar a day.

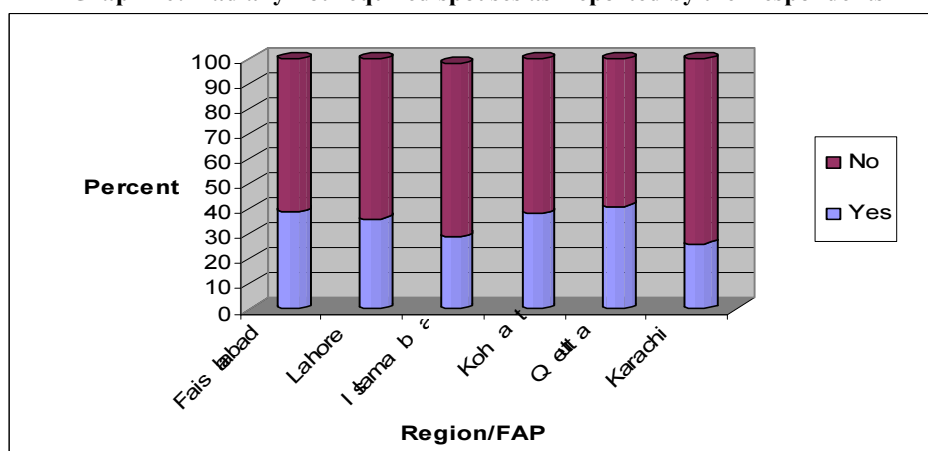
Section II: Reproductive Behavior

Graph 9: Had any Infant death as Reported by the Respondents



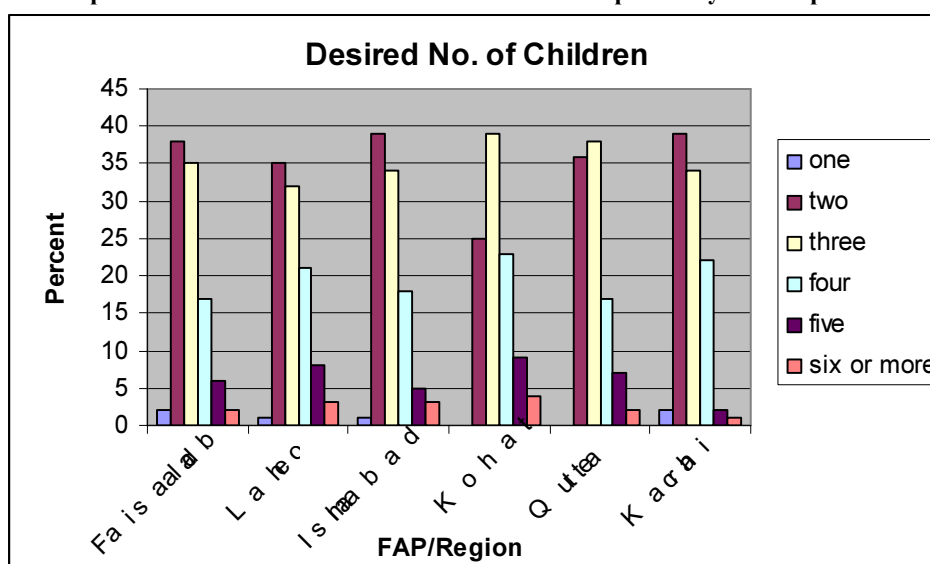
Graph 9 [6] showed that a considerable number of respondent reported that they had at least one infant death. The data matches with the Govt.'s estimation of high infant mortality in Pakistan; however, since the project works in marginalized rural and peri-urban communities, the magnitude of the problem is worse. The data also showed that IMR is relatively low in Islamabad and Karachi, due to better access to services.

