Improving the Quality of Service Delivery in Nigeria

Young-Mi Kim, Jose Rimon, Kim Winnard, Carol Corso, I.V. Mako, Sebioniga Lawal, Stella Babalola, and Dale Huntington

This study evaluates the effect of a nurse training program in family planning counseling skills on the quality of service delivery at the clinic level, as well as its impact on client compliance with prearranged appointments. The study used a quasi-experimental design to compare certified nurses who received six weeks of family planning technical training with certified nurses who, in addition to the technical training course, received a three-day course in counseling skills. Data were collected through client exit interviews, expert observation, and inspection of medical record abstracts. Trained nurses performed better than their untrained counterparts in the quality-of-care areas investigated—interpersonal relations, information giving, counseling, and mechanisms for encouraging continuity. The likelihood that clients will attend follow-up visits was also found to improve when they were attended by trained professionals. Short-term counseling training can significantly improve the quality of care provided by family planning workers, as well as client compliance with follow-up appointments. (Studies in Family Planning 1992; 23, 2: 118–127)

Most family planning programs set quantitative targets to reach their ultimate goals of reducing population growth and improving people’s health. The number of new acceptors, the number of continuing users, the couple-years of protection afforded, and contraceptive prevalence rates are the most common measurements of success. Until recently, little attention has been paid to measuring the quality or the impact of family planning service delivery on clients’ initial acceptance, satisfaction, correct method use, follow-up clinic visits, or continued use (Bruce, 1989).

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In the late 1980s, Jain developed an analytical framework supporting the hypothesis that by improving the quality of services, more people will adopt contraceptives, continuation rates will go up, contraceptive prevalence will increase, and eventually population growth will be reduced (Jain, 1989). In a 1987 review of the literature, Gallen, Lettenmaier, and Green highlighted the need for good counseling skills to improve service delivery; they proposed a mnemonic system to assist service providers in counseling clients, called GATHER (Gallen et al., 1987). Several of the GATHER elements overlap with the six quality-of-care elements in Bruce’s framework for effective family planning programs (Bruce, 1989). In 1990, a United States Agency for International Development (USAID) task force modified and expanded Bruce’s framework so that it could be used to assess quality in a variety of family planning programs in developing countries. The evaluation criteria included whether the program offers a choice of methods; the degree of technical competence of program staff; the quality of information giving and counseling for clients; the quality of interpersonal relations; the mechanisms instituted to ensure contraceptive continuity; and the appropriateness and acceptability of services (USAID Task Force, 1990).
Since the mid-1980s, family planning programs in Nigeria, Egypt, El Salvador, Ghana, and Gambia have attempted to improve the quality of their services through training (Population Communication Services of the Johns Hopkins University, 1988 and 1989). In addition to the technical competence training that family planning service providers received regularly, they were trained in interpersonal relations, information giving, and mechanisms to encourage contraceptive continuity. Although several manuals were developed to evaluate such training programs, few systematic evaluation efforts were actually carried out; hence, few reports are available. The most commonly used method for evaluating training programs is a questionnaire given to participants directly after the completion of the program.

Attempts to evaluate the quality of service delivery have ranged from observing procedures to using coached clients to collect data. For example, as early as 1978, clients in Mexico were interviewed in focus groups to investigate family planning awareness, attitudes, and practices (Folch-Lyon et al., 1981); the interaction between service providers and clients was studied in India and Bangladesh (Simmons et al., 1986); and intercept interviews with consumers were used in the Dominican Republic (Green, 1988). Coached clients, called “simulated” clients in a study in Nepal (Schuler et al., 1985) and “mystery” clients in a later study in Ghana (Huntington et al., 1990), provided data from the client’s perspective and sidestepped the distraction usually caused by outside observers.

The present study examines the effect of counseling training on the quality of service delivery in Nigerian clinics and investigates the impact of training on the likelihood that clients will return to the clinic for follow-up. No systematic study prior to this evaluation looked at the relationship among training in family planning skills, the quality of service delivery in clinics, and client behavior (such as adopting a method, visiting a clinic for follow-up, or using contraceptives over a long period). The lessons learned from this type of evaluation will help to improve future counseling training.

Evaluating Counseling Training in Ogun State, Nigeria

The Ogun State Ministry of Health oversees the family planning programs of all state clinics, provides family planning training for nurses, and certifies nurses for family planning clinical practice. In 1988, the Ministry’s School of Family Planning added a counseling skills training component to the family planning certification curriculum for nurses. The study discussed here specifically compares the performance of certified nurses trained in counseling skills with certified nurses not yet trained in such skills. The study was carried out in eight selected Ogun State clinics. All of the clinics provided similar service delivery in that (1) a similar variety of contraceptive methods was available; (2) all of the nurses had received family planning certification; and (3) only some of the nurses in each clinic had received counseling skills training.

The quality-of-care elements in the Ogun project were similar to those of the USAID’s task force, even though the Ogun work was designed, implemented, and evaluated at an earlier date. Interpersonal relations, counseling, and information giving are looked at primarily from the client’s perspective, ascertained through exit interviews and backed up with data from an expert observer. Mechanisms for encouraging continuity and client compliance are analyzed through the use of data from medical records.

The Counseling Training Program

The counseling training component was added to the Ogun State family planning training curriculum by its Ministry of Health in collaboration with the Population Communication Services of Johns Hopkins University. The decision to implement counseling training was based on the existence of low levels of contraceptive use among the population, in spite of a relatively high level of knowledge of contraceptives and large client turnover at the clinics. Many family planning clients would not commit themselves to a method, were often not persistent with a chosen method, or did not return to the clinic for follow-up appointments.

The first group of nurses was trained in January 1988. They took a three-day course in interpersonal communication and counseling skills. Basic theoretical information on communication and media/materials development was incorporated into the training sessions, as well as practical steps and exercises. Participatory activities, small and whole group discussions, and role playing were the primary means of imparting skills. During the role playing, the trainees had ample opportunity to assume the roles (derived from hypothetical case studies) of spouses, family members, clients, and counselors.

The training consisted of seven sessions: The first session was an introduction to interpersonal communication and counseling. Sessions two through four concentrated on values clarification and verbal and nonverbal communications, including listening and response skills. Through these sessions, the nurses developed a sense of the importance of perceptions, attitudes, and behavior in interpersonal communication and counseling. The fifth session focused on family planning awareness and adopt-
tion, including decision-making, choosing an appropriate method at different stages in the reproductive life cycle, and issues related to informed choice and helping clients make their own decisions. Sessions six and seven dealt with role playing and observation in groups of three participants, as well as case studies. Participants were given an opportunity to practice their interpersonal skills to assist clients in the decision-making process of the family planning counseling session, as well as in special stress situations. A more detailed description of the workshop is offered in Table 1.

Throughout the training sessions, participants were encouraged to relate their skills to the essential aspects of family planning counseling, as expressed in GATHER, and to verbal and nonverbal skills and behaviors, as expressed in CLEAR and ROLES (Gallen et al., 1987). The elements of these three procedures are as follows:

GATHER (Greet clients; Ask clients about themselves; Tell clients about family planning and clinic procedures; Help clients choose a method; Explain how to use the method; Return for follow-up visit);

CLEAR describes Clarifying, Listening, Encouraging, Acknowledging and asking for feedback, and Repeating;

ROLES describes Relaxing, Opening up to the client, Leaning toward her, Establishing eye con-

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| I. Introduction to counseling | Participants will be able to define interpersonal communications and counseling. | • Pretraining questionnaire  
| | Participants will become familiar with basic counseling and communication techniques. | • Partner introduction and discussion  
| | | • Counseling vs. education vs. motivation  
| | | • Skills needed  
| | | • Objectives and schedule  
| II. Values clarification | Participants will be better able to understand their own attitudes, feelings, and values, and the significance and impact of these on their counseling process. | • Survey of sexual attitudes  
| | | • Priorities exercise  
| | | • “Street talk”  
| | | • Method choice exercise  
| III. Verbal and nonverbal communication | Participants will become more aware of and be able to identify forms of verbal and nonverbal behavior used in communication and counseling. | • Nonverbal communication exercises  
| | Participants will be able to use praise and encouragement when counseling a client. | • Feelings charade  
| | Participants will be able to use support materials with groups or individual clients. | • Verbal communications  
| | | • Praise and encouragement  
| | | • Translating into simple language  
| IV. Interviewing and listening skills | Participants will be able to reflect, paraphrase, and summarize client concerns. | • Levels of response  
| | Participants will be familiar with the appropriate responses to deal with a client’s concerns. | • Reflection exercise  
| | Participants will be able to identify and demonstrate the use of a close-ended question, an open-ended question, a probing question, and a leading question. | • Types of questions  
| | | • Listening practices and listening skills  
| V. Helping clients make a decision | Participants will be able to assist clients in making an informed decision regarding contraception. | • Decision-making  
| | Participants will be able to identify family planning methods using appropriate and different points in the client’s life cycle. | • Stages of family planning awareness/adoption  
| | | • Method choice case studies: family planning through the life cycle  
| VI. Counseling | Participants will be able to use their interviewing and listening skills to identify client concerns about family planning. | • Situation identification  
| | | • Counseling observation and practice  
| VII. Special stresses and counseling | Participants will be able to recognize stresses within and outside the counseling environment that may compromise their effectiveness and identify possible solutions to these. | • Special stresses  

