

REPORTS

Barriers to Effective Family Planning in Nepal

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To investigate why family planning (FP) services in the Kathmandu Valley of Nepal are underused, a study was initiated under the auspices of the Nepal Family Planning/Maternal-Child Health Project. The study was intended to provide a user perspective, by examining interactions between FP clinic staff and their clientele. "Simulated" clients were sent to 16 FP clinics in Kathmandu to request information and advice. The study revealed that in the impersonal setting of a family planning clinic, clients and staff fall into traditional, hierarchical modes of interaction. In the process, the client's "modern" goal of limiting her family size is subverted by the service system that was created to support this goal. Particularly when status differences are greatest, that is, with lower-class and low caste clients, transmission of information is inhibited.

This report describes a small study conducted in the capital of Nepal, where reproductive attitudes are rapidly changing and where there is evidence that women often have more children than they wanted to have. The question behind the study was whether the professional providers of family planning services are themselves inhibiting effective use of contraception. The findings of the study strongly suggest that they are, especially when the clients or prospective clients are lower-class, of low caste, or uneducated.

The identification of this phenomenon simply as "social discrimination" is not particularly illuminating, and does not indicate a direction for attempting to improve the situation. A closer look at the fears and perceptions of the simulated clients who participated in the present study and at the accounts of their interactions with family planning clinic staff reveals more. The clients' perceptions and the statements and behavior of the clinic staff are clear illustrations of traditional modes of social interaction translated into a new context. The result in many cases is that the purpose for which the context was

created—that is, to assist people in realizing their "modern" reproductive goals—is defeated.

As the following will illustrate, clients and providers of family planning services in Nepalese clinics quickly fall into traditional, hierarchical patterns of interaction. In some cases the professional actually articulates traditional, pronatal norms, and pushes the client to conform. In other cases the client is impeded in more subtle ways. Often information is withheld, and the client is left with the impression that there is no other option for contraception should the recommended course of action prove unsatisfactory.

These findings suggest that the present clinic-based system is not effective for providing family planning services in urban areas of Nepal. In unfamiliar, impersonal situations, people fall back on traditional patterns of interaction, to the detriment of the task at hand. A more personalized (and, paradoxically, more familiar and traditional) setting very likely would be more conducive to helping couples realize the nontraditional goal of regulating and limiting their fertility.

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Background

Nepal has made little headway in reducing high fertility and population growth. Between 1971 and 1981, census figures show a 19 percent increase in the annual growth rate, from 2.1 percent to 2.6 percent (Goldstein et al., 1983). The Contraceptive Prevalence Survey (CPS) conducted in 1981 reported a total fertility rate¹ of 5.9 percent. Reported rates of contraceptive use for Nepal are among the lowest in the world. According to the CPS only 8.7 percent of all currently married Nepalese women aged 15–49 years old were using contraception in 1981 (HMG Ministry of Health, 1981). Even in 1981, Nepal's population was over 90 percent rural. Given the relatively low cost of raising children, and children's economic utility as unpaid family laborers in subsistence agriculture, it is doubtful whether many rural couples want small families.

Recent research in the country's main urban center, however, suggests a somewhat different picture. An intensive study of fertility, contraceptive use, and reproductive decision-making in several sites in the Kathmandu Valley has revealed an increasing preference for small families (Goldstein et al., 1984). This finding is not surprising. Kathmandu, the capital and largest city of Nepal (1981 population: 235,211), exhibits many of the classic features of urbanization such as wage labor, availability of education, widespread literacy, modern health facilities, consumption of manufactured goods, mass communications, opportunities for socioeconomic mobility, and the elimination of the family as the basic unit of production. It is also characterized by inflation and low wages, both of which increase the cost of having large families.

In-depth interview data from the same study indicate that reproductive attitudes are changing much more rapidly than is behavior. Despite acceptance of the idea that small families are preferable, a substantial number of unplanned births was found in both low and middle income families, and among both high and low castes. The majority of the 67 couples in two urban subsamples expressed an urgent need to regulate their fertility for economic reasons, but many had not been successful in doing so. Sixty-seven percent already had more children than they considered ideal and, of these, 49 percent were not using a modern method of contraception. Thirteen percent had adopted a method of contraception in order to terminate childbearing, but had stopped using the method because of side effects or other problems and had one or more unplanned children because they had not adopted an alternative method. Others had unplanned children before adopting an initial method of contraception (Schuler et al., forthcoming).