Graph 10: Had any not required spouses as Reported by the Respondents



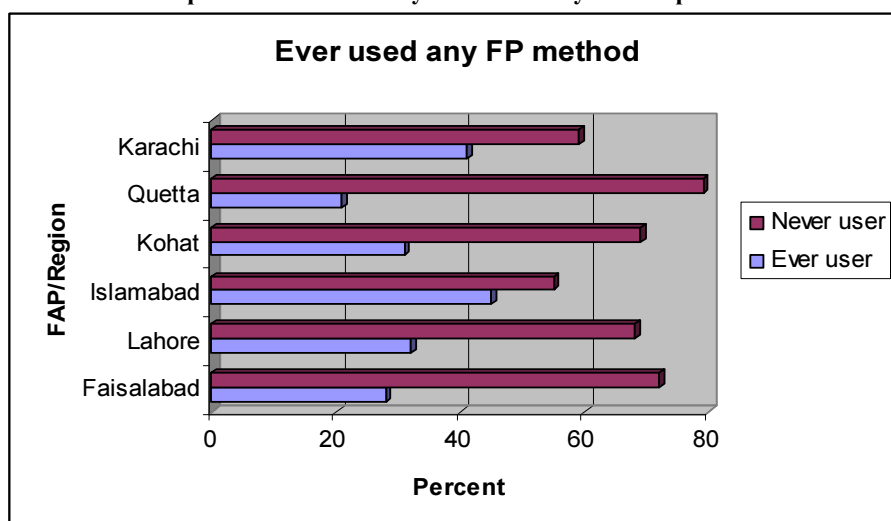
Graph 10 showed that a sizable number of the respondents reported not required spouses; the matter of not required spouses in the societies like Pakistan is quite serious, where people, due to lack of knowledge, non-availability of services etc, have a lot of not required spouses. The data can be compared with the desired and actual number of children. It was interesting to note during the field work that a lot of people do not admit the occurrence of the not required spouses; it required a lot of probing to get response regarding this matter, as people would say, it's all because of will of God and he sends children as many as he desires.

Graph 11: Ideal/Desired Number of Children as Reported by the Respondents



The data presented in the graph 11 depicted the attitudinal changes that occurred over a long period of time, when people stated thinking about the small family. A majority of the respondents were of the view that two children are ideal [3]. The desire-practice is a deep matter of concern for policy makers; it is not a, very simple desire-practice duo, rather a complex phenomenon, many governed by various social, psychological and cultural factors.

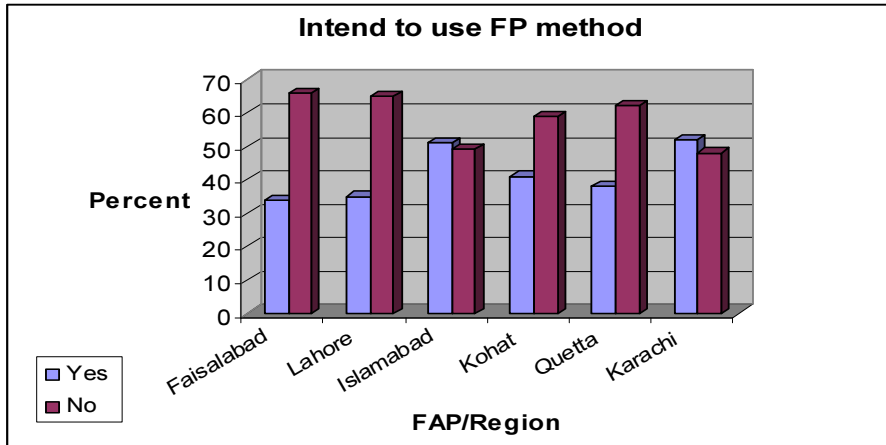
Graph 12: Ever Used any FP method by the Respondents



Graph 12 described that majority of the respondents reported that they never used any FP method; since this question was asked in the very beginning of the interview, many respondent practicing withdrawal or rhythm methods, who are not acknowledged as the FP methods, did not answered in affirmative. However, from the overall

data (coming graphs) it is obvious that a majority of the respondents were not using any FP method due to various reasons.

