CHAPTER III

Counselling services for family planning clients: A strategy to improve contraceptive use among currently married women of reproductive age in Gajuri, Dhading, Nepal

3.1. INTRODUCTION

3.1.1. Rationale of the study

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 is concluded that high fertility and low use of contraception among women of reproductive age are the causes of high population growth in Nepal (NHEICC, 1996).

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). We can say that couples want fewer children in Nepal. In this context, unwanted pregnancies have played a great role in explaining the total fertility rate of 4. 6 births per women (Pradhan et. al. , 1997).

The low contraceptive prevalence rate (CPR) is also another important factor for high population growth and fertility (NHEICC, 1996). For example, contraceptive prevalence rate (CPR) of China is 83% where population growth rate is 1% and total fertility rate is 1. 95/woman (Sadik, 1995). However, it can be said that contraceptive use can reduce the total fertility rate by avoiding unwanted pregnancy and child birth.

Nepal Family Health Survey shows that the use of contraceptive methods is only 29%, although knowledge of contraception is 98. 3% among currently married women of reproductive age (CMWRA) in Nepal. Low contraceptive use is seen in many areas of Nepal, i. e. , Rasuwa 16%, Sindhuli, 16% and Kalikot 3%. In Dhading district, the use of contraceptive methods is relatively low which is 17% among currently married women of reproductive age (DoHS, 1995). More seriously, the use of contraceptive methods in Gajuri Primary Health Centre, Dhading 6. 8% is very low in comparison to the national target 37% by the year 2000 AD.

Government as well as NGOs, social marketing organizations and private practitioners have been involved in providing family planning services to target couples in Nepal. Despite those efforts, contraceptive practices have not increased according to the expectation and target set by the government. Several factors are responsible for low or non-use of contraception among currently married women of reproductive age which include (1) fear of side effects (16%), (2) desire to have more

children (15%), (3) religious restrictions (9%) and (4) husband's opposition (4%) of currently married women of reproductive age 15-49 years (Pradhan et al., 1997).

By viewing the nature of the causes of low or non-use of contraception, family planning counselling should be one of the most appropriate intervention. Similarly, family planning counselling has been identified as the essential component of reproductive health care package for side effects of methods (WHO, 1996).

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. One year study 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 the same methods from the health post without counselling services (Shrestha, et al., 1993). It showed double difference between with counselling and without counselling services from the health post in using temporary contraceptive methods. The result of operation research project carried out in Egypt showed that the use of contraceptive methods increased by 30% due to improved counselling among post abortion women (Huntington et al., 1995).

According to its suggested evidence of success, counselling services should be given a priority in the family planning program but the services has not yet been incorporated into practice by the providers as an essential component of the family planning program. Similarly, counselling service is available only in limited number of health facilities. The main reason for the unavailability of counselling services to the client is the lack of family planning counselling skills to health workers (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. It is found that 79% of currently married women of reproductive age 15-49 use their contraceptive methods from government health facility (Pradhan et al., 1997) where free family planning services is provided. In addition, the community level health workers have the strongest influence on contraceptive decisions by women in Nepal (Storey and Karki., 1996).

We, therefore, need family planning counselling services for the currently married women of reproductive age through health workers who are trained in family planning counselling skills in order to increase present contraceptive use. Therefore, this study proposes to provide counselling services through trained health workers to the family planning clients at Gajuri Primary Health Centre, Dhading, Nepal.

3.1.2. Rationale of the counselling services

Literacy rate of female is only 25% in Nepal. Literacy rate of Gajuri village is not available but it is assumed to be the similar of Dhading District where 19. 5% female population are literate (Central Bureau of Statistics, 1996) . Illiterate women can not read and understand family planning information given through print media. Similarly, the exposure of family planning messages through print media is 14. 4% among illiterate and 57. 2% among literate married women of reproductive age (Pradhan et al., 1997). This shows the very low exposure to family planning information among illiterate married women of reproductive age.

The print media just gives the messages to the people for reading but the readers can't provide feedback as well as print media does not work among illiterate women. So, on one hand, print media is one way communication and in the other hand, counselling services is a two way communication. Health workers can provide clear, accurate and adequate information to the clients and get feedback immediately after they provide information to the clients when they are in counselling session for counselling services. Therefore, in this two-way communication provides a mean for illiterate women to understand, make decision and apply information provided by the health workers.

The counselling service can make the clients satisfied and satisfied clients will spread the information to their friends and relatives even to the illiterate married

women of reproductive age. A qualitative research project conducted in the Dominican Republic, Egypt, Indonesia and Thailand showed that the informal communication between satisfied users and potential users was found to be an important channel for motivating new acceptors for contraception (Zimmerman et al., 1990).

Discontinuation of temporary contraceptive methods are also very high due to the lack of proper counselling services to the clients (DoHS, 1995). Discontinuation rate of spacing methods is 62. 3% with no counselling services health facilities in Nepal (Shrestha et al., 1993). So that use of spacing methods are only 10% among currently married women of reproductive age 15-49 years. Clients who receives counselling have higher continuation and low dropout rate of contraceptive usage (Shrestha, et al., 1993). So, higher continuation is attributed to the higher contraceptive prevalence rate. The complete and clear information on contraceptives such as advantages and disadvantages, available methods, side effects, effectiveness and correct use of methods assist the clients in making appropriate decision. If the clients do not have complete information before using contraceptives, there will be a chance of high discontinuation and low use of contraception among users. The low use of contraception and high discontinuation of methods may lead to unwanted pregnancy which result in unsafe abortion, high fertility and high growth of population in Nepal.

Counselling services can provide free and informed choices to the clients. 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). Counselling is an effective way of countering the rumors about contraceptive methods for increasing method acceptance, use and continuation by the couples. It helps individually to the clients to learn how contraceptive works, how to use it effectively, where and how to get the methods (FHD, 1995).

Usually, people find out about family planning services from relatives, friends, family members and neighbors (Storey and Karki, 1996). In addition, it can be assumed that they are not counselled by trained counsellor because counselling services is available in very limited health facilities in Nepal. So, information obtained through this kinds of sources are not adequate for voluntary decision about contraception. Therefore, counselling is an essential and useful strategy.

3.1.3. Application of the study

The contraceptive use rate was 24. 1% in 1991 and it was 29% in 1996 among CMWRA (Pradhan et al., 1997). The level of contraceptive use is at a take off stage. This study of counselling services will further be an evidence whether this type of communication activities can promote the present situation of contraception also in

other health facilities. This study will help to determine how communication activities like counselling affect client behavior such as contraceptive use, follow-up visits and particularly continuous use of a method.

Actually, the family planning program of Ministry of Health is one of the beneficiary of the study. This low or non-use of contraception is a broad problem recognized and faced by the family planning program of Nepal which has affected all social phenomena such as women education, employment, maternal and child health and so forth. Several causes are responsible for the origin of the problem but fear from side effects, desiring for more children, religious restriction and husband's opposition are the most important causes. This study will help to tackle those problem.

Little of this type of study has been conducted in Nepal. Therefore, one of the priority activity focused by the National Health Education, Information and Communication Centre is to conduct a qualitative/quantitative research on family planning communication activities. This study will complement the government efforts in conducting a research. The product of this study will help to family planning program of Ministry of health in program planning and improve effectiveness, efficiency and management of such type of program. It will also provide useful information for family planning policy, plan formulation and making action plan as needed. The lesson learned from this study will help to improve the

future counselling training program in Nepal. Therefore, this study will be suitable and timely.

3.2. PURPOSE STATEMENT OF THE STUDY

The purpose of the study is to increase contraceptive use among married women of reproductive age 15-49 years through improved family planning counselling services in Gajuri primary health center. Family planning counselling training to health workers is essential to improve the counselling services in Gajuri Primary Health Centre. Therefore, the main focuses of the study is to provide counselling services to the family planning clients through trained health workers. The impact evaluation will be carried out after completion of a year program intervention. The service statistics will also be used to evaluate the program.

3.3. OBJECTIVES OF THE STUDY

3.3.1. General Objective

The general objective of the study is to improve the family planning counselling services through trained health workers in order to increase the use of contraception among clients in Gajuri primary health centre, Dhading, Nepal.

3.3.2. The specific objectives of the study are as follows

1. to train health workers of Gajuri Primary health centre in family planning counselling services.
2. to implement the counselling services through trained health workers to the family planning clients of Gajuri primary health centre.
3. to facilitate health workers by providing available information, education and communication materials for counselling to the clients.
4. to monitor counselling activities conducted by health workers in order to look at the service achievements.
5. to supervise counselling activities conducted by health workers in order to improve their counselling performances.
6. to evaluate the immediate impact of counselling services provided through trained health workers after training in terms of increase contraceptive use among currently married women of reproductive age 15-49 years.

3.4. GAJURI VILLAGE, DHADING DISTRICT, NEPAL

Gajuri is one of the village of Dhading district, Nepal. It is nearly 50 Km. from the capital city Kathmandu and nearly 30 Km. from Dhading district headquarter. It is situated along the Trisuli river and a highway runs across the Gajuri village which is called Prithivi Highway that connects the Pokhara and east-west terai districts with Kathmandu.

There is a Primary Health Centre (PHC) with 3 beds consists of 2 emergency beds and one maternity bed in the Gajuri village which is primary level health institution of Nepalese health care system. The population ratio determined by the National Health Policy is 100, 000 per PHC for provision of health services. The population of Gajuri village is 7, 105 with 1, 071 households and family planning targeted 15-49 MWRA group population is 1367 where PHC is located.

The PHC is an organization established by the government for providing primary level health services such as curative, preventive and promotive health services. It is recognized as a referral centre of sub-health posts and health posts to provide better level health services regarding curative, preventive and promotive.

The PHC provides temporary and permanent family planning contraceptive methods such as Pills, Condom, Injectable, IUD, Norplant and Male Sterilization on regular basis and scheduled Female Sterilization camp as provided by the District Health Office under the preventive services. Condom is provided through the condom box in which condom as well as IEC materials are kept there and clients can take the condom with IEC materials whenever they need. Primary health centre just monitor those system. The Village Health Worker (VHW) and Female Community Health Volunteer (FCHV) also distribute Pills, Injectable and Condom as a door to door services after selecting the clients for those methods from PHC at the time of home visit. The technical staffs sanctioned for the PHC is mentioned below.

1. Medical Officer 1
2. Health Assistant 1
3. Staff Nurse 1
4. Auxiliary Nurse Midwife 3
5. Auxiliary Health worker 2
6. Lab Assistant 1
7. Village Health Worker 1

The present use of contraception in PHC is only 6. 8% among CMWRA (DHO, Dhading, 1996). The evidence of reasons for low or non-use of contraception by married women of reproductive age in Gajuri village is not available. Therefore, it can be assumed to be the same reasons found from the Nepal Family Health Survey, 1996 which include perception of side effects of the contraceptive methods, desire to have more children, religious restriction and husband's opposition. By viewing the nature of the reasons for not using contraception by CMWRA, the counselling services to the clients should be most appropriate strategy to increase the contraceptive use among them. Gajuri primary health centre is chosen as a study area for providing counselling services to the clients. The following reasons are considered in choosing Gajuri village as a study area.

1. The national target of contraceptive prevalence rate is to increase to 37% by the year 2000 AD The use of contraception is 29 % as whole country but the contraceptive methods use of Gajuri PHC is 6. 8% among CMWRA. Looking at the

other selected country's use of contraception, it is found that China has 83% and Sri Lanka has 62% use of contraception (Sadik, 1995). Therefore, it is very low use of contraception in Gajuri village.

2. Technical staff are available for any kinds of family planning services so that it is easy to conduct counselling services to the clients of each methods.

3.5. PROPOSED PROGRAMMES

The main focus of this study is to provide counselling services to the family planning clients through trained health workers of Gajuri primary health centre. Therefore, family planning counselling training is a major component of the proposed plan. The purpose of training is to teach health workers how to counsell family planning clients as well as health workers will develop their interpersonal communication skills and learn how to communicate effectively with family planning clients.

The proposed plan also includes provision to provide information, education and communication materials to the family planning clients through primary health centre before, during and after counselling services. It will help the clients to know what is family planning as well as understand and memorize the information given by the health workers. The monitoring and supervision of counselling services will be done as planned in which monitoring will help to determine the achievement of the

services and supervision will help the health workers to perform their counselling job better by improving knowledge and skills.

After completing a year of counselling services to the family planning clients in Gajuri primary health centre, plan is made to evaluate impact of counselling services in the family planning clients. As we will have made provision of counselling services to the family planning clients, the impact evaluation will answer the question such as are family planning clients satisfied with the counselling services provided by the trained health workers ? are they received enough information to make informed choices ? are they willing to continue their method longer ? have they decided their method themselves ? In summary this study proposes the following programs and describes in detail below.

Table: 3. 1. Summary of the proposed program

S.No.	Programs	Commence Date
1	Family planning counselling training	March, 1998
2	Provision of IEC materials	March, 1998
3	Implementation of counselling services	April, 1998
4	Supervision of counselling services	July, 1998
5	Monitoring of counselling services	August, 1998
6	Evaluation of counselling training	April, 1999

3.5.1. Training Program of Counselling for Health Workers of Gajuri Primary Health Centre, Dhading, Nepal

A. Introduction

Presently, every health workers should provide counselling services when they are dealing with their clients . However, they are not following the process of counselling services which results in ineffectiveness of family planning program. Health workers at Gajuri Primary Health Centre have not been trained formally in counselling services. Family planning counselling is a special form of interpersonal communication between service provider and clients. Most people require training to become proficient counselors (Robey et al. , 1994). Therefore, health workers of Gajuri Primary Health Centre needs family planning counselling training.

B. Responsible organization

First of all, as a researcher, I must review the proposed study to the Director of National Health Training Centre and the Director of National Health Education, Information and Communication centre because they have the mandate to provide different kinds of training to health workers and information, education and communication services to the people. Implementation of the project will be carried out in Gajuri primary health centre, thus the National Health Training Centre will be responsible for conducting the training to the health workers of Gajuri Primary Health Centre. Although, sole responsibility of conducting health related training is

National Health Training Centre, as a study purpose, this training will be conducted by the researcher in close co-ordination and co-operation with the National Health Training Centre. After training, all the staffs of primary health centre will be responsible in the implementation of the counselling services to the clients.

C. Training objective

The main objective of the family planning counselling training is to improve the counselling knowledge and skills of health workers who interacts with family planning clients. At the end of the training, the health workers will be able to:

1. describe the difference between motivation, education and counselling.
2. discuss the benefits of family planning counselling.
3. explain the principles of family planning counselling.
4. demonstrate the qualities and skills of an effective counsellor.
5. demonstrate interpersonal communication skills in family planning counselling
6. demonstrate the steps in counselling process using greet, ask, tell, help, explain clients and return for follow-up (GATHER).
7. describe and demonstrate initial, method specific and follow-up counselling.
8. explain about contraceptive methods.

D. Training approach

Competency based and participatory approach of training will be applied in the family planning counselling training. Active participation and discussion are

essential to develop the skills of counselling. These approach are effective in developing performance skills of health workers.

Trainers will explain the skills or tasks to be learned and then demonstrate it in a simulated clinic setting under the competency based training approach. Similarly, after completing the demonstration and discussion, trainer will observe the health workers in their practice of skills first in classroom and then in the clinic with clients. The trainer will give feedback to health workers which helps to improve the performance and increase confidence in their skills.

In the participatory training approach, trainer will encourage the health workers to contribute what they know about the topic being discussed. This approach encourages health workers to participate and discuss actively in the training. It helps to share their experiences with other group members.

E. Training methods

Group discussion, exercise, demonstration, role play, case studies, lecture and brainstorming are the methods of counselling training to the health workers. Lecture method of training will be applied very few during the training because training is organized for developing the counselling skills to health workers. One handbook will given to health workers which contains background information that

reinforces the content of each module and that health workers use throughout the training.

F. Curriculum of family planning counselling training

The curriculum of counselling training for health workers will be the National Health Training Centre's training package with some necessary modification to fulfill the desired objectives of the project.

The curriculum is divided into 14 modules each of which focuses on an aspect of family planning counselling. Module 1 is about introduction of the counselling training. Modules 2-5 and 7-12 apply to counselling clients about all types of family planning methods. Module 6 is a contraceptives technology update. It includes basic review of contraceptive methods. Module 13 concerns the particular counselling needs of clients who are interested in tubal ligation or vasectomy. Module 14 discusses client populations with special needs including pregnant, postpartum, post abortion women, men and unmarried adolescents. The detailed description of each module is illustrated in Appendix I.

The main objectives of these modules are to introduce initial, method specific and follow-up family planning counselling process, to introduce key concepts of interpersonal communication and to review basics of contraceptive methods.

G. Duration of training program

The duration of training program will be 7 days. Date of training will be scheduled by discussing with the Director of National Health Training Centre and Medical Officer of Gajuri Primary Health Centre.

H. Venue of training

Family planning counselling training will be carried out in Gajuri Primary Health Centre, Gajuri, Dhading. This is the work place of those health workers who will get counselling training and provide counselling services to the clients after training. This is the right place for conducting counselling training because training of the health workers on counselling skills requires real clinic setting.

I. Trainees

Trainees of this training will be 8 selected health workers (paramedical staffs) of Gajuri Primary Health Centre. They are 1 Staff Nurse, 1 Health Assistant, 2 Auxiliary Health workers, 3 Auxiliary Nurse Midwife and 1 Village Health Worker of the primary health centre.

J. Trainers

The required trainers for the counselling training will be available from the National Health Training and Regional Health Training Centre to conduct counselling training to the staffs of the Gajuri Primary Health Centre. The trainers have already

been trained in family planning counselling. For this purpose, researcher will request to the Director of National Health Training Centre to provide the trainers.

3.5.2. Implementation of Counselling Services

A meeting will be organized with National Health Training Centre, National Health Education and Communication Centre and Gajuri Primary Health Centre to form a implementation team to implement the counselling services in Gajuri primary health centre as planned and successfully. The potential member of the team is attached herewith in the Appendix II but actual team will be formed by discussing with the Director of National Health Training Centre.

After completing the counselling training, trained health workers will provide counselling services to each and every family planning clients attending in the primary health centre. Female health workers will provide counselling services to the female clients and male health workers will provide the counselling services to the male clients. Counselling session for male and female clients will be organized in separate room in the primary health centre. Counselling services for clients will be provided from 10:30 AM to 2:00 PM every day excluding Saturday because Saturday is holiday.

The sufficient supply of temporary contraceptive methods will be ensured through daily ledger book which provide the information of how much temporary contraceptive methods expense and how much its stock in the primary health centre.

Family planning counselling process is divided into three major stages in family planning services such as initial counselling, method specific counselling and follow-up counselling. Counselling clients in every stage is essential for increasing initial use of contraception, longer continuation, appropriate method choice, effective method use and countering rumors and misinformation. Health workers will follow the basic counselling steps GATHER (see page 75 for details) in each stage of counselling whether clients are for initial, method specific or follow-up counselling.

A. Initial counselling

Initial counselling is needed when counsellor meet the family planning clients at first time in the clinic. The main intention of initial counselling is to familiarize the clients with all available contraceptive methods, health care services, clinic procedures and policies as well as to explore the client's experiences. Therefore, trained counsellor will manage initial counselling according to the attached figure no. 3. 1. The key points for initial counselling include to:

- tell clients about available contraceptive methods.
- ask client's method of interest and explore their experiences about that method.
- describe briefly how each methods work, advantages and disadvantages.

B. Method specific counselling

Method specific counselling is provided just prior to, during and immediately after the provision of a specific contraceptive method chosen by the clients. The family planning clients will be provided with the opportunity to ask potential questions on chosen method with counsellor in this process. Therefore, trained counsellor will manage method specific counselling according to the attached figure no. 3. 1. The key points for the method specific counselling include:

- tell clients with simple and understandable language on how each methods work, its effectiveness and side effects.
- tell clients to repeat the information about contraception as told by the counsellor.
- If clients did not understand the information given by the counsellor, again counsellor should add and correct those information for the clients.
- Counsellor should encourage the clients to ask questions as much as they can.
- Counsellor should counter the rumors and misinformation perceived from clients by providing clear, appropriate and complete information about contraception.

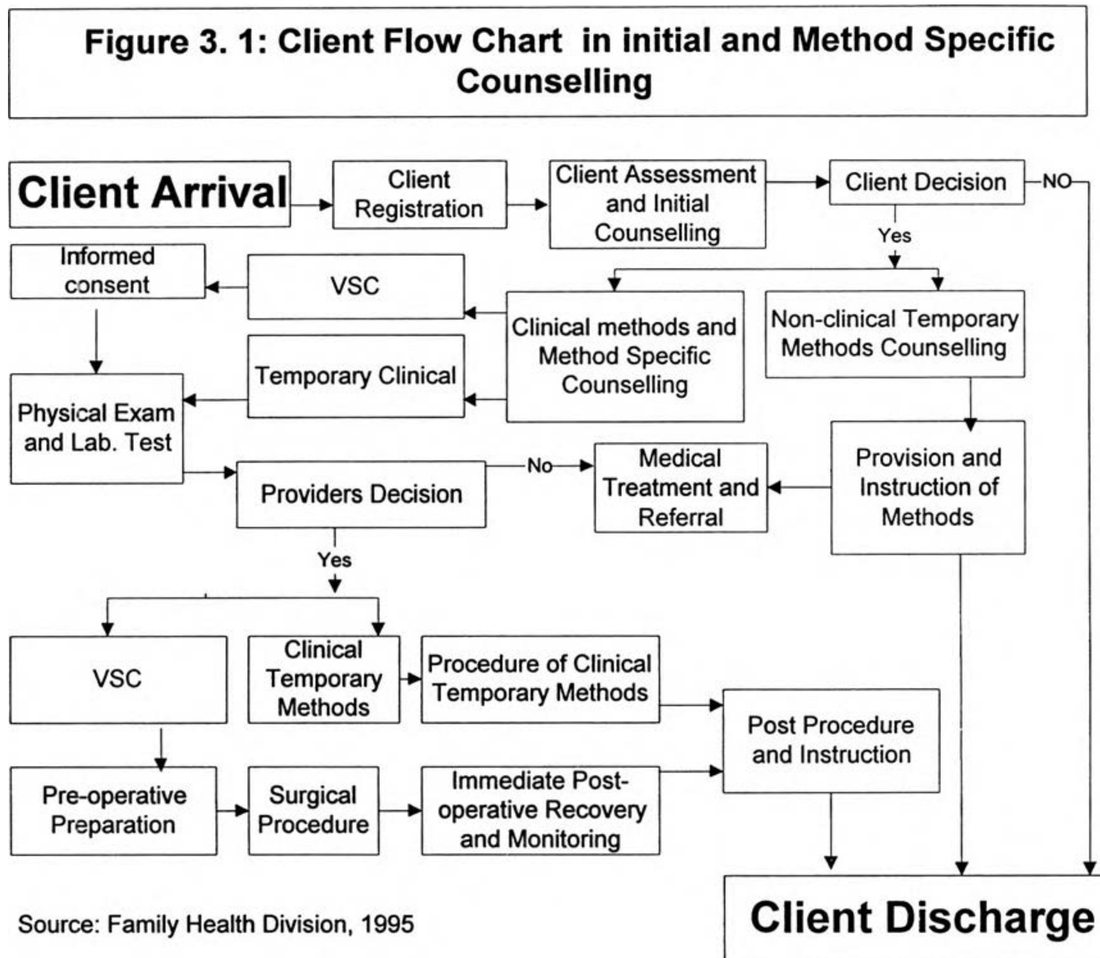


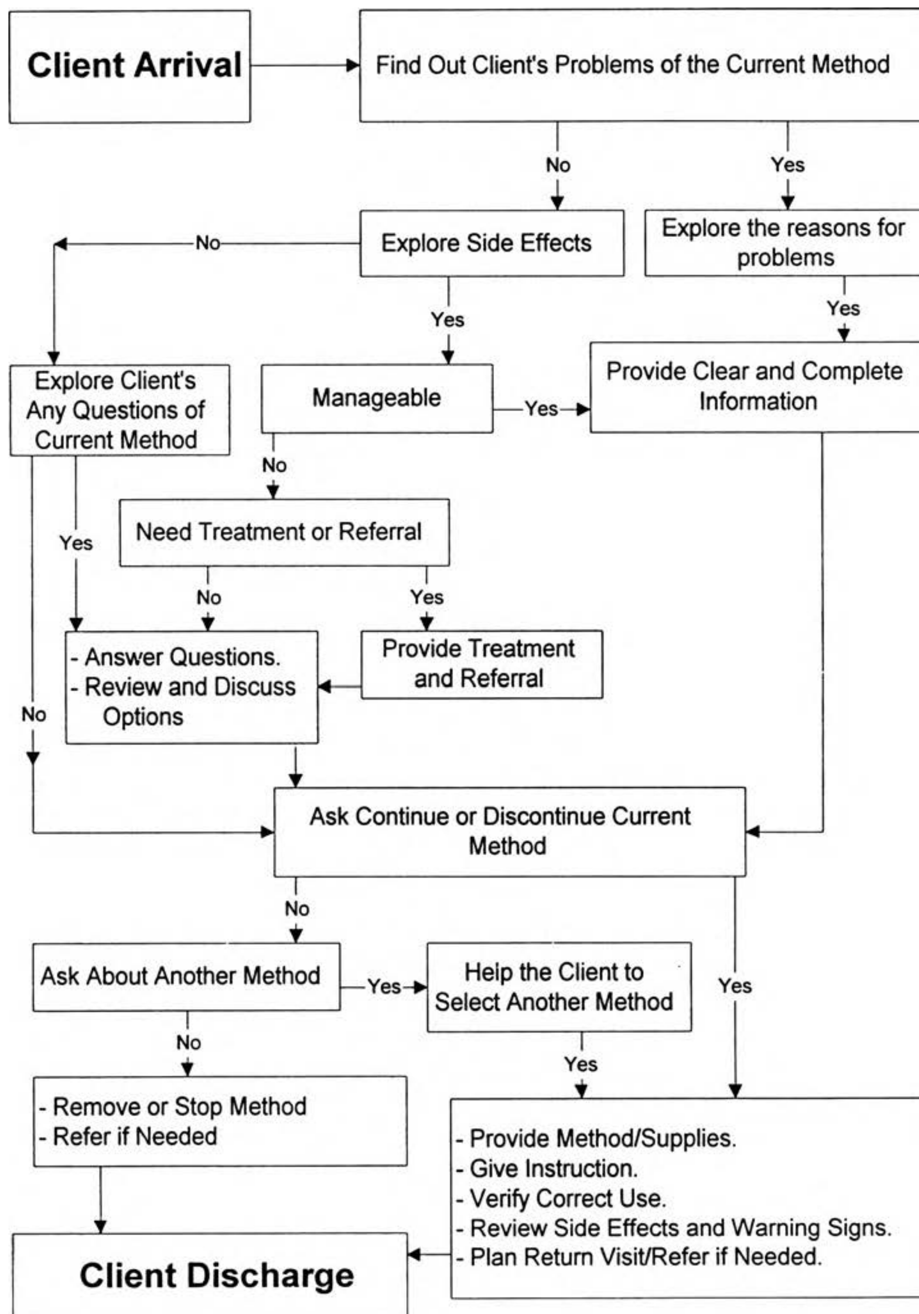
Figure 3. 1: Client Flow Chart in initial and Method Specific Counselling
Client Arrival
Client Registration
Client Assessment and Initial Counselling
Client Decision
NO
Yes
Informed consent
VSC
Clinical methods and Method Specific Counselling
Non-clinical Temporary Methods Counselling
Temporary Clinical
Physical Exam and Lab. Test
Providers Decision
No
Medical Treatment and Referral
Provision and Instruction of Methods
Yes
VSC
Clinical Temporary Methods
Procedure of Clinical Temporary Methods
Post Procedure and Instruction
Pre-operative Preparation
Surgical Procedure
Immediate Post-operative Recovery and Monitoring
Client Discharge
Source: Family Health Division, 1995

C. Follow-up counselling

Follow-up counselling is provided to the clients when clients come back for more supplies, advise about side effects and other problems, changing another method, removal of an IUD and Norplant or for referral services. It can be assumed that repeat visit by family planning clients tend to be very short and routine and are usually only to renew supplies. Health workers do not ask whether client's contraceptive behavior changed or whether clients have any problems. Therefore, trained counsellor will manage follow-up visit according to the attached figure no. 3.2. The key points for the follow-up counselling include to:

- find out whether clients are satisfied with the current method.
- make sure clients are using their methods correctly, if necessary repeat instruction about correct use of method.
- provide additional temporary contraceptive to the clients.
- answer clients questions with clear instructions and information.
- treat clients with minor side effects and medical complications, if necessary provide referral services.
- help clients change or stop methods.

Figure 3. 2: Client Flow Chart of Follow-up Visit



Source: Population Reports, Series J, No. 35, 1987

3.5.3. Provision of Information, Education and Communication (IEC) Materials for Counselling Family Planning Clients

Every health service providers including counselors need Information Education and Communication (IEC) materials that inform and educate them about national standards and norm for contraception. Specially visual aids during the counselling session makes the session attractive and likely to understand and remember messages easily by the clients. Counselling is needed to address misconceptions also in the knowledge of interested couples about all contraceptive methods and their advantages and disadvantages. These materials help health workers to remember everything to cover during counselling to the clients.

IEC materials such as Flash Cards, Flip Charts, Fliers and Posters are effective to let them know about contraceptive specially to the illiterate women during the counselling session. It will assist in the decision making for contraception by women.

His Majesty's Government of Nepal has been given the mandate to produce and disseminate the health information through different kinds of methods and media in Nepal. Although, IEC materials are provided to each and every health outlet, we can not say that provided quantity is sufficient for the health outlets. A survey of 200 Sub-health posts which are also the community level health outlets shows that only 64% health outlets have IEC materials. So it can be assumed that Gajuri primary

health centre may be the one among 36% health outlets that may not have sufficient IEC materials.

Researcher will request to the Director, National Health Education, Information and Communication Centre (NHEICC) to provide sufficient IEC materials about family planning for Gajuri primary health centre. Researcher is one of the staff of the NHEICC. IEC materials needed for counselling family planning clients have already been developed and produced. NHEICC will deliver family planning related IEC materials to Gajuri primary health centre in every 4 months through government vehicle.

3.5.4. Monitoring of Counselling Services

The main purpose of the monitoring of the counselling services is to look at the services achievements in primary health centre. For this purpose monitoring of counselling services will be made only through routinely collected data during the counselling intervention to look at the services achievement.

In 1996, out of 1367 married women of reproductive age of Gajuri village, service achievements of contraceptive use was 6. 8% without counselling services at the Gajuri primary health centre. Nepal Family Health Survey, 1996 showed that the use of contraceptive increased on an average 1. 3% per year from 1991 (24. 1%) to 1996 (29%).

Discontinuation of spacing methods are very high which is 62. 3% (Shrestha et al., 1993) in Nepal. However, counselling services will encourage the clients to continue use of contraception by offering clients adequate, clear and accurate information in order to make an informed choice among contraceptive methods. Therefore, we can be assumed that discontinuation of contraception will be decreased as much as we have faced presently. Thus, I expect an increased use of contraception from 6. 8% to 10. 8% by March 1999 as the service achievements in which 1% from usual increase and 2. 8% from counselling services provided through trained health workers to the family planning clients. Thus, use of contraception will be 10. 8% (10.8% of total married women of reproductive age in 1999) by 1999 if the use of contraception has increased as expected.

The sources of this data includes monthly record keeping forms, master registers and acceptors facesheets (there are same 3 pages of report forms in one set, first page of the report form is called facesheet) of use of contraceptive methods from primary health centre. The monthly report forms shows the number of new acceptors and number of follow-up visits done by the clients during the month. It helps to know the use trend of contraceptive methods by month.

Similarly, master Registers shows the record of each visit including visit for counselling, acceptance methods and follow-up visit by the clients. Primarily, it helps to know the counselling visit done by the clients.

The acceptors facesheets shows the characteristics such as age, education, number of children and occupation of the clients. It helps to cross check monthly report forms and generate analysis of acceptor characteristics.

Therefore, these forms, mainly provide the information on number of new acceptors and follow-up visits of different contraceptive methods. It is useful to monitor program for an understanding of how and why an intervention is successful or unsuccessful or intervention is being implemented as expected.

Primarily, medical officer of the primary health centre will be responsible for monitoring the counselling services conducted from primary health centre. Since, it is a research project, I will go to Gajuri Primary Health Centre every 4 month during counselling program implementation to attend the meeting with the staffs involved in the counselling services to assess the situation of counselling services.

3.5.5. Supervision of Counselling Services

Supervision is an important part of improving the performance of health worker and in the success of family planning program. Health workers will learn counselling skills from training, then, they will apply skills of counselling learned from training in actual problem solving situation. Periodic supervision of counselling services by trained supervisors will help the health workers to perform counselling services more effectively. In this supervision, supervisors will supervise counselling

performance of workers, evaluate their competence, instruct them in what to do, teach additional skills and new skills as needed and help to solve the problem as they arise (Gallen and Rinehart, 1986). The supervision of counselling services will be done every 4 month during regular counselling services that are provided by trained health workers and clinic observation will be applied as a supervision method which is described below.

A. Supervision method i. e. clinic observation

Observation will be made during counselling services to measure skills of counsellor in providing counselling services to the clients. The elements of counselling process GATHER will be applied in the checklist (see Appendix-III) of observation. Since, counselling is a client provider interaction, it is necessary to interact with step by step to exchange their information and express their feelings toward each other. In good counselling session, providers not only give clear, adequate and accurate information but also establish relationship of trust and confidence and show clients that providers care for the clients. Therefore, acronyms GATHER will help remind the health workers to cover all these elements in the counselling session. The acronyms GATHER has been translated into Nepali acronyms ABHIBADAN which covers the steps of counselling. The detailed of the acronyms GATHER is mentioned below.

Table: 3. 2. Acronym of GATHER.

G	Greet each clients warmly.
A	Ask the clients about their family planning need.
T	Tell the clients about each family planning method available through the program and through referral services.
H	Help the clients choose a method that is best for them.
E	Explain how to use the method that the clients chooses.
R	Return for follow-up. Agree on a time to meet again.

Source: Church and Rinehart, 1990. Population Reports, Series A, No. 8.

The observation will be done by expert who have skills in counselling and interpersonal communication. As far as possible, the observer will be selected among female for female contraceptive method specific counselling and male for male contraceptive method specific counselling.

The observer will sit in that room where a trained counselors provide counselling services to the clients. The observer will study how counselling sessions are organized and counsellor's performance during counselling to the clients.

Tape recorder will be used to record all information expressed during counselling session from the client-provider interaction. Tape recorder will help to

analyze the information taken from observation in which all information of client provider interaction is recorded.

3.5.6. Evaluation of Counselling Training

Evaluation is important aspect of counselling training. It helps to know the effects of the training to the health workers in terms of their knowledge, attitude and skills. It also helps to improve the future counselling training activities. Counselling training evaluation includes 4 stages such as (1) training process (2) learning outcome (3)trainees behavioral changes to evaluates the knowledge, attitude and practice of trainees and (4) impact on services in the clients of community (Gallen and Lettenmaier, 1987). These can be described as follows:

A. Training process evaluation

Training process evaluation is the observation and description of how training program is being conducted. It suggests strengths, weaknesses and potential improvements in the future counselling training program. It focuses on the training objectives, contents, methods, materials, facilities, duration, effectiveness of the trainers in conducting training and application of the training in the work place.

One of the technique of training process evaluation will be done through short written questionnaires (see Appendix IV) to the health workers for their reaction about counselling training. We can say it is a reaction evaluation of the counselling training.

Usually, training process evaluation will be done daily by observing role play, demonstration and feedback exercise of trainees during the counselling training. The trainers will perform this task informally during the counselling training. However, process evaluation also can be done at the end of the counselling training program (Gallen and Lettenmaier, 1987). It will help to determine whether trainees have improved their counselling skills and satisfied with the counselling training course from the trainees perspective.

B. Learning outcome evaluation

Knowledge and skills of family planning counselling is essential for proper counselling to the clients. Counselling training is provided to enhance such types of knowledge and skills of the counsellor. It is necessary to measure whether their knowledge and skills improved as we have desired for providing counselling services to the family planning clients. Therefore, pretest and posttest will be done before and after training with multiple choice and true-false questions.

(1) Pre-test of trainees with written questionnaire

Pretesting is essential to know the existing knowledge of health workers. We can measure the level of knowledge of health workers through pretesting. Pretesting of health worker helps to identify the topics that which needs more emphasis and which needs less emphasis during training period. It will help both to the health workers and trainers to carry out training smoothly.

Pretesting will be done at start of the first day of the training course. The main purpose of pretesting include sharing of experiences between trainers and health workers and comparing with the posttest whether they gain knowledge and skills. True false and multiple choice questionnaires (see Appendix - V) will be provided for this purpose.

(2) Posttest with written questionnaires

Posttest is necessary to measure whether their knowledge increased as we have desired to provide counselling services to the clients. It helps to measure whether the knowledge and skills of health workers have improved by the end of counselling training. Therefore, the posttest of health workers with written questionnaires will be taken who will participate in the counselling training. The posttest will be the same as the pretest questionnaires (see Appendix V).

The counsellor trainer will determine their knowledge through the score obtained by the health workers. At least 85% score will be considered as a successful health worker of the counselling training because 85% and above score is graded in distinction level in Nepal. So, they will be competent to provide counselling services to the clients. In addition, it can be assumed that health workers will obtain 100% score because the training approach and methods is intended to do so. If they themselves do not obtain 85% or more score, it is questionable whether they will provide good counselling services to the clients of family planning.

C. Health workers behavioral change evaluation

This types of evaluation will be done 1 month after training which will determine whether the health workers attitude and behavior have changed after training. The attitude and behavior such as active listening, attending behavior, questioning, summarizing and paraphrasing, reflecting feelings, information giving, facial expression, eye contact, tone of voice, smiling, sitting position, showing concern and interests, greeting clients shaking hands, introducing himself/herself, inviting client to sit down and politeness component will be observe during counselling service. Clinic observation technique will be used to evaluate the attitude and behavior of the health workers.

The elements of counselling process GATHER which determines the quality of counselling service and steps of counselling process, will be applied for the check list of observation (see Appendix-III). The observation will be done by expert who have skills in family planning counselling and interpersonal communication. As far as possible, the observer will be selected among female for female contraceptive method specific counselling and male for male contraceptive method specific counselling.

The observer will sit in that room where a trained counsellor provides counselling services to the clients. There are 8 health workers in the Primary Health Centre. One session of counselling services for each health worker will be observed

by using checklist. Tape recorder will be used to record all information expressed by the health worker during counselling session from the client-provider interaction.

One observation for each health workers will be done before counselling training. Instruments of the observation for this purpose will be the same as the after training observation instruments because before and after training observation will be compared to determine whether the health workers behavior changed.

This type of observation will be done periodically as a supervision which will improve the performance of health workers and encourage them to work sincerely and continually.

D. Impact evaluation

1. Introduction

The main intention of family planning counselling training is to improve the quality of family planning services (Gallen and Lettenmaier, 1987). After completion of a year counselling services to the family planning clients of Gajuri village, the impact evaluation will be carried out in Gajuri to assess impact of counselling services in the clients, that has been provided by trained health workers.

Counselling to the family planning clients can increase the initial use as well as continuation of contraception and counter rumors and misinformation. Good

family planning counselling consists of two elements such as establishing a trusting and caring relationship with clients and giving and receiving relevant, accurate information to help clients make decisions (Gallen and Lettenmaier, 1987). Therefore, impact evaluation will determine the effects of the program and will be used to improve the future family planning activities. Component to be evaluated are mentioned below in table 3.3.

Table 3.3. Component to be evaluated in impact evaluation

Knowledge of family planning	Attitude towards family planning	Practice (Use) of family planning methods
- knowledge of methods - knowledge of advantages and disadvantages. - knowledge of side effects. - knowledge of information source about contraception.	- method preference by women. - attitude towards side effects.	- used method - decision to use - duration of use - continuation of method - reason for using method - reason for switching method - dissemination messages to others - perception of side effects - suggestion taken or not taken - time spent for counselling - attention and interests - language used in counselling services - follow-up visit - waiting time - comfortable place for waiting - privacy - expected provision in the primary health centre

2. Method of evaluation

Client survey research method will be used to evaluate the impact of counselling services after training program. Household survey of each clients will be carried out after a year intervention of counselling services. The measurement indicators of the evaluation will be knowledge, attitude, decision making, continuation, follow-up visit and practices of the clients on contraception. The individual semi-structure interview guideline (see Appendix- VII) will be used as data collection instruments. Similarly, focus group discussion and review of official statistics will also be used to evaluate the impact of counselling services. Focus group discussion guideline (see Appendix- VI) and official statistics, such as, monthly reports and master register will be used as data collection instruments.

The official statistics includes the name of clients, date of her follow-up visits, counselling service received or not received, type of contraceptive method taken by the clients and number of new acceptors registered.

The questionnaires is divided into 3 parts. Part 1 determines the respondent's background, part 2 determines the knowledge, attitude, decision making, continuation and satisfaction of the method and the use of contraception of the clients who receive counselling services through primary health centre and part 3 determines the knowledge, attitude , decision making and satisfaction of the method and the

discontinue use of contraception of the clients who receive counselling services through primary health centre.

3. Study population

In family planning program, target population are the married women of reproductive age 15-49 years. There are 1367 married women of reproductive age who are living in the Gajuri village. The counselling services is directly related to the clients who receive the counselling services from the primary health centre. Therefore, those clients who receive counselling services in the family planning clinic at Gajuri Primary health centre from 1st April 1998 to the end of March 1999, will be the study population.

4. Sampling

The sampling for this study in order to conduct semi-structure interview will all the clients of Gajuri primary health centre who receive counselling services from 1 st April 1998 to the end of March 1999. In 1996, out of 1367 married women of reproductive age in Gajuri village targeted for family planning services, continuous contraceptive users totaled 93 clients at the Gajuri primary health centre or 6. 8 %. I expect an increased use of contraception from 6. 8% to 10. 8% by March 1999. Thus, sampling will be approximately 150 clients of Gajuri village if the use of contraception has increased as expected (10.8% of total married women of reproductive age in 1999).

5. Data collection

a. Focus group discussion

Since, focus group discussion method was not planned before data exercise it is felt necessary to obtain in-depth information on contraception from the clients. It will also help to develop the interview instruments and appropriate messages for clients on contraception. The main content of the discussion will be knowledge, attitude, decision making, continuation, discontinuation, follow-up and practices of contraception.

Two focus group discussion will be organized consisting of 9 currently married women of reproductive age in each group because group of 8-12 persons are appropriate for a focus group discussion (Green and Kreuter, 1991). The member of the focus group will be selected purposively. The women will be selected those who are current users for one group and those who are discontinuing the use of contraception for another group. The women will be selected purposively 1 from each 9 wards of Gajuri village. The two separate session will be conducted on Saturday evening because they go to their personal work in the morning and afternoon time.

The venue of the focus group discussion will be in class room of a school with two group separately. The discussion will be in Nepali language which is easy to spoken and easy to understand by the group members. The duration of focus group

discussion will not be more than one hour. The guidelines for the focus group discussions is given in the Appendix VI.

This focus group discussion will be conducted with the help of moderator , who will be Staff Nurse from the district health office of Dhading district. The focus group discussion will be conducted by moderator smoothly with non-threatening environment. The discussion will be started with introduction of participants, objectives of the discussion and to get permission to use tape record. The participants will be encouraged by the moderator to express their perception, ideas and concepts on contraception in their own terms with free environment and will be asked general questions to the participants. Moderator also will observe the reactions of participant hand, face and body gestures. These type of reactions will be included in the results of discussion.

One Auxiliary Nurse Midwife will be a note taker for this group discussion who will note all the content of the discussion. She will help to the moderator in missed topic of discuss. She will take note by giving number to the each participants for the easy to remember when they will be in discussion.

Assistant will assist to operate the tape record to capture all of the information emerge from discussion. Assistant will be taken from the Gajuri primary health centre for the focus group discussion.

Researcher as observer, will be sit back of the group member if the participants of focus group discussion gave the consent to sit. Moderator, note taker and assistants will be trained before conducting focus group discussion in Gajuri primary health centre. At the end of session moderator will thanks to the session and play the recorded conversation.

b. Semi-structured interview

The semi-structured interviews will be done in order to get accurate information from family planning clients which is in the form of guided discussions. This technique of data collection will mainly determine the knowledge, attitude, continuation, decision making, discontinuation, follow-up and practices of contraception of the clients.

The semi-structured interview technique contains a core of structured and unstructured questions. This will help the interviewer to move in related directions for in-depth probing. The aims of semi-structured interview will be to explore more accurate information on (Rubinson and Neutens, 1987) contraception. Similarly, semi-structured interview will help to determine specific responses and measurement on certain topics which could not be identified by open-ended questions and helps to move from more general open-ended questions to more specific questions. Thus, this interview technique is the appropriate tool to explore the knowledge, attitude,

decision making, continuation and discontinuation practices of contraception of the clients because these variables are quite personal matters of an individual.

The semi-structure interview guideline (see Appendix VII) will be developed and used for the purpose. Interview will be conducted in Nepali language with translation from English questionnaires.

Two interviewers will be selected among the female staff nurse working in the District Public Health Office Dhading. The researcher will train them by organizing 2 days orientation program in Gajuri primary health centre. Interviewers will be trained through classroom orientation as well as demonstration of data collection technique in the real field. Interviewer will take 5 interview per day and will finish within 15 days from starting date.

c. Review of official statistics

Official statistics will be used as one of the technique of data collection. It helps to look at the service achievements of the counselling services conducted in the Gajuri primary health centre. These data will be collected from Master Registers, Monthly Report forms and Acceptors Facesheets (there are same 3 pages of report forms in one set, first page of the report form is called facesheets). Master Registers shows the record of each visit including visit for counselling, acceptance methods and follow-up visit by the clients.

Primarily, it helps to determine the counselling visit done by the clients. Similarly, monthly report forms shows the number of new acceptors and number of follow-up visits done by the clients during the month. Monthly trend of contraceptive uses by methods will also be available.

The acceptors facesheets shows the characteristics such as age, education, number of children and occupation of the clients. It helps to cross check monthly report forms and generate analysis of acceptor characteristics.

3.6. ACTIVITIES PLAN WITH TIMETABLE

S. No.	Activities	1997		1998				1999				
		Nov	Dec	Jan	Feb	Mar	Ap - Dec	Jan	Feb	Mar	Ap	May
1	**Preparation Phase**											
	A. Meeting with NHTC and NHEICC	↔										
	B.Project implementation team formation		↔									
	C. Request to donor for fund		↔									
	D. 1st meeting with PHC staffs in Gajuri		↔									
	E. Implementation team meeting			↔	↔							
	F. Observation of Health Workers				↔							
2	**Operating Phase**											
	A. Conducting Counselling Training					↔						
	B. Providing Counselling Service						↔	↔	↔	↔		

3.6. ACTIVITIES WITH TIMETABLE (conti.)

S. No.	Activities	1997	1998							1999			
		Nov	Feb	Mar	Ap -June	July	Aug	Nov	Dec	Mar	Ap	May	June
	C. Health Edu. Materials Delivery			↔			↔						
	D. Monitoring of counselling services						↔		↔		↔		
	E.Supervision of Counseling Services					↔		↔		↔			
3	**Evaluation Phase**												
	A. Recruitment of interviewer										↔		
	B. Training of interviewer										↔		
	C. Focus group discussion										↔		
	D. Interview with the subjects										↔		
	E. Analysis and Interpretation of data											↔	
	F. Writing report												↔

3.7. BUDGET FOR THE STUDY

Budget will be needed for carrying out the counselling training and evaluation of impact of counselling services in the community people. Similarly, provision of budget will be needed for supervision and monitoring of counselling services. The detailed description of the budget is as follows:

Table: 3. 4. Budget for the study.

Descriptions	Amount (in Dollar)
Training Program	
A. Participants allowance 8 persons × 7 days × $4	224
B. Trainers allowance 3 persons × 9 days × $9	243
C. Researcher allowance 1 person × 9 days × $9	81
D. Travel allowance 4 persons × 2 ways estimated	30
E. Assistants allowance 3 persons × 9 days × $4	108
Sub-total	686
Materials and supplies	
A. Stationary estimated	200
B. Questionnaires printing	30
Sub-total	230
Field expenses	
A. Researcher 1 person × 20 days × $9	180
B. Interviewer 2 persons × 18 days × $9	324
Sub-total	504

Descriptions	Amount (in Dollar)
Supervision of counselling	
A. Perdium 1 supervisor × 3 days × 3 times × $9	81
B. Travel cost two ways × 3 times × $10/visit	30
Sub-total	111
Monitoring meeting	
A. Allowance 9 persons × 1 day × 3 times × $4	108
B. Researcher 1 person × 3 days × 3 times × $9	81
C. Travel cost two ways × 3 times × $10/visit	30
Sub-total	219
Report writing and printing	300
Miscellaneous 10%	205
Grand Total	2255

3.8. POTENTIAL PROBLEMS

The proposed family planning counselling is a interaction between health workers and clients about contraception. In this process, health workers and clients should interact each other to solve the client's problems on contraception. Therefore, commitment of health workers may be one of the potential problems in implementing

counselling services in the Gajuri Primary Health Centre. If health workers are not committed to provide counselling services to the family planning clients, the objectives of the study will not be fulfilled as desired. Actually, we can not guarantee the commitment of health workers in implementing counselling services. In this regard, periodic monitoring and supervision of counselling services by the counsellor trainer from National Health Training Centre will be helpful to encourage and make commitment to health workers in providing counselling services. In addition, the provision will be made to provide recommendations for the cash prizes, medals or increased increments of grade for the health workers as incentives.

Transfer of health workers who trained in family planning counselling skills may be another potential problems in providing family planning counselling services continuously in Gajuri. Prior to the family planning counselling training to the health workers of Gajuri primary health centre, requisition will be made to the Director General of Department of Health Services not to transfer for one year from April 1998 to the health workers who are trained in family planning counselling skills. After March 1999, National Health Training Centre will organize and provide such type of training to health workers of Gajuri primary health centre as a retraining.

Counselling is a client-health workers interaction. The client attending in the clinics will be of different characteristics. Some clients will be highly educated, some clients will have no education at all, even illiterate. Some clients will not

understand the language used by the health workers. Culture of the clients may be different from the provider. In this situation, health workers will provide the counselling services by assessing the need and desire of the clients. Health workers will consider their cultural norms and beliefs during interaction. The training program includes these issues in its content.

3.9. HUMAN RESOURCE REQUIREMENTS

Additional human resources will not be needed for providing counselling services to the family planning clients in Gajuri primary health centre because existing manpower is sufficient for the study purpose. Additional human resource such as three trainers, two assistants (including one audio-visual assistant) will be needed for conducting counselling training. Two staff nurses of District Health Office will be needed for conducting semi-structure interview. The audio-visual assistant will be available from National Health Education, Information and Communication Centre and trainers and other assistant will be available from National Health Training Centre. Health workers of the primary health centre will be utilized for providing counselling services to the clients of the community and carrying out impact evaluation of counselling services in the clients of the community.

3.10. REQUIREMENT OF TECHNICAL EQUIPMENT

A over head projector, screen, video deck, monitor, still camera, and necessary cassettes will be needed during the counselling training. A still camera and tape recorder will be needed for impact evaluation when conducting interview with the clients of the community. These equipments will be available from National Health Education, Information and Communication Centre and National Health Training Centre.

3.11. SUSTAINABILITY OF THE COUNSELLING SERVICES

Actually, sustainability of counselling services will depend on impact evaluation which will be done in April to June 1999. If evaluation result will show the positive impact, effort will be made to sustain the counselling services in Gajuri primary health centre. Similarly, government is committed to provide family planning services to the people in a more effective manner up to the village level for population control by making easily accessible to them. Family planning services is mentioned in number one under the preventive health services of the present national health policy (PPMSD, 1991). There is no rule and regulation which affects the availability, accessibility, acceptability, distribution of contraceptives and dissemination of information related to contraceptives. Therefore, government policy

is intended to provide full support for any family planning program which increases the use of contraception.

For this proposed study, family planning counselling services to the clients will be provided through government health workers. Government has been providing yearly regular budget to primary health centre. The proposed counselling services will be provided within the regular budget. Therefore, financial sustainability can be ensured through the regular budget.

Management aspects of counselling services will be sustained by providing re-training to health workers of Gajuri primary health centre. Therefore, National Health Training Centre will take initiation to organize and provide such type of re-training to health workers of Gajuri primary health centre after March 1999.

3.12. ETHICAL ISSUE IN THE STUDY

Counselling is a process of interaction between person to person. However, Family planning is the quite personal matter of the clients. When health workers and clients talk about family planning in the counselling session, clients may feel embarrassed, confused or worried and afraid. The health workers will maintain the confidentiality of all client's personal matters. In this regard, the health workers will also assure the clients about the intention of communication between them.

Health workers will inform clients that whatever are discussed in the counselling session will be to the clients benefit. Health workers will care for the client's best interests in the counselling session. Health workers will consider their feelings, cultural and religious norm about contraception in the counselling session. Counselling services will be arranged in privacy. Health workers will assure the clients that discussion of the counselling session will be confidential. The consideration will be made the client's right to not participating in the counselling session. Similarly, consent will be taken before observing the client and health workers interaction during the counselling session in the clinic.

At the time of interview with the subjects, interviewer will assure them about confidentiality and interpretation of information taken from subjects. For this purpose, prior to data collection, each subject will be explained about the purpose of data collection. The interviewee will have right to not participating in the interview. The plan has made to use tape recorder at the time of interview with the clients. Before using tape recorder, consent will be obtained with the clients in order to use tape recorder in the interview.

3.13. LIMITATIONS OF THE STUDY

The sample clients taken for the study will be only one small village of Gajuri primary health centre, Dhading which will not be the representative of the country as

whole. Therefore, result emerged from the study can not be generalized. The conclusions of the study will refer only to those groups selected to participate in the study.

The proposed study will be conducted in Gajuri primary health centre which is one of the primary level health institution of Nepalese health system. The management and implementation of the program will be out of control from the researcher because primary health centre is directly controlled by the Central Regional Health Services Directorate and District Health Office. Therefore, expected outcome of increasing use of contraception among currently married women of reproductive age 15-49 by providing counselling services may not be fulfilled.

Focus group discussion, semi-structure interview and review of official statistics method of data collection will be used in this study. Method of data collection is triangulated but information source for the impact evaluation can not be triangulated because counselling services is directly related with the counselled clients. The study is limited to the married women of reproductive age 15-49 years because family planning policy of the country has targeted only to this group for family planning services in Nepal.

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