Behind these unwanted births, the study suggests, is a pervasive syndrome of fear, misinformation, and indecision that often results in inaction. Individuals and couples are torn between their desire to stop having

children and their fear of the health consequences of both permanent sterilization and temporary contraceptive methods. An ubiquitous fear among those whose livelihood depends upon their ability to do manual labor is that the deleterious side effects of family planning may undermine their family's very subsistence. Often this fear outweighs the acknowledged economic and health rationales for limiting family size. Hence, a great many urban couples who want small families, including many who have already exceeded their desired family size, have never set foot in a family planning facility, despite their physical accessibility. Others, according to the interview data, have briefly tried contraception and quit because of perceived problems, inconvenience, or fear of side effects. Even among those individuals who obtained their contraceptive method from a family planning clinic, interview material revealed very few cases in which the person returned to the clinic to seek a solution to a perceived problem or additional information or advice.

Population Policies and Programs

Organized provision of family planning services in Nepal began on a small scale in 1959 with the founding of the Family Planning Association of Nepal (FPAN), and in 1968 the Family Planning/Maternal and Child Health (FP/MCH) Project was established within the Ministry of Health. Beginning in 1969, the Fourth, Fifth, and Sixth Five-Year Plans of His Majesty's Government (HMG) set goals for limiting population growth, and in 1978 a high-level National Commission on Population was established. Over the years HMG has articulated a continuing commitment to population activities, and has received funding and technical support from a number of international and bilateral agencies, as well as from private voluntary organizations.

HMG's population activities are conducted mainly through the FP/MCH Project, which administers family planning services in 52 of the 75 districts; the Integrated Community Health Services Development Project (ICHSDP) is responsible for the remaining 23. The Family Planning Association of Nepal, which is a private association and receives assistance from the International Planned Parenthood Federation, also provides services in 17 districts.

The district offices of the FP/MCH Project are generally staffed with a family planning officer, nurse, auxiliary health worker, auxiliary nurse midwife, a second and third class officer, an intermediate supervisor, and a healthworker. The service centers are staffed with one or two healthworkers.² In the Kathmandu Valley the central office has several branch clinics. The central office and the Lalitpur District Office also operate approximately ten "mobile clinics" maintained by one or two health aides, where a doctor makes scheduled visits weekly or biweekly. Four FPAN clinics, including

the central clinic, are located in the Kathmandu Valley. The clinics offer a wide range of services to Kathmandu residents either free of charge or for a nominal fee. These include oral contraceptives, condoms, Depo-Provera, IUDs, and surgical sterilization. The clinics are scattered throughout the city and the urban-fringe villages. All are accessible by bus.

Methodology of the Field Study

The possibility that the providers of family planning services themselves contribute to underutilization of contraception was investigated in a study initiated under the auspices of the FP/MCH Project³ in the fall of 1982. The purpose of the study was to examine interactions between family planning clinic staff and their clientele. For this purpose, six couples and two individual women with different socioeconomic backgrounds posed as clients (referred to throughout this report as "simulated" clients) and were sent to 16 of the 25 family planning clinics in the Kathmandu Valley over a period of about a month.⁴ One would expect family planning service provision to be most effective in the Kathmandu Valley, which in 1981 contained a quarter of the country's urban population. The 16 clinics included all of the government clinics and two FPAN clinics in the urban area and the four nearest branch clinics in the semi-rural areas adjacent to the city. Two or three separate "clients"/couples were sent to each of the larger clinics, and one to the six smaller urban and semi-rural branch clinics. When only one visit was made, it was always by a lower- or lower-middle-class client.

The simulated clients were trained individually and as couples, using role-playing techniques⁵ and acting out roles that did not deviate much from their actual life situations. They were instructed to ask for guidance in choosing a family planning method, to ask specific questions about one or two methods and the potential risks and side effects, and generally, to elicit as much information as they could about the advantages, disadvantages, and procedures for obtaining and using the various available methods. They were told simply that the object of the study was to find out how much and what type of information they would receive from the clinics and that, since many different kinds of people used the clinics, various kinds of people were participating. We did not say that we were investigating discrimination, since we did not want the participants to expect it.

After each clinic visit the couple was immediately "debriefed," that is, asked to relate their experience in a narrative style in as much detail as possible, and to describe their subjective impressions of the clinic and the staff. In eliciting the latter, the interviewers took care to seem matter-of-fact and to not show excessive interest in any of the details of what was being reported; they were also careful not to convey positive or negative

judgments about what was reported. Each debriefing session was tape-recorded and later transcribed, and edited versions were then prepared. Upon completion of 33 visits by the simulated clients we developed a supplementary questionnaire and interviewed family planning staff at four clinics to investigate some of the apparent biases that had emerged from our clients' accounts, and to juxtapose their experiences in the clinics against the perceived constraints and problems faced by the staff.