Graph 13: Respondents' Intention to Use any FP Method

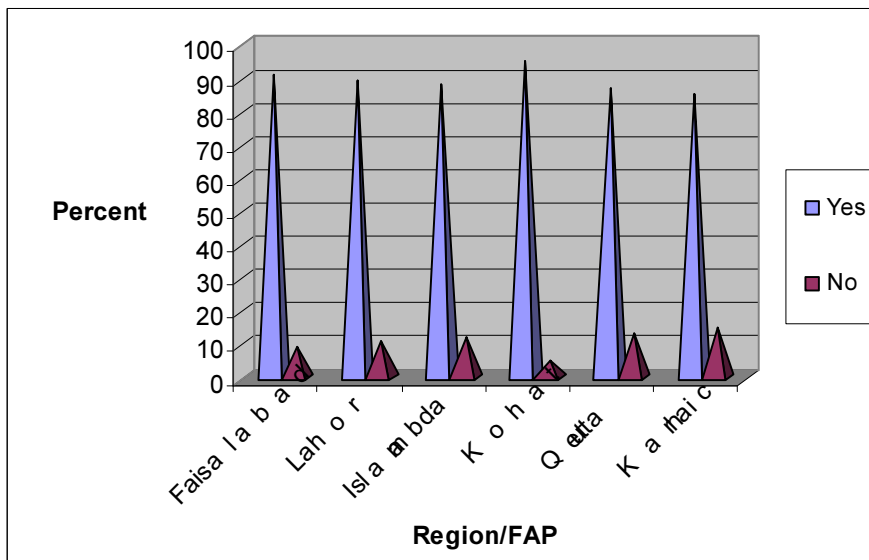


Graph 13 clearly defined that a lot of respondents showed their intention of using some family method; it was observed that mostly those respondents who had a family with four or more children, expressed their intention of using some reliable (modern) FP method. Interesting, some respondents asked the researcher which method was appropriate for them and what should they used; obviously it was because of the rapport build for the interview that the people trusted and asked for 'Mashwara' (counseling for FP).

Section III: Role of CBRHEP:

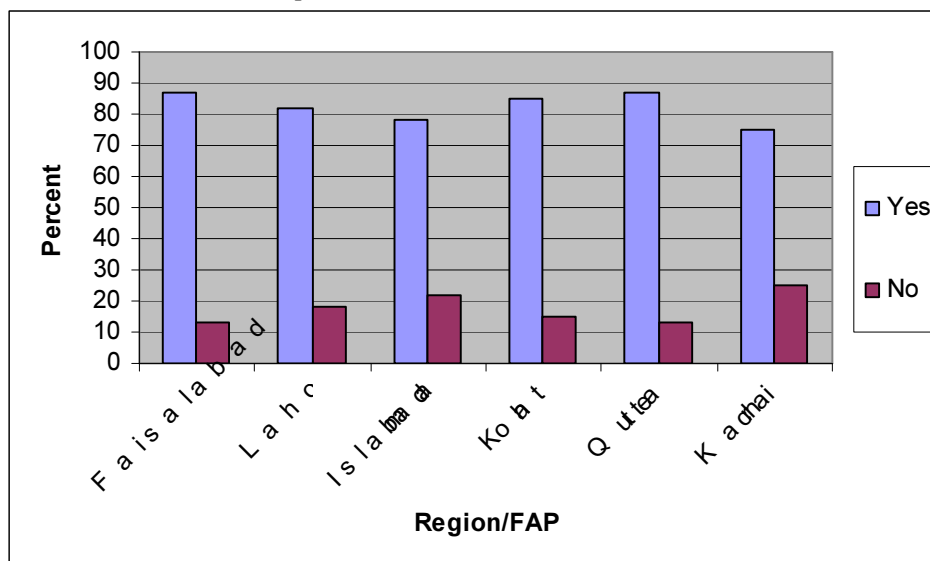
It was important to know about the role of CBRHEP and perceptions of people about its functions and effectiveness. Keeping in view this objective, the researcher asked questions specifically about FP, despite the other components of the project.