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tact, and smiling and sitting squarely, all nonverbal cues that help establish rapport and trust between the client and provider.

Throughout the process, trainees exhibited a high level of motivation and participation. Trainees were eager to apply their newly developed skills to real-life settings, despite the fact that no material reward or job promotion was offered for their participation in the workshop.

Following these sessions, the newly trained family planning service providers returned to their clinics; they had four weeks to practice their interpersonal communications and counseling skills before being reviewed by the evaluation team. No constraints were placed upon the nurses to inhibit practice of their newly learned skills.

Evaluation Methodology

Although all of the nurses were certified in family planning, for the purposes of this study “trained” nurses refers to those who completed the three-day counseling training; and “untrained” nurses refers to those who had not yet received counseling training. All nurses worked individually with their clients, usually in a specific room dedicated to this activity.

A quasi-experimental research design with a comparison group and posttest only was used for the study. Three sets of data were gathered: (1) the quality of the family planning services provided as perceived by clients; (2) the quality of service delivery as observed by a counseling expert; and (3) clients’ return to the clinic for follow-up visits, as abstracted from medical records. The study included 480 exit interviews with clients, 39 reports of observations by an expert, and 1,001 abstracts of medical records. The data collected from exit interviews and medical records were subjected to chi-square analysis to test significance. No statistical analysis was applied to the expert observation data, because of the small size of the sample and the possibility of observer bias.

Client Exit Interviews

Data to assess clients’ perspectives on the quality of services during counseling sessions were collected during client exit interviews conducted from February to June 1989. The data compared the performance of trained and untrained nurses in eight selected clinics in Ogun State as assessed by 480 women who were questioned directly after their family planning consultations; 242 women had consulted with trained nurses, and 238 women had consulted with untrained nurses.

Ideally, the exit interview system would use four clinics with only trained nurses and four other clinics with only untrained nurses in order to reduce any likelihood of a “spillover effect” in the counseling practices from trained to untrained nurses. The clinics selected for this study, however, had both trained and untrained nurses. Analysis of variation among individual nurses with respect to the quality of their care-giving skills was not included in this study.

To differentiate the clients of trained nurses from those of untrained ones, trained nurses were given colored slips of paper and untrained nurses were given white slips of paper: During the interviews, all nurses gave their clients the colored or white slips of paper and instructed them to pass the slips to a designated interviewer outside the consultation room. Systematic sampling was used. In each clinic, a total of four clients were interviewed daily during three consecutive days each month. On the given days, every fourth client with a colored slip of paper and every fourth client with a white slip of paper was asked for an interview until four interviews were completed. Interviewers did not know whether clients had been seen by trained or untrained nurses, because they were “blind” to the significance of the colored slips, but they did conform strictly to the interviewing process rules established beforehand.

The exit interviews were geared toward finding out how clients perceived the performance of the nurse who had attended them during their counseling session. Interviewers asked how carefully the attending nurse listened; how polite she had been; how clearly and thoroughly she had offered explanations; whether she had demonstrated concern about the client’s medical history; whether she had asked about the client’s knowledge of contraceptive methods; whether she had asked about the client’s interest in using a particular contraceptive method; and how comfortable the client had felt with the nurse.

A profile of the clients who participated in the exit interviews showed no difference in age, education, or purpose of clinic visit between clients of trained and untrained nurses. Of the total group, 17 percent were aged 17–24; 31 percent were aged 25–29; 25 percent were aged 30–34; 18 percent were aged 35–39; and 9 percent were above age 40. Among clients interviewed, 23 percent had never attended school; 30 percent had attended primary school; 29 percent had attended secondary school; and 18 percent had a postsecondary education. In terms of contraceptive use, 83 percent of the women interviewed had previously used a method, and 17 percent were new acceptors. Twenty-nine percent had come to the clinic for follow-up; 23 percent, for resupply; 17 percent, to report a problem; 7 percent, to stop contraceptive use; 6 percent, to change their method; and 18 percent, to adopt a method.
Expert Observation

During the same period that the exit interviews took place, an outside observer was assigned to sit in on consultations and to assess the quality of services delivered by both trained and untrained nurses. The observer, a specialist in interpersonal communications and counseling skills, had been involved in the nurses’ counseling training. A total of 39 nurses were observed: 18 had been trained, and 21 had not been trained. The observer studied the nurses’ counseling skills as well as how they organized the sessions and performed during them. She observed such nonverbal aspects of service delivery as the nurses’ overall manner—was it relaxed, did the nurses make eye contact, smile, listen attentively, or use visual aids? The observer noted whether the nurses accepted their clients’ views in a nonjudgmental manner; whether they used simple language and praised clients where appropriate; and whether they gave accurate information, summarized information, helped clients clarify information, provided feedback, and managed consultation time efficiently.

Medical Records Abstracts

Between March 1988 and March 1989, information was abstracted from the medical records of 1,001 women who had attended the same eight Ogun State Ministry of Health clinics. From examining these records, evaluators were able to measure whether clients returned to the clinic for their scheduled follow-up visits after their initial interviews. Approximately 10 client records per clinic were systematically selected and reviewed each month. Half of the clients (501) had been seen by trained nurses and half (500) had been seen by untrained nurses during their initial visits.

The information abstracted from the records included the date of the reference visit, the training status of the attending nurse, and the client’s age, educational level, family plans, previously used contraceptive method, method selected during visit, reasons for changing method (if applicable), scheduled date of follow-up appointment, and follow-up attendance.

A profile of clients selected from the medical records showed no significant difference between clients who had been attended by trained or untrained nurses in terms of age, educational level, or prior contraceptive use. Of the total group, 14 percent of the women were aged 17–24; 29 percent were aged 25–29; 33 percent were 30–34 years old; 17 percent were aged 35–39; and 7 percent were age 40 or over. Among the group as a whole, 23 percent had received no schooling; 33 percent had attended school; and 44 percent had attended secondary school. Fifty-three percent of the clients had never used any method before; methods adopted by the 47 percent of current users included the pill, condoms, IUDs, injectables, and foaming tablets.

Results

Data from the study can be viewed from the perspective of the following quality-of-care elements: interpersonal relations and counseling, information giving, and mechanisms to encourage continuity. Client compliance in returning to the clinic for the appointed follow-up visit was also studied.

Interpersonal Relations and Counseling

To compare the interpersonal relations and counseling skills of trained and untrained nurses, evaluators looked at data from client exit interviews and the information gleaned from an expert observer. The data revealed that in general, trained nurses performed better as counselors, although in certain areas covered in the client exit interviews, untrained nurses performed almost as well as their counterparts.

As Figure 1 shows, exit interviews indicated that trained nurses were significantly more likely than untrained nurses to have listened attentively to their clients ($\chi^2 = 75.0, p<0.001$). Ninety-seven percent of the clients who consulted with trained nurses, compared with only 66 percent of the clients of untrained nurses, reported being listened to attentively.

The exit interviews also showed that clients who were counseled by trained nurses were significantly more

![Figure 1](https://example.com/figure1.png)

**Figure 1** Percentage of untrained and trained nurses who used specific family planning counseling skills, as reported by clients, Ogun State, Nigeria, 1989

Note: N = 480 clients.
likely to have felt comfortable during consultation sessions than were the clients of untrained nurses ($\chi^2 = 34.0, p<0.001$): Ninety-five percent of the clients of trained nurses, compared with 76 percent of clients attended by untrained nurses, felt comfortable discussing family planning methods and practices. Clients of trained nurses were more likely to perceive their providers as being polite during the session (89 percent) than were the women attended by untrained nurses (53 percent) ($\chi^2 = 75.8, p<0.001$).

Information from the expert observer supports many of the findings from exit interviews. According to the observer, trained nurses performed better than untrained nurses in all areas—they were more relaxed, listened more attentively, made more frequent eye contact, smiled more often, helped clarify method choice, gave feedback, were not judgmental, praised clients, used client language, and managed their time efficiently.

Results from exit interviews revealed no significant differences between trained and untrained nurses in terms of their performance as information givers. Among a total of 193 clients who came to the clinic to adopt a method, who were having problems with their selected method, or who desired to change methods, 91 percent of those attended by trained nurses reported that such nurses requested a medical history, compared with 85 percent of those attended by untrained nurses. Further, 49 percent of trained nurses asked clients about their knowledge of family planning, compared with 45 percent of untrained nurses; and 57 percent of trained nurses asked clients about their interest in a particular method, compared with 48 percent of untrained nurses. In addition, 89 percent of trained nurses and 87 percent of untrained nurses asked those clients who visited the clinic for resupply or follow-up whether they had experienced any problems with the method.

Another area in which there was little apparent difference between the performance of trained and untrained nurses was in the clients’ willingness to recommend clinic services. Exit interviews indicated that 96 percent of clients attended by trained nurses, compared with 95 percent of clients attended by untrained nurses, said they would recommend the clinic to their friends. Because of the nature of this question, in which the client had to state a future intention about something she may not have thought about previously, it is possible that a “politeness bias” influenced both sets of results.

**Information Giving**

To make intelligent decisions about family planning, clients need information about the range of methods available, especially their effectiveness, advantages, disadvantages, potential side effects, and correct use. Since all nurses in the Ogun clinics included in the study had received family planning training, it is not surprising that in the area of information giving even the nurses who had not yet received counseling training performed well in imparting family planning information to their clients. For example, client exit interviews showed that overall, 94 percent of clients could name at least two methods, 76 percent could name at least three methods, and 43 percent could name at least four methods.

Regardless of the technical competence of all the family planning nurses, those trained in counseling skills performed better overall in the information-giving area than did their untrained counterparts. According to client exit interviews, trained nurses explained family planning clearly in more cases than did untrained nurses: Ninety-four percent of women attended by trained nurses reported that they had received a clear explanation, compared with 76 percent of women attended by untrained nurses ($\chi^2 = 32.5, p<0.001$).

Findings from a subgroup of 104 clients who accepted a method during their visit showed that trained nurses excelled in four skill areas, as Figure 2 shows. These areas were: (1) requesting that clients repeat the instructions for the method chosen ($\chi^2 = 5.2, p<0.05$); (2) asking if the clients had any questions ($\chi^2 = 5.0, p<0.05$); (3) demonstrating the use of a contraceptive method ($\chi^2 = 10.3, p<0.001$); and (4) showing booklets or leaflets about the chosen method ($\chi^2=5.2, p<0.05$). Figure 3 shows that in the same subgroup of 104 acceptors, almost all of the nurses (91–100 percent) had described how the contraceptive method worked, as well as its advantages, disadvantages, and possible side effects. Even without the specialized training in counseling, this subgroup of method acceptors reported that 96 percent of the untrained counselors explained method use clearly and 88 percent of them described possible side effects.

Data from the expert observer support many of the client exit interview data showing that overall, trained nurses were better than untrained ones in the area of information giving. The observer found that trained nurses were better in giving accurate information, using visual aids, summarizing information, and asking clients to summarize key information. The observer found no difference, however, between trained and untrained nurses’ performance in the explanation of the benefits of using a particular method, the description of different reproductive methods, the possible consequences of switching methods, and the medical examination.

One notable difference between trained and untrained nurses occurred among a subgroup of 112 clients who visited the clinic for resupply and 138 clients who were there for follow-up. Client exit interviews showed that significantly more trained nurses (84 percent) pro-
vided contraceptive supplies than did untrained nurses (60 percent) \( \chi^2 = 11.5, p<0.001 \). This difference may be explained by the enhanced communication skills of the trained nurses due to counseling training, which permitted them to make their clients aware of the need to receive supplies at the session.