Collecting the Data

A comprehensive review of methodologies that have been used to study the "client-provider interface" in family planning and MCH clinics was conducted by the Pan American Health Organization (Gay, 1980). Many methodologies (e.g., Katz et al., 1969; Whyman, n.d.; Pridham and Hansen, 1980; Forberg, 1971; Udry, 1972) entail direct observation and recording of interactions, either by hand or using a tape recorder. The interactions are then analyzed by breaking them into units and categorizing and scoring the units. In Whyman's scoring procedure, points are assigned based on the number of sentences in various categories, for example, "assurance sentences," "bias sentences," and so forth. Since the point of such an analysis is to determine the probable effect of the interaction on the client, we believe that the number of "bias," "assurance," and other types of sentences is likely to be a less accurate indicator than a more qualitative judgment.

In some methodologies direct observation is supplemented with on-site interviews with clients (e.g., Stiles, 1979). The use of simulated clients has been reported in at least two instances, in one case to study the role of pharmacists in providing family planning services (Bailey, 1971, 1972), and in the other to investigate the attitudes and behavior of health care providers in Peruvian clinics (Carlos Michelson, 1984).

In the present study, direct observation was rejected as a methodology because it would not have been feasible without informing the clinic staff, and had they been informed we would have expected some modification in their behavior. Moreover, data gathered by means of direct observation is filtered through the observer's perceptions and interpretations. We felt that the perceptions of the client would be more useful for understanding the behavior of users and potential users of family planning clinics. Obviously, accounts supplied by simulated clients in debriefing sessions cannot reproduce accurately all of the specific details of what clinic staff members actually say. However, it is important to realize that, in some ways, what the client remembers is more important than what is said by the staff members. Information that a client is unable to grasp and remember is not very useful.

Our apprehensions that the knowledge gained by

the simulated clients in earlier clinic visits might be reflected in subsequent visits were not borne out by the transcripts. In fact, we tried to encourage the lower-class clients during the debriefing sessions to ask more questions of the clinic staff than they had during the previous visit, but their first and subsequent visits were equally brief.

The Simulated Client Groups

Three groups of simulated clients with different caste, class, and educational backgrounds were trained and sent to nearby family planning clinics. Group A consisted of two high caste, urban couples. They belonged to the urban middle-class who, in Kathmandu, generally come from landed (i.e., landowners by inheritance), aristocratic, or business families and may hold mid-level positions in government. The men typically hold SLC (School Leaving Certificate, which is approximately equivalent to a tenth-grade education) or higher academic degrees. The Group A clients projected self-confidence and were polite without being subservient. Their use of the Nepali language demonstrated their level of education and their worldliness. The husbands wore western-style clothing and their wives wore *saris* and accessories that reflected current fashions.

Group B consisted of two lower middle-class couples and two individual women. The lower middle-class in Kathmandu generally come from landed families, and are generally literate but rarely hold degrees above the SLC level. Our lower middle-class clients lacked the sophistication of middle-class people; their manners were not as polished and their style of speaking was not as cultivated. Their clothing was somewhat soiled, somewhat worn, and not as stylish as that of the Group A clients.

The two couples in Group C were lower-class. One couple was also low caste, a fact that might have easily been guessed from their appearance and manner. In Kathmandu the lower-class, or urban poor, generally work as porters, or unskilled laborers in agriculture or construction, often on a daily wage basis, or they are employed in service at the lowest levels. Some belong to occupational castes—that is, a caste traditionally associated with an occupation, such as blacksmith. The majority are illiterate or barely literate, and many have never attended school. The manner of the Group C simulated clients was markedly subservient. They were unfamiliar with the euphemisms employed by more educated clients to facilitate discussion of potentially embarrassing details. They appeared ill-at-ease, as though accustomed neither to making small talk nor to carrying on lengthy conversations with their social superiors. They wore an assemblage of traditional and western-style clothing and, though somewhat untidy, nonetheless gave the impression of struggling to achieve a respectable appearance.

Qualitative Findings

During the first week of the study we became exasperated with what we perceived at first to be simply a methodological problem. We found it extremely difficult to recruit uneducated, lower-class (Group C) people to work for us, despite the attractive salary and short hours we offered for study participation. Time after time we trained new simulated clients who lost their nerve and then made feeble excuses for failing to visit the clinics. One of our trainers became so fed up that he personally escorted a simulated client couple to the door of the family planning clinic, only to learn the following day that they had bolted as soon as he was out of sight.