Graph 14: Knowledge about CBRHE Project



Graph 14 showed that an overall 88% percent of the community members knew about the project. The data described that majority of people were aware about the services of the project.

Graph 15: Ever Visited the Mobile Clinic



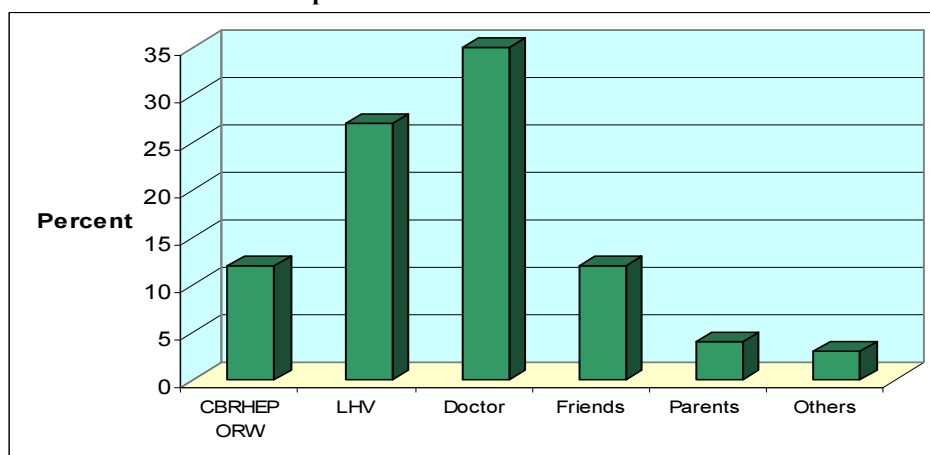
Graph 15 described that an overall 82% of the respondents had visited or their spouse visited the mobile clinic in their locality for some purpose. This shows that a large majority of the people visit the mobile clinic due to non-availability of the services in their area. Further, when the respondents were asked about the purpose of their visit, about half of 40% of them reported that they visited for PHC or some seasonal infections; about 35% were those who visited for having some kind of FP services. About 12% said they visited but did not remember what kind of services they went for.

The respondents were also asked, whether they face any misbehavior or absence of staff or any other unpleasant event at the clinic. About 84% of those who visited said they faced no such event; however some people (9%) reported that they had to wait for long time. Some respondents also shared that occasionally it happens that they wait but the team does not come. This might be because of teams' engagement in workshops for which they had to drop their mobile clinic.

When the respondents were asked what should be the Purchi fee of the project for services, a majority of the respondents (78%) said that Rs. 5 is fine; however some respondents (9%) said that it should be totally free for all kind of services. Interestingly, some 6 % respondents also said that nominal charges of Rs. 5 for quality services, devalues the project: it should be more.

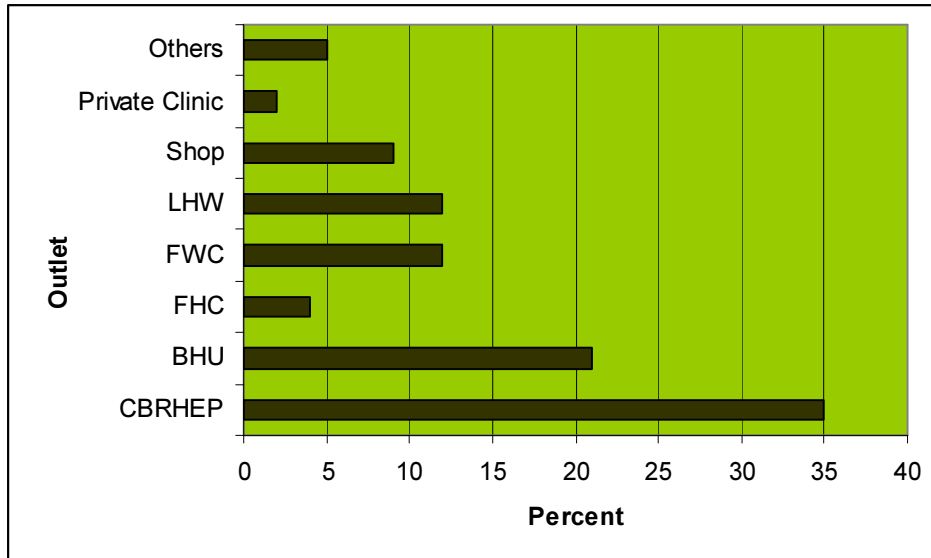
The respondents were then asked, whether they even received counseling for FP. About 32% of them said No; 61% said yes they received the counseling and 7% of the respondents gave no response.

Graph 16: Who Counseled for FP Use



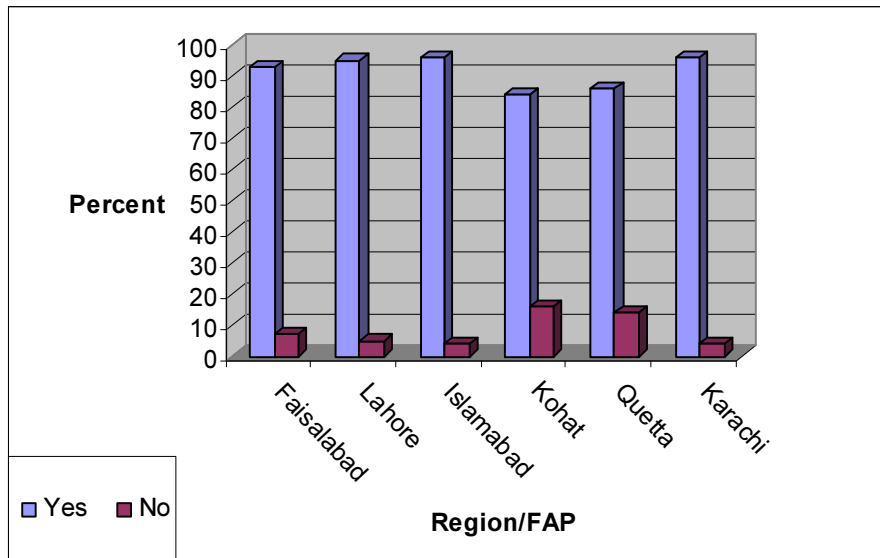
The respondents were asked about the details that who counseled them for FP use. Majority of them said the project doctor or LHV counseled them. It is noteworthy that majority of the women in the communities consider the project Counselor a doctor also. LHV was also a major source of counseling for many women. However, the project outreach workers (ORWs) who are the community members and expected to counsel more people being the part of them did not show a good progress.

Graph 17: Where to Go for FP Services



When the respondents were asked where they get the FP services from, a most of them said that CBRHEP provides them such services. Basic Health Unit of the Govt. was also another big source of FP services. The FWC of Govt. and LHW contributed about 13% to the FP services. About 8% respondents (mostly men) also said they can get services, usually condoms, from the local shop.

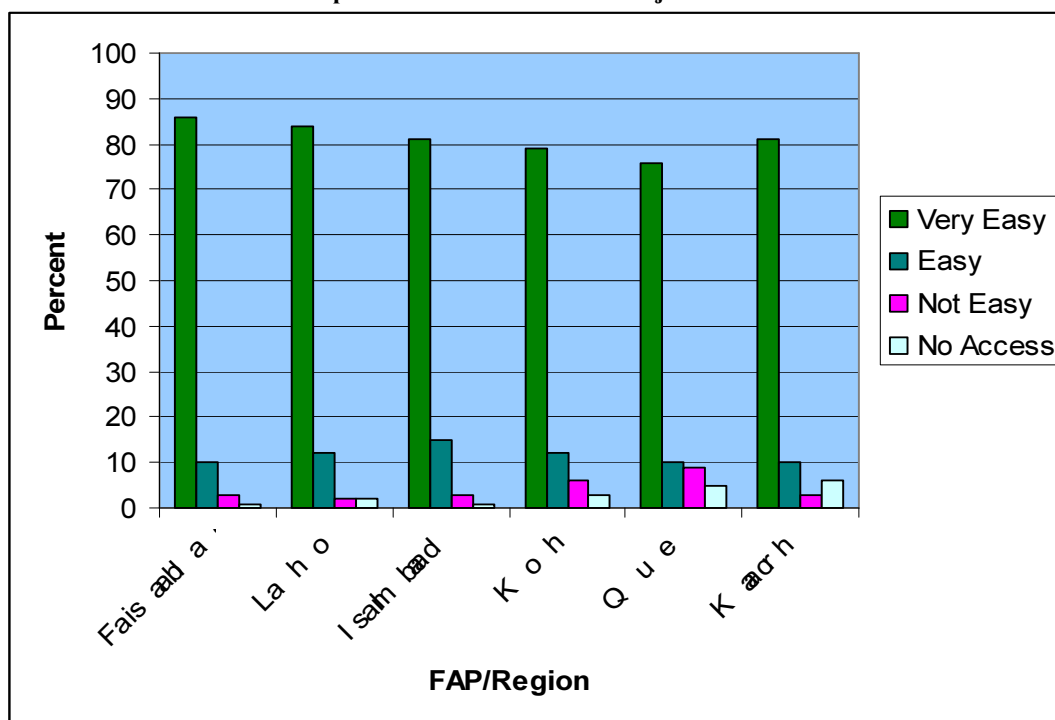
Graph 18: Whether has an Easy Access to FP Services



When the respondents were asked whether they had an easy access to services related to FP, a large majority (89% overall) said that had easy access to FP services and contraceptive. This is an important point that, through CBRHEP or other health outlets/service providers, there is an increases access to services for the people, but still

many people do not avail the services. Affordability may be an issue for non use, but when the respondent were asked in their view, which FP methods were affordable to them. A majority of them said that pills, condoms and injections were the methods they can easily afford [4].

Graph 19: Access to CBRHE Project Services



Graph 19 described that a majority (84% overall) of respondents had very easy access to the services of the project; some respondents (5%) reported that they had not easy access, as the camp site is far away. 3 percent of the respondent (mostly women) were those who said they had no access to the mobile clinic, as they were not allowed to avail the services.

Section IV: Focus Group Discussions:

As described earlier, for having an extensive picture of the situation, triangulation technique was applied for the present study and both qualitative and quantitative approaches were used. In the qualitative part, FGD method was used for making thematic analysis. Two FGDs, one of men and one of women, were conducted at each Region/FAP. The ORO facilitated the male FGDs whereas the counselor facilitated the female FGDs. An FGD guideline was developed keeping in view the objectives of the study and detail discussion against each issue, as well as information about basic demographics was manually recorded. Before conducting the FGD respondents were briefly described the purpose of the study and after brief introduction discussion was started. After completion of FGD, the doctors & researcher/counselor thanked the participants and were presented refreshment and their time and participation was acknowledged.

CONCLUSIONS AND RECOMMENDATIONS

Conclusions:

The obstacles in prevention methodologies acceptance, though, range from social to economic and perceived/fear of side effects, however the social factors mainly affect the FP use. The social obstacles are rooted deep in the superstructure and culture of the society. The attitude of fellows, whether favorable or not, influence of the aged people, religious mindedness and perceptions that Islam is against the FP use, least women empowerment

and son preference, all directly or indirectly affect the attitude about FP and consequently the use of prevention methodologies.

Son preference, which has its roots in the patriarchal form of society, dependence on sons for financial support during old age and continuation of the family name, and the necessity of a dowry for female children, remains a big obstacle in fertility decline and usage of prevention methodologies in many parts of the country. The same phenomenon applies to CBRHEP locations as well. Since the project primarily covers the rural and peri-urban areas, the effect of son preference is there. However, it was observed that the men's preference for a male child is more than the women; many men reported that they will go for repeated demands for having male child like 'Try Try Again!'. Interestingly, many women were also in favor of repeated 'tries' for getting a male child; in the Pakistani culture if a woman is failed to produce a male child she is stigmatized and considered responsible for this 'inability' or sometimes she may be divorced or man would go for another marriage. A woman, afraid of this fact and for 'survival', would also prefer repeated needs.

Despite other social factors, a stigma is also related to prevention methodologies use. Since the matters related to prevention methodologies and FP are actually the issues actually related to gender; studies also suggest people often feel shame to talk about matters related to gender. People often want to avoid the embarrassment when the others will know about their use of prevention methodologies. This phenomenon was observed more in the location with most traditional culture, like Kohat and Quetta.

Pakistani culture has its deep roots in Religion; despite the history of a half century of the population programs by Govt. and the private sector, still many people think that FP is against religion and the MoPW or NGOs who are working on it, are actually against Islam and 'Agents' of the West. Though in the various strategies by FPAP and MoPW has addressed the issues of Islam and FP, still there is great need to focus on this issues and all the efforts made in this regard needed to be revisited.

The project has definitely great effect in changing attitude of the community members regarding basic hygiene, FP, SMH, SRH, and SRH rights; however the change is very slow and difficult process. The 'Catalyst' of CBRHE Project brought remarkable change among the men, women and youth of the communities, however still there is need to focus on the Advocacy aspect. The marginalized communities, under-served people and poverty stricken face need more than what the project offered; the number of general health and PHC cases was so high that team cannot give full attention to the advocacy component. So we realistically accept the limitations of time and human resource.

Proper knowledge about prevention methodologies remains a big issue for the communities; the data compared with the researches National Institute of Population Studies gives encouraging picture. But due to lack of education many people don't have proper knowledge of FP methods. However, the project has increased access to the services, which definitely brought about good change among people and by counseling when they get proper knowledge they do share it with friends and fellows.

Perceived dissatisfaction of a method and fear of side effects remains another big challenge for service providers and policy makers; many people do not try to know about the method and just believing on the prevailing myths, do not attempt to know or use a method.

The research drew the conclusion that the complicated issue of low acceptance of prevention methodologies should be seriously taken care of. The increased access to services has really an immense effect; however there should be comparatively more focus on the community level activities, because this is what differentiates CBRHEP from Mobile Service Unit and vast network of FWCs of the Federal and Provincial Governments.

Recommendations:

The researcher is of the view that the prevention methodologies use or non use is not an easy matter to describe; it is an extremely complex phenomenon with multiple dimensions and causes. The whole issue should be holistically seen in a particular social setting. All above mentioned factors not necessarily effecting prevention methodologies acceptance with same magnitude at all locations; particular social, economic, cultural and social psychological conditions can never be ignored when developing strategies for a locality. Not necessarily the same macro level strategies apply to all locations however; they can be amended and should be flexible enough to change for a specific social setting. For example, PHC which was the entry point of the project, not necessarily was needed to be focused that much as in, say, Islamabad, as it was needed in Quetta; they could focus more on advocacy however. The present study, like the previous evaluative researches, highlights remarkable changes in people's knowledge, attitude and practices by comparing the data with the national level statistics. However, at the 'take-off' stage of the 'Visible Change', the project services and activities should not be discontinued, which remain a big question mark for organization as well as the donor.

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