**Mechanism to Encourage Continuity**

An effective follow-up system is the primary mechanism to encourage a client to continually use a contraceptive method (USAID, 1990). Scheduling follow-up appoint-

**Figure 2** Percentage of untrained and trained nurses who used specific family planning counseling skills with new acceptors, as reported by such clients, Ogun State, Nigeria, 1989

![Figure 2](image)

Note: \( N = 104 \) new acceptors.

ments at the end of the initial consultation session is one way to encourage clients to continue with their chosen method. In Ogun State, family planning nurses were instructed to set up follow-up appointments and to establish medical records for clients who decided to adopt a method.

Analysis of the mechanism to encourage continuity was taken from the medical records of 1,001 contraceptive adopters some time after their initial visit. A review of such records showed that 96 percent of the trained nurses had scheduled a return visit with their first-time method-adopter clients, compared with 78 percent of the untrained nurses \( \chi^2 = 77.2, p<0.001 \). Among a subgroup of pill adopters, 99 percent of trained nurses and 89 percent of untrained nurses scheduled return visits \( \chi^2 = 11.6, p<0.001 \), and among IUD adopters, 98 percent of trained nurses and 72 percent of untrained nurses scheduled follow-up appointments \( \chi^2 = 81.7, p<0.001 \).

**Client Compliance with the Follow-up Clinic Visit**

The purpose of improving quality of care is to promote an ongoing relationship between client and service provider and continued contraceptive use among clients. After clinic personnel have provided the service, it is up to the client to act—to return to the clinic for scheduled appointments.

Client compliance data for this study were abstracted from the medical records of 1,001 clients. Analysis showed that clients of trained nurses were almost twice as likely as clients of untrained nurses to return to the clinic for follow-up visits. As indicated in Figure 4, 84 percent of the clients attended by trained nurses, com-
Figure 4 Percentage of clients of untrained and trained nurses who returned to clinics for family planning visits, by method obtained at initial visit, Ogun State, Nigeria, 1989

Note: N = 1,001 client records.

pared with 44 percent of the clients attended by untrained nurses, returned for their scheduled follow-up visit ($\chi^2 = 178.1, p < 0.001$).

Among a subgroup of IUD and pill users, the difference between clients attended by trained and untrained nurses is even more dramatic. Of the 621 clients who chose the IUD at their initial visit, 85 percent of those seen by trained nurses, compared with only 30 percent of those seen by untrained nurses, returned for follow-up appointments ($\chi^2 = 199.3, p < 0.001$); of the 269 clients who chose the pill during their initial visit, 91 percent of those attended by trained nurses, compared with 70 percent of those seen by untrained nurses, returned for follow up ($\chi^2 = 18.4, p < 0.001$).

The statistically significant difference in clinic attendance between clients of trained and untrained nurses is maintained across client age categories. Younger clients (aged 17–25), however, returned for follow-up appointments slightly less often than did older clients, regardless of whether their nurse had been trained (71 percent) or untrained (28 percent) (not shown).

Discussion

The Ogun State study was able to measure the difference that training in counseling skills can have on the quality of family planning service delivery. The findings strongly suggest that short-term counseling training can improve quality of care and client compliance. Data collection and analysis provided evidence that nurses trained in counseling did indeed perform better in the quality-of-care areas investigated—interpersonal relations, counseling, information giving, and mechanisms to encourage continuity—and the superior performance of trained nurses over untrained nurses in these areas resulted in greater compliance by the clients of trained nurses.

In the often ignored area of interpersonal communications, clients' perceptions of services are critical for understanding how family planning services are delivered. Interpersonal relations is that element of quality of care that may strongly influence clients' confidence in their own choices and ability, satisfaction with the services, and the probability of a return visit (Bruce, 1989). The use of client exit interviews in the Ogun study allowed evaluators to look at programs from the clients' perspective. Data in the areas of interpersonal relations, counseling, and information giving—all of which overlap somewhat with each other—showed that:

1. 98 percent of trained nurses compared with 66 percent of untrained nurses were reported to have listened attentively to their clients;
2. 95 percent of trained nurses compared with 76 percent of untrained nurses were reported to have made their clients feel comfortable discussing family planning methods and practices;
3. 94 percent of trained nurses compared with 76 percent of untrained nurses gave their clients clear explanations; and
4. trained nurses excelled in demonstrating methods to new acceptors, asking them to repeat instructions, asking if they had questions, and showing them methods booklets or leaflets.

Clearly, these data indicate that, from the clients' perspective, the nurses trained in counseling provided a better quality of service than did untrained nurses, because they performed better in interpersonal relations, counseling, and information giving.

Trained nurses also performed significantly better than untrained nurses in encouraging client continuity and compliance. Abstracts from medical records showed that 96 percent of trained nurses, compared with 78 percent of untrained nurses, had scheduled follow-up appointments for clients, and 84 percent of the clients of trained nurses, compared with 44 percent of the clients of untrained nurses, returned to their clinics for follow-up visits. It is generally believed that client return visits are highly correlated with continuation rates. If so, the high level of return visits for clients of trained nurses bodes well for continuity rates in the long run. It strongly suggests that short-term counseling training could make a difference in clients’ family planning behavior and that a strong relationship exists between the quality of care and clients’ continued use of contraceptives. The fact that almost twice as many clients of trained nurses as clients
of untrained nurses returned for their follow-up appointments also supports Jain's hypothesis that improvements in the quality of service delivery will lead to continued contraceptive use (Jain, 1989).

A less obvious aspect of client compliance that has implications for continuation rates is that client exit interviews showed that more trained nurses (84 percent) than untrained nurses (60 percent) provided contraceptive supplies to clients who went to the clinic for resupply and follow-up. Studies in Thailand and Kenya indicate that when service providers give contraceptives directly to clients, they contribute to substantially greater contraceptive use (Pongsupsaht et al., 1986; Prince of Songkla University and Population Council, 1985; Norton, 1989).

Client exit interviews also showed some areas where untrained nurses performed almost as well as trained nurses:

1 94 percent of all clients could name at least two methods; 76 percent could name at least three methods; and 43 percent could name at least four methods;

2 A subgroup of acceptors showed that more than 90 percent of all nurses had described how the method worked, its advantages and disadvantages, and its side effects;

3 91 percent of trained, compared with 85 percent of untrained nurses, asked their clients for background information;

4 89 percent of trained and 87 percent of untrained nurses asked if their clients had experienced difficulties with their previous method; and

5 96 percent of clients of trained nurses and 95 percent of clients of untrained ones said they would recommend family planning clinic services to friends.

The superior performance of all the family planning nurses, both trained and untrained in counseling, may reflect that, at the time this study was undertaken, the Ogun State Ministry of Health clinics already had in place the basic quality-of-care elements for effective family planning service delivery—a cadre of technically competent family planning nurses, a variety of contraceptive methods, and mechanisms for return visits.

Because of the interaction between trained and untrained nurses in the same physical and social setting, the risk of spillover skills existed. Actually, it was observed that the untrained health providers were curious to know which methods were used by their trained colleagues. The implication is that a spillover of skills diminished the difference in performance between both groups of nurses. Acceptance of this assumption would suggest that the advantages of counseling training are probably even greater than this study has identified.

There were also a number of skill areas in which both trained and untrained nurses needed improvement. Client exit interviews of a subgroup of clients who were having problems with their methods showed that only (1) 49 percent of trained nurses and 45 percent of untrained nurses asked clients about their knowledge of family planning; and (2) 57 percent of trained nurses compared with 48 percent of untrained nurses asked clients about their interest in a particular method. Since clients are more likely to continue contraceptive use if they are able to use a method they choose (Pariani et al., 1987), future training sessions should emphasize these skills and further time should be allotted to skills practice.

In terms of study design and data collection methodology, the use of three different measures proved useful in understanding the effect that counseling training had on nurses' ability to improve the quality of service delivery and on client compliance. The three measures also provided the opportunity for evaluators to determine which counseling skills needed to be further emphasized.

It would be worthwhile in future studies to interview greater numbers of new clients, contraceptive method switchers, clients experiencing problems in using methods, and contraceptive dropouts. It would also be valuable to match the abstracts of clinic records with the same clients participating in the exit interviews and to provide more information about the relationship of client satisfaction, return visits, and continuation rates. Future studies could also explore other techniques to measure quality of care, such as interviews with service providers, focus groups with clients, client diaries, videotaped observation sessions, and so forth. To measure the effect of training on possible long-term contraceptive use, a follow-up survey should be conducted to examine whether trained counselors maintain quality of care over an extended period of time.

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