When we finally succeeded in persuading two lower-class couples to visit the family planning clinics, no amount of training and encouragement seemed adequate to induce them to stay long enough to ask even a small fraction of the questions we had intended them to ask. We used role-playing techniques and continually tried to build up their self-confidence and to reinforce their training during the debriefing sessions, but such efforts had little effect. Despite the many hours we invested in the lower-class clients, their interactions with staff in the family planning clinics were extremely brief. We tried to understand why. One couple from Group C, having failed for the second time to ask about possible problems or side effects, explained:

We did not ask whether the loop might have harmful effects because they had already told us that the loop would be best for us.

This particular couple made only two clinic visits. We finally dropped them from the study because they kept falling ill on the day they were scheduled to visit a clinic, and making up other excuses for not going. The second couple in Group C (who were low caste as well as lower-class) were a little older and seemed somewhat more worldly. They were slightly more daring about entering clinics, but once inside they rarely stayed for more than a few minutes. Their constant fear was that they would be forcibly sterilized.

We could not help but wonder what sort of information an "authentic" lower-class client would receive, when our highly trained lower-class simulated clients were finding it difficult to even obtain the names of the available contraceptive methods. When we questioned one couple after their second debriefing we discovered that they still did not know what methods were available. They could not name more than one or two, and they doubted whether contraceptives would "work."

The problems we had with the simulated clients made us realize that when they interacted with family planning staff they were not merely playing roles. They were acting spontaneously, as genuine members of the population with which the study was concerned: urban Nepalese who do not make use of available family planning services, or who do not use them effectively.

Most of the Group C clients we recruited did not know the location of a single clinic. They did not understand or believe, although we told them many times, that the clinics exist to provide information and services for people like them, that the staff are paid to answer their questions—it is their job.

If people like the lower-class clients we recruited ever do visit family planning clinics they probably do not ask questions when presented with information that they do not understand, or when they receive suggestions they feel are unacceptable. The Group C simulated clients would not think of demanding better service, because they do not perceive that the clinics are "for them." They expected poor treatment and they got it, yet they were reluctant to criticize.

At the conclusion of each debriefing session we asked the simulated clients whether they believed what the family planning staff told them and whether they would go back to that particular clinic. In one case the dialogue was as follows:

Interviewer (I): Did you believe what they told you?

Client (C): Well, those were the things they told me. What should I say about whether I believe or disbelieve it?

A few days later the same couple was treated very rudely at one of the clinics:

C: When we asked about other methods he got angry, and said: 'Why are you mocking me when I have already told you that the operation is the best method for you? Do not behave like fools!'

I: Do you think he gave you good advice?

C: Yes.

I: Would you go back there if you wanted to use family planning?

C: We would not go. We are not going to do family planning.

I: Suppose you did decide to?

C: No. We never would.

I: Please do not feel that we are trying to force you into anything. It's just that you never know when a person may change his mind. Suppose that one day you changed your minds and wanted to do family planning. Would you go back to that place?

C: We might go there.

Of course they wouldn't. Only a "fool" would. The simulated clients were responding to the person who was debriefing them much as they had responded to the staff in the clinics. Rather than question or challenge someone in a position of authority, particularly a stranger, they had been socialized to dissimulate and try

to extricate themselves. Such behavior is reinforced by the family planning staff, for they too have been socialized, and automatically assume a posture of authority. Hence they talked down to the Group C clients, withheld information, and often dismissed them summarily.

Quantitative Analysis and Findings

The accounts provided by the simulated clients were analyzed qualitatively for overall content, and rated using a scale of 1 through 3, based on the following criteria:⁶

- *accuracy* of the family planning information provided,
- *completeness* of the information,
- *attitude* of the staff toward the client,
- *bias* of the staff toward the client.

There was necessarily some variation in the scoring procedures related to differences in the nature of the four criteria used. *Accuracy* and *completeness* permit a more strictly quantitative evaluation, while *attitude* and *bias* require more qualitative judgments. For this reason, the data upon which the *attitude* and *bias* scores are based are described below in some detail. (A summary definition of scores is presented in Table 1.) The underlying assumption was that a good attitude and lack of bias on the part of family planning staff would be conducive to a desirable outcome, that is, a well-informed, free decision by the client to adopt a particular family planning method.

Accuracy and Completeness

Accuracy was computed on a percentage basis. The correct and incorrect items of information recalled by the simulated client were added up. If a total of 75 percent or more of the items recalled were correct, the interview received a score of 3. A score of 2 was assigned when 50–75 percent of the items of information were correct, and a score of 1 was assigned when less than 50 percent were correct.

In scoring the interviews for completeness, points were given for each item of information recalled—the name of a method, a detail about its use, effectiveness, benefits, or risks—regardless of whether the information provided was correct.

Attitude and Bias

Attitude scores were based on the degree of courtesy, consideration, attentiveness, and respect shown toward the client, and the extent to which the staff seemed sincere in trying to provide assistance. Relevant behavior included greetