CHAPTER II

Enhancement of family planning services: An approach to increase low or non-use of contraception in Nepal

2.1. INTRODUCTION

The main issue addressed here is low or non-use of contraception among currently married women of reproductive age (15-49 years). The Nepal Family Health Survey (NFHS) 1996 shows that use of contraception is only 29% whereas knowledge of contraception is 98. 3% among currently married woman of reproductive age (CMWRA). Similarly, the total demand for family planning of this age group is 60%. The total demand for family planning refers to the sum of the total met need (current use of contraception 29%) and unmet need (31%) for family planning (Pradhan et al., 1997). Therefore, we must be concerned about low or non-use of contraception in comparison to knowledge and total demand of family planning.

The unmet need is defined on the basis of women's responses to survey questions where they said that they wanted to avoid or postpone pregnancy but they

are not using contraception. This group is large, consisting of 31% among currently married woman of reproductive age 15-49 years (Pradhan et al., 1997).

There are 5, 672, 615 women aged 15-49 year in Nepal (CBS, 1996). Among them 3, 961, 434 are married women of reproductive aged 15-49 targeted for FP services. In other words 736, 827 (31% of 3961, 434) married women of reproductive age constitute the unmet need for contraception.

For the last 30 years, Nepal has been experiencing an increasing trend in population growth, while the population growth rate in 1991 was 2. 1, it was 2. 41 in 1996. If this trend continues, the population is projected to be increased 37 million mark by the 2025 AD (Central Bureau of Statistics, 1996). It is also concluded that high fertility (4. 6 birth/women) and low use of contraception (29%) among women of reproductive age are the causes of high population growth in Nepal (NHEICC, 1996). The wanted fertility (if all unwanted births were avoided) of Nepalese women is 2. 9 birth per women but actual total fertility rate is 4. 6 birth per women (Pradhan et al., 1997).

Maternal mortality is high in Nepal which is 515/100, 000 live births in which unsafe abortion accounts 50% of the maternal deaths. Infant and child mortality also high which accounts 86/1000 and 118/1000 live births in Nepal. It can be assumed

that contraceptive use by couples can help to prevent infant, child and maternal mortality as well as help to reduce total fertility.

Nepal family planning program has been set a target to increase contraceptive use to 37% by the year 2000 AD. But, the last 20 years (1976-1996) trend of contraceptive use is increasing only by 1. 3% on an average per year. If the target has to meet, present trend must be increased, otherwise set target can not be met.

The reasons for low or non-use of contraception are: lack of knowledge of services and methods of family planning, accessibility and affordability of family planning services, side effects of the methods, desire to have more children by the couples, religious restriction and husband's opposition (Pradhan et al. , 1997). Among these reasons, CMWRAs are not using contraceptive methods mainly because of fear of side effects (16%), desire to have more children (15%), religious restriction (9%) and husband's opposition (4%) of currently married women of reproductive age 15-49 years (Pradhan et al. , 1997).

There are many alternative solutions to increase the use of contraception such as maximizing access to good quality family planning services, focusing on men as well as women, integrating contraception services with other health services and emphasizing communication activities (Robey et al. , 1996).

The government of Nepal has been implementing primary health care outreach clinic, postpartum family planning clinic in order to make the contraceptive methods widely available. The commodity distribution program for sufficient delivery of contraceptive supplies and medical standard for clinical contraception for quality of care family planing services have already been introduced. Further, social marketing organization and the non-governmental organizations are also involving for providing family planning services. The efforts have been made to apply multi-media information, education and communication approach to change knowledge, attitude and behavior of the people about family planning

Considering the nature of the causes of low or non-use of contraception, family planning counselling services to the clients should be one of the most appropriate intervention. It is found that counselling family planning clients in health facilities have increased the use and continuation of contraception and decreased the discontinuation of contraception.

A one-year long study of the impact of counselling services at a health post in Nepal with a control group showed that 70. 8% of women continued using temporary contraceptive methods from the health post with counselling services whereas only 37. 7% women continued using these same methods from the health post without counselling services (Shrestha, et al. , 1993). It suggests a difference between health posts with or without counselling services in using temporary contraceptive methods.

Despite the perception of side effects are high among counselled clients, there is higher continuation and low dropout rate of contraceptive methods (Shrestha, et al. , 1993). The result of an operational research project carried out in Egypt among post abortion clients shows that the use of contraceptive methods increased by 30% due to the improved counselling. In addition, the family planning counselling has been identified as the essential component of reproductive health care package for dealing with side effects of methods and change of methods (WHO, 1996).

Priority has been given to the introduction of counselling services in the family planning program for the clients but the services have not yet been incorporated into practice by the health workers as an essential component of the family planning program. Similarly, counselling services are available only in a limited number of health facilities. The reason is that health workers lack family planning counselling skills (FHD, 1994). Trained health worker can provide family planning counselling services competently to the clients. As a result, client will receive clear, accurate and adequate information about contraception which will ensure the continuation of a contraceptive methods. The community level health workers have the strongest influence on contraceptive decisions by women in Nepal (Storey and Karki, 1996). Family planning clients, therefore, need counselling services through health workers who are trained in family planning counselling skills to increase present contraceptive use among currently married women of reproductive age 15-49 years.

2.2. NEED FOR CONTRACEPTION

2.2.1. Control population growth

For the last 30 years, Nepal has been experiencing an increasing trend in population growth, while the population growth rate in 1991 was 2. 1, it was 2. 41 in 1996 (Central Bureau of Statistics, 1996). It has been concluded that low contraceptive use is the causes of high population growth in Nepal. According to National Planning Commission, if this trend continues, population of Nepal will reach the 37 million mark by 2025 AD from present 20. 32 million (NHEICC, 1996).

Table 2. 1: Percentage of population growth, contraceptive prevalence rate (CPR) and total fertility rate (TFR) by country.

Country	Pop. Growth Rate	TFR	CPR
China	1. 00	1. 95	83
Sri Lanka	1. 20	2. 39	62
Indonesia	1. 50	2. 77	50
India	1. 80	3. 59	41
Bangladesh	2. 20	4. 13	45
Nepal	**2. 41	*4. 60	*29

Sources: 1. Sadik N., 1995. The State of the World Population, 1995
* 2. Pradhan et al., 1997. Nepal Family Health Survey, 1996
**3. Central Bureau of Statistics. Statistical Pocket Book, 1996

Table 1 shows that population growth 2. 41 and fertility rate 4. 6 of Nepal is higher than other selected Asian countries. It can be assumed that low contraceptive prevalence is one of the contributing factor for high population growth for example, contraceptive prevalence rate of China is 83% where population growth is 1% and total fertility is 1. 95/woman. Similarly, contraceptive prevalence rate of Sri Lanka is 62% where population growth rate is 1. 2% and total fertility rate is 2. 39/woman. Since, the use of contraception has no immediate impact on population control, the

ultimate impact of the use of contraception is to control population growth by reducing fertility rate in the country. Therefore, contraceptive use by CMWRA should be increased to control the high population growth in Nepal.

2.2.2. Control fertility

Despite that the total fertility rate has decreased from 5. 8 in 1991 to 4. 6 in 1996, it is still higher than the desired fertility rate which is 2. 9 births per women in Nepal. The use of contraception is one of the main proximate determinant of fertility. The main purpose of using contraceptive is to control fertility and bring the population under control in the country. The fertility rate depends not only with the use of contraceptive but also depends on the duration and continuity of use of contraceptive methods during the most fertile period of their life. Therefore, encouraging women to use contraception for long duration continuously is essential to control fertility and to bring replacement fertility rate. Enabling women to control their fertility give them greater control of their lives permitting to make a plan to take new education, economic and other opportunities. Specially young women benefited most from being able to control their own fertility in their younger age from contraceptive use (McCauley et al., 1994).

The use of contraceptive method makes the women healthier by avoiding too close, too young, too old and too many pregnancies and unsafe abortions and it enables women to limit or space their families (McCauley et al., 1994). It can be

assumed that if this situation not avoided, it leads to high maternal mortality and fertility.

2.2.3. Prevent maternal mortality

Complication during pregnancy or child birth take the life of one women every minute in the world. Experts have used an estimate of 16 morbidities per maternal death based on a small-scale study in India in 1980 (Sadik, 1995). Nearly 99% of the 500000 maternal deaths annually are in the developing world from pregnancy related causes. It is the equivalent of one death per minute. The major factor in preventing maternal morbidity and mortality is access to appropriate health services including family planning (Sadik, 1995). So contraception is a key factor in preventing maternal mortality.

Complication related to pregnancy and during child birth are among the leading causes of maternal mortality in Nepal. Recently, maternal mortality was 515 per 100, 000 live birth in Nepal in which 50% of the maternal deaths occurred due to unsafe abortion (Sadik, 1995). Most of the complications related to pregnancy and child birth are easily preventable. One measure to prevent pregnancy-related diseases and for reducing maternal mortality is to avoid pregnancy by using contraceptive methods.

The practice of contraception significantly reduces pregnancy related mortality primarily by reducing the overall number of pregnancies and naturally reduces the related complications. Reducing unwanted pregnancies also reduces maternal deaths by reducing the unsafe abortions. If contraceptive method not used by the couple, it leads to unwanted pregnancy and consequently undesired child birth. The unwanted pregnancy might lead to unsafe abortion. Unsafe abortion leads to maternal mortality. Nearly half of the maternal death could be prevented by avoiding unwanted pregnancy (Sadik, 1994). A study at Matlab Bangladesh showed that a low level of maternal mortality is associated with increased levels of contraceptive use. Therefore, contraceptive use contribute to a decrease in maternal mortality.

2.2.4. Prevent high infant and child mortality

Infant mortality in Nepal is very high in comparison with other countries of the world, at 86/1000 live births (Pradhan et al. , 1997). It can be assumed that the use of contraceptives is associated with infant mortality. By policy, the ideal number of children per couple is two in Nepal but parents assume that some children would die between their 1st and 5th birthdays. As a result, couples tend to give birth to more than this ideal number of children and too closely spaced. When spacing of children is less than 2 years and more children are born in the family, proper child care will be reduced. The first child will suffer different kinds of diseases due to lack of full time breast feeding and nutrition. The low care of infant and child can cause

the high mortality rate. Children born less than 2 years after the older brother or sister is twice as likely to die as children born after at least 2 years interval (Mckeithen, 1987). It is found that higher the contraceptive use, lower the infant mortality. For example, in Sri Lanka contraceptive use rate is 62% and infant mortality rate is only 15/1000 live birth. Therefore, using contraception and spacing pregnancy for more than 2 years is one of the measure to prevent infant and child mortality.

2.3. DEFINITION OF CONTRACEPTIVE METHODS

Contraceptive methods are, by definition, preventive methods to help women avoid unwanted pregnancies. They includes all temporary and permanent means to prevent pregnancy resulting from coitus (Park, 1994).

According to the population report "*Contraceptive use, of course, is use by an individual or couple as a means to avoid pregnancy. Contraceptive use helps women to meet their practical and strategic needs by enabling women to control when and how many children to have*" (McCauley et al. , 1994, p. 4). Practical need includes good child care, better agricultural technology and better housing in which women need to perform these current roles and activities more effectively. Similarly, strategic need includes training of new jobs, enforcement of equal legal rights and access to more education which broaden their choices and opportunities (McCauley et al., 1994).

Contraceptive methods are devised mainly for women. We can say that women are one and only persons who bear the physical burden of pregnancy and child births. They bear the complications resulting from pregnancy and child births so that birth control is primarily a women's concern. By viewing the expected complications of pregnancy and childbirth, they seek to prevent that complications. Contraceptive methods are those measures which prevents unwanted pregnancy and child birth.

2.4. SITUATION OF CONTRACEPTIVE USE IN NEPAL

The use of contraceptives have increased considerably over 20 year period, 1976-1996. The current use of family planning methods is 28. 8 % among currently married women of reproductive age (CMWRA) 15-49 years. It was 3% in 1976 among CMWRA 15-49 years. On an average, it shows that contraceptive use increased 1. 3% per year during 20 years period.

Table 2. 2: Percentage of yearly use of contraception among CMWRA, 1976-1996

Years	Use
1976	3. 0
1981	7. 0
1986	15. 1
1991	24. 1
1996	28. 8

Source: Pradhan et al., 1997. Nepal Family Health Survey, 1996

Table 2 shows that despite the efforts made by the government to increase contraceptive use among CMWRA, the contraceptive use among CMWRA non-

pregnant women found very low in comparison with knowledge in Nepal. Nevertheless, the use of contraception is in increasing trend in Nepal.

Table 2. 3: Percentage of methodwise use of contraception among CMWRA, 1996

Methods of Contraceptive	Use
Female Sterilization	13. 3
Male Sterilization	6. 0
Injectable	5. 0
Condom	2. 1
Pills	1. 5
Norplant	0. 5
IUD	0. 3
Diaphragm/Foam/Jelly	0. 1
Total	28. 8

Source: Pradhan et al., 1997. Nepal Family Health Survey, 1996

Table 3 shows that the sterilization methods (male and female) are predominant over the spacing methods. More than 65% of contraception consists of sterilization and remaining is by spacing, i. e., temporary methods. It includes 19. 3% sterilization and only rest of the 10 % includes spacing methods. The total use of family planning methods is 29% among CMWRA.

The priority has given to encourage to use spacing methods but still, sterilization method is predominant. The main purpose of contraceptive is to stop birth and space birth by the couple. The couples use sterilization method while they have completed their desired fertility of their whole life. In this situation, the purpose of spacing birth will not be made as desired and there who have sterilized have more than 2 child.

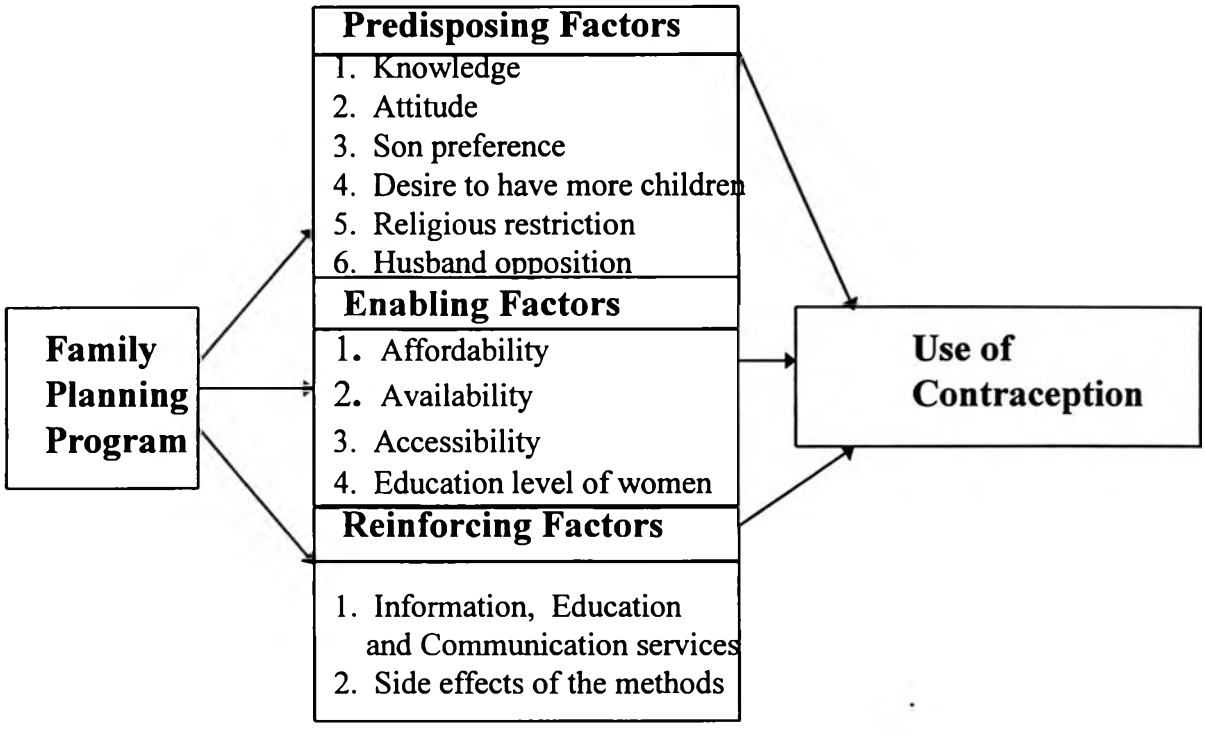
2.5. FACTORS AFFECTING CONTRACEPTIVE USE

Family planning services is one of the component of primary health care. It is a basic primary health care services for the people. For this purpose, the government has established one sub-health post consists of 3 paramedical staffs for each village to provide basic primary health services to the people. At present, family planning efforts has been made to provide easy accessibility, availability and quality of contraceptive services to the clients.

Even though, the low or non-use of contraception among currently married women of reproductive age (CMWRA) has been seen as a problem to control population growth, reduce unwanted pregnancy, unsafe abortion, maternal mortality, infant and child mortality and other STD/HIV problems in Nepal.

The efforts to provide contraception services may be affected by the different other factors. Therefore, any family planning efforts must be ready to deal and in a position to react and solve with those factors which could have negative impact on the program achievements. What are those factors contributing in using contraceptive methods by couples ? We need to analyze the situation of those factors. Figure 1 shows some of those factors which affects the use of contraception.

Figure 2. 1. The causal relationship of factors affecting contraception behavior.



Source: Green, L. W., Kreuter, M. W., (1991). Health Promotion Planning, An Educational and Environmental Approach.

2. 5. 1. Predisposing Factors

A. Knowledge of contraceptive methods

The knowledge of contraception is essential before deciding to use. It means knowledge precedes the use of contraception but knowledge alone can not change behavior. Even though, it has positive association with changes in behavior (Green and Kreuter, 1991) by women. Here, knowledge of family planning is defined as having heard of a method by CMWRA. They know and can name any one of the method spontaneously.

Table 2. 4: Percentage of yearly knowledge of contraception among CMWRA 1976-1996

Years	Knowledge
1976	21. 0
1981	52. 0
1986	56. 0
1991	93. 0
1996	98. 3

Source: Pradhan et al., 1997. Nepal Family Health Survey, 1996

Table 4 shows that the knowledge of family planning has increased considerably over 20 year period, 1976-1996. Current knowledge of family planning methods is 98. 3% among currently married women of reproductive age (CMWRA) 15-49 and CMWRA are familiar with at least one specific modern contraceptive methods in Nepal (Pradhan et al. , 1997). The knowledge of family planning is in increasing trend.

Table 2. 5: Percentage of methodwise knowledge of contraception among CMWRA 1996

Methods of Contraceptive	Knowledge
Female Sterilization	96. 3
Male Sterilization	89. 7
Injectable	85. 0
Pills	80. 5
Condom	75. 3
Norplant	57. 3
IUD	35. 9
Diaphragm/Foam/Jelly	28. 3
Total	98. 3

Source: Pradhan et al. , 1997. Nepal Family Health Survey, 1996

Table 5 shows that the knowledge of spacing methods is lower than that of permanent methods but the use of permanent methods is predominant. The knowledge of IUD, Norplant and Diaphragm/Jelly is slightly low in comparison to

other methods. The knowledge of sterilization specially female sterilization method is predominant. NFHS, 1996 indicate that less than 2% CMWRA are not using contraception due to lack of knowledge of methods.

B. Attitude towards family planning

Most of the societies are male dominant in the Asian countries. Nepal is one of the countries where male dominance is prominent. Males dominate in every aspect of life and even in contraceptive use of couples. But unlike many Muslim countries, women don't have problem to choose method of their choice. Only 15% of husbands of the CMWRAs do not approve family planning and 90% approvement of family planning is made by wife in Nepal (Pradhan et al. , 1997). But, joint decision making on contraceptive use is essential for continuous use, long term use and understanding and keeping warm relation between husband and wife.

C. Son preference

Preference of son over daughter is no doubt a universal feature in South Asian countries. But some of the countries have a more acute problem. Nepal is one of those countries where son preference is a more acute problem. A son is perceived as insurance for old age. "*One needs a son to perform religious rituals at their death and death anniversaries*" (Schuler and Melvyn, 1986, p. 68). Daughter is viewed as burden on the family and it is assumed that they have no responsibility for the parent's old age security as they are married with the son of another family. The

practice of dowry at the time of marriage of daughter is another reason for son preference. Thus, couples are giving birth until they give birth to a son (Glennon and Fegan, 1993). They don't want to use any birth control method at that time due to their son preference. They adopt contraception only after giving birth to a son.

Trying for a son, many couples have more children than they would prefer in the family as well as large number of birth is needed to assure the survival of at least a son. Counselling services to those clients can be reduced to try for a son over daughter. They get direct information on advantages of small family and disadvantages of larger family from this services. A recent study in Matlab, Bangladesh indicate that son preference can have a strong effect on contraceptive use and fertility.

Researchers have estimated that eliminating preference for sons would increase contraceptive use by 10% and continuation rates by 15% among couple. This situation would prevent nearly one birth for every two couples (McCauley et al., 1994). It can be happen because when couples don't want son over daughter, they seek to avoid pregnancy. For this reason, they need contraception. Therefore, seeking to avoid pregnancy will be attributed to the increase of contraception.

D. Desire to have more children

Despite the modern norm of family should be small, some couples desire to have more children in the family. It can be assume that couple desire to have more children because of a son preference but having daughter only, looking after parents at the old age if one did not look after, controversy between husband and wife in using contraception, feeling of side effects of the methods who used contraception and not meeting replacement fertility of the couple.

The main reason of desiring more children in the family is lack of confidence to the couple of a survival of one or two children. So they are unlikely to control their fertility (Douglas and D'souza, 1996). Therefore, they don't use contraception until getting birth of desired number of children. NFHS, 1996 shows that 15% of CMWRA are not using contraception because of desiring to have more children.

E. Religious restriction

One of the main determinants of contraception is religious restriction. It affects in acceptability of contraception by couples. Thus, despite couples want , they don't use contraception due to religious restriction. They are afraid of their religion. They are afraid of social stigma when they break their religion. It is assumed that someone who uses contraception will not be eligible to worship the God in Hinduism. Muslim religion does not allow the use of contraception except

reasonable cause such as health concern. NFHS, 1996 shows that 9% of CMWRA are not using contraception because of religious restriction.

F. Husband opposition

Actually, Nepalese family is dominated by the male (Husband). Husband opposition is major obstacle to use contraception by his wife. Some male have negative attitude about women choosing and using contraceptive. They assume that contraceptive use will make their wives independent of their control and have sex with other men. The couples who have only daughter in the family also do not allow their wives to use contraception due to a need of son in the family. *"There are many societies where a wife's use of birth control triggers her husband's suspicion that she is promiscuous"* (Gupta and Currie, 1996, p. 12). In Nepal, only 4% CMWRA are not using contraception due to their husband's opposition. Therefore, husband opposition may affect not only whether or not wife use of contraception but also the choice of a method and how long it is used.

2.5.2. Enabling Factors

A. Affordability of family planning methods

All contraceptive services are provided free of cost to the clients from the government sector in Nepal. In the case of sterilization method of contraception, the government provides sterilization service with a payment to client of Rs.100/ person in the form of incentive at the time of sterilization for their dieting purpose to

clients. If someone, who is eligible for contraception, does not want to go to the government health facilities to get contraceptive services, he or she can obtain these services from private medical facilities such as private hospital, nursing home, pharmacy, female community health volunteer (FCHV). Family planning association of Nepal also provides free of costs contraceptives to all its clients in 27 districts out of 75 districts through volunteers. The Nepal Family Health Survey (1996) shows that the 79% of modern methods users obtain their methods from a public service, 14. 1% from private medical service and 5. 6% from other source such as FCHV, shop, friends/relatives. The cost of contraceptive methods are not significant because only 0.2% CMWRA are not using contraceptive methods due to high cost.

B. Availability of family planning Services

The availability of services is an important factor which influences the success of family planning program. Family planning clients need convenient availability of services. At present, the program has expanded its coverage with increasing numbers of services delivery outlets and services have been provided through varied channels and agencies such as hospitals, primary health centres (PHC), health posts (HP), sub-health posts(SHP), primary health care (PHC) outreach clinics, mobile voluntary surgical contraception (VSC) camps, village health workers (VHW), female community health volunteers (FCHV) and other non-governmental organizations (NGO) in Nepal. But IUD, Norplant and sterilization methods have been provided

through specific Hospitals, PHCs and HPs because these services need trained manpower.

The availability of services have increased over the years by establishing sub health posts in each village so that the injectable, condom and pill are currently available through the majority of the health outlets in the country. However, no one method of contraception is appropriate for all couples. Some of the family planning services outlets such as sub-health posts and health posts lack regular Norplant, IUD and sterilization services. Similarly, female sterilization is only provided through mobile camps and hospitals. So, method of choice of contraception is not available in all family planning outlets.

The present approach in family planning programs is to provide a "cafeteria choice" that is to offer all methods from which an individual can choose according to his needs and wishes and to promote family planning as a way of life (Park, 1994). We can say that there is no cafeteria choice in every family planning services outlets in Nepal. Nonavailability of services or method of choice of family planning services at the health facilities could result low use of contraception and increase unwanted pregnancy and child birth.

C. Accessibility of family planning services

The accessibility of service is another important factor which influence the success of family planning program. The accessibility defined as the perceived travel time to reach a closest health facilities from household. Family planning clients need family planning services within easy reach. They need the services within their communities where they live. The summary of the program of action of the International Conference on Population and Development 1994 has mentioned new approach for achieving population and demographic targets. One of the key to this new approach is providing women with more choices through expanded access to health services (UN, 1995). However, Family planning services are the part of primary health services.

Nepal living standard survey 1996 shows that the 45% of the household have access to health post within a travel time of half an hour. The other 55% of the households have access to health post within a travel of half an hour to 3 hours (Central Bureau of Statistics, 1996). The health posts are the closest health facilities for the community which is primary level institutions of health services. People have much better access to family planning services in urban areas than in rural and in terai areas than in hill and mountain areas. However, accessibility has not seen as a reason for non-use of contraception or low use of contraception because the government has already established a sub-health post in each village to provide primary health

services. NFHS 1996 also shows that only 0. 5% CMWRA expressed that they are not using contraceptive method due to lack of access.

D. Education level of women

Out of 5, 672, 615 women aged 15-49, only 17. 9% have completed a primary level education whereas 46. 6 men have completed a primary education in that same age group (Pradhan et al. , 1997). Therefore, education level of women in Nepal is low in comparison with men.

The education level of women also influences the use of contraception. Lack of education reduces the earning potential of a person in labor market. It cause the poverty. The poorer the household, the lower the chances of getting education. As a result of lack of education, they don't get more chances to be familiar with the outside environment of family life and generally, women don't know about consequences of not using contraceptive. In addition, they don't know about where, how and when to get contraceptives and its information . NFHS, 1996 shows that 26% of CMWRA with no formal education are contraceptive users compared with 52% of CMWRA with an School Leaving Certificate (SLC). It shows that use differences among CMWRA is double between no formal education and education with at least SLC.

We can be assumed that the higher the level of education, the higher the exposure in the social environment. As a result, they themselves enable and want to explore and learn more about their social life as well as actual benefit of contraceptive use in their married life. They will minimize all the side effects and problem to be faced for obtaining the contraceptive services when they are aware of disadvantage of large families, short interval of birth between two children, unwanted pregnancy, unsafe abortion, maternal mortality, infant and child mortality and other STD problems. Then, they seek to use contraception and it helps to be free more or less from these problems. However, educated women are more able to communicate, plan and involve in improving their lives (Sadik, 1994).

2.5.3. Reinforcing Factors

A. Health information, education and communication(IEC)

Presently, IEC is one of the component of any health related activities for successful program implementation and to obtain desired outcome of implemented activities. The main objectives of the IEC is to encourage a change in the knowledge, attitude and behavior of the people toward family planning services. The current knowledge of family planning methods have 98. 3% among CMWRAs and they are familiar with at least one specific modern contraceptive methods in Nepal. The 90% of CMWRAs have positive attitude and 29% of CMWRAs are using family planning methods (Pradhan et al., 1997). We can say that increased knowledge of family planning is the product of IEC program specially exposure to

mass media about family planning information in which 40% CMWRA are exposed to Radio, 23% exposed to print media and 1. 4% exposed to television. But family planning methods are not used as gained knowledge by CMWRA because IEC program could not change the behavior of the CMWRAs as expected.

It is found that some reasons to use low contraception or non-use are the fear from side effects of the contraceptive methods & belief about contraceptive cause weakness, people's perception on no sufficient fund to buy nutritious food to overcome perceived weakness, socio-cultural belief on religion is against the contraception, desiring more children in the family and husband opposition in using contraception (Shrestha, et al., 1988).

Effective IEC program can encourage to change family planning behavior of the people by motivating them to use contraceptive methods for their advantage. We can assume that if people are motivated to use contraceptive methods, demand for contraceptive services will be generated and increased so as to contraceptive use will be increased in the same manner. Counselling is one of the effective approach of health education, information and communication which helps to increase contraceptive use among the married women of reproductive age. A study on the role of Information, Education and Communication in family planning service delivery in Tunisia, 1987 showed that the number of new acceptors increased by 125% where only IEC program was implemented as an intervention. In addition, this study

suggested that IEC component of the family planning services is more effective than that of increasing the number of new services outlets (Coeytaux et al., 1987).

B. Side effects of the methods

More or less every methods have side effects but somebody feel side effects and some don't. Different methods have different types of side effects. User's perception is that condom makes allergy and foam makes vaginal irritation. Since Pills, Injectable and Norplant have different side effects, some common side effects are amenorrhoea, bleeding, headache, weight loss or gain, breast tenderness and mood change. The side effects of IUD are cramping, pelvic infection, irregular bleeding, amenorrhoea, vaginal discharge and partner's complaint about strings. Similarly, the side effects of the sterilization are wound infection, hematoma, pain and swelling (FHD, 1995). It is found that the main side effects perceived by the couples are (1) headache, weakness, nausea (2) weight loss (3) heavy bleeding and (4) reduce sexual potency (Shrestha, 1988). NFHS, 1996 shows that 16% of CMWRA are not using contraception because of perception of side effects of the methods.

2.6. POSSIBLE STRATEGIES FOR INCREASING CONTRACEPTIVE USE

The different approach has been applied so far to solve the problem of low or non-use of contraception in Nepal. Considering different kinds of strategies have always been an important issue to program managers specially among those who want

to enhance services, attract more clients for family planning and increase contraceptive prevalence at service points.

In general, the reason for low or non-use of contraception suggest some of the strategies to improve the situation such as maximize access to good quality family planning services, emphasize communication activity, focus on men as well as women and integration of family planning services into other health services (Robey et al., 1996). The details of these strategies are described below.

2.6.1. Maximizing access to good quality of family planning services

Quality of family planning program consists of six elements such as choice of method, information given to client, technical competence, interpersonal relations, follow-up or continuity mechanism and appropriate constellation of services (Bruce, 1989). Thus, access to good quality family planning services can be one of the six element of quality of care family planning program which offer number of choices of contraceptive methods recently available in the country.

Similarly, clients have different contraceptive preferences and needs. A lack of contraceptive choice may be problem because no one method of contraceptive is appropriate for all clients attending in the service outlets. Some client wants to use long acting contraceptive methods such as IUD and Norplant, some clients want to use sterilization and some clients want to use short-acting contraceptive methods such

as pills, condom and injectable. If there is no provision of these methods, the use of contraception will be low or non-use.

Maximizing access to good quality contraceptive methods can attract new users and enable current clients to continue use rather than discontinue when their needs change. Therefore, the key elements of access and quality are the number of contraceptive methods available, the quality of counselling about side effects and the attitudes of providers towards their clients (Robey et al., 1996).

2.6.2. Focus on men as well as women

Family planning methods are devised mainly for women. Decision of husband is one of the important aspect to use contraception by the wife. The men have more decision power in each and every aspect of life even in use of contraception. Some males have negative attitude about women choosing and using contraceptive. They assume that contraceptive use will make their wives independent of their control and have sex with other men so that they do not allow to use contraception. Thus, NFHS, 1996 shows that 45% women discussed their husband in using contraceptive method at once.

The family planning program has already been focusing for women. Therefore, focusing men in family planning program can increase their contraceptive use, encourage women's use of contraception and improved continuation. For this

reason, any family planning program should be focused to promote husband wife communication on family planning matter.

2.6.3. Integration of contraceptive services with other health services

Health services includes availability of related health care as well as family planning services. An integrated approach to family planning services can improve the contraceptive use among CMWRAs. Family planning services have been provided through clinics, mobile camp, outreach clinic but these have not been sufficient for the wider availability of contraceptive services.

The contraceptive services should be incorporated with other health programs such as childhood immunization, postnatal visits, care of complications of unsafe abortions, women development programs, population programs, formal and non-formal education programs. We can assume that the women are more likely to use one or both services than when just one service is available in the health facilities. Therefore, this strategy can reach many women with need for contraception as wider availability and can increase the use of contraception by women. It is found that telling mothers about family planning services when they brought their children for immunization services increased the average monthly number of family planning clients by 54% in Togo (Huntington and Aplogan, 1994). But this strategy need more cost and personnel in order to provide contraceptive services with other health services.

2.6.4. Emphasize communication activities

Many couple have never tried contraception because of lack of information about contraceptive methods that where to get, how to get and when to get. We assume that some couples feel contraception can cause infecund, reduce sexual potency and it is riskier than became pregnant. Similarly a study of non-use of contraception in Nepal shows that couple did not use contraception because contraception cause weakness and need additional food to replace the weakness (Shrestha et al. , 1988). Family planning program can overcome these obstacles through mass media and interpersonal communication. But interpersonal communication specially counselling family planning client should be the most important approach where mass media communication is not easy access like in Nepal.

Among the four strategies considered, communication activities covers most of the problems emerged in using contraception by CMWRAs. The communication activities specially counselling can be one of the component of quality family planning services. It is a most effective way of communication. Even husband can be invited to accompany the family planning clients in discussing about the contraception with health workers. In counselling process, we can focus both husband and wife together in counselling session. The satisfied women who counselled with health worker can discus more with her husband and spread information to her friends, neighbors and relatives. In this way, it helps to increase contraceptive use by women.

We can provide counselling services childhood immunization and postnatal care simultaneously. Providing counselling services don't need extra cost in health facility because existing resources are sufficient. Therefore, counselling component of communication activities covers most of all four strategies.

2.7. COUNSELLING FOR FAMILY PLANNING CLIENTS

Counselling is the process of encouraging and helping an individual in identifying family planning problems, the ways of their solution and encouraging necessary decisions and actions to solve it as obtained advice from the counsellor (FHD, 1995). Family planning counselling is a special form of interpersonal communication between service provider and clients. Most people require training to become proficient counsellor (Robey et al. , 1994). It is one of the component of family planning program to increase contraceptive use among married women of reproductive age 15-49 years.

Improving proper counselling services in health facilities where contraceptive services is provided , can help to address the low or non-use of contraception. Counselling to the family planning clients can increase the initial use of contraception, longer continuation, help to appropriate method choice, help to use methods effectively, counter rumors and counter misinformation. Good family planning counselling consists of mainly two elements such as establishing a trusting and caring

relationship with clients and giving and receiving relevant, accurate, clear information to help clients for making decisions (Gallen and Lettenmaier, 1987).

Counselling helps the client to make free and informed choice about family planning and to act on those choices continuously with satisfaction of the method. The concept of informed choice consists of provision of information on range of family planning methods, advantages and disadvantages, risks of not using contraceptive methods as well as efforts to ensure that range of methods is actually available through the service provider or through referral agency (Gallen and Lettenmaier, 1987).

There are 75% women illiterate in Nepal. Specially, illiterate women can not read and write so that they can not understand well about family planning information given through mass media. Therefore, illiterate women can be benefited more from the counselling services provided through trained health workers. Discontinuation of use of contraception is one of the problem of low use of contraception so that counselling services is specially useful for temporary contraceptive method users.

It can be assumed that some educated women may not need counselling services through trained health workers because they have already exposed about contraceptives in their education process. Some women may hesitate to attend in the

counselling session because of embarrassment with health workers. Therefore, they can reluctant to attend in the counselling session in the primary health centre.

It is established that counselling services is not provided to family planning clients because of lack of counselling skills to health workers. Therefore, health workers need training on counselling skills. It can also be said that mere providing family planning counselling skills training to health workers could not be sufficient for increasing contraceptive use among CMWRA because we can not guarantee the health workers commitment and interest to provide counselling services to the family planning clients as desired after training. If so, the objectives of providing family planning counselling to the clients such as making informed choice can not meet.

Similarly, we can not say that the married women who will take counselling services, will change their contraceptive behavior as told by the trained health workers. Clients will not be under control of health workers. They can do whatever they want even against the information given through trained health workers. It can be happen when client don't trust to the health workers.

2.8. CONCLUSION

By reviewing the situation and contributing factors for low or non-use of contraception, it is found that the contraceptive methods are not used mainly because of fear of side effects (16%), desire to have more children (15%), religious restriction

(9%) and husband's opposition (4%) of currently married women of reproductive age 15-49 years (Pradhan et al. , 1997). This leads to the notion that counselling approach should be an appropriate strategy to improve the contraceptive use situation in Nepal. It is found that counselling family planning clients in health facilities have increased the use, continuation and decreased the discontinuation of contraception.

A one-year comparison of the impact of counselling service in a health post of Nepal with control group shows that 70. 8% women continued using temporary contraceptive methods from the health post with counselling services where as only 37. 7% women continued using same methods from the health post without counselling services (Shrestha, et al. , 1993). The result of an operational research project carried out in Egypt among post abortion clients shows that the use of contraceptive methods increased by 30% due to the improved counselling. In addition, the family planning counselling has been identified as the essential component of reproductive health care package for dealing with side effects of methods and change of methods (WHO, 1996).

The community level health workers have the strongest influence on contraceptive decisions by women in Nepal (Storey and Karki, 1996). Therefore, we need counselling services for the currently married women of reproductive age through health workers who are trained in family planning counselling skills to increase present contraceptive use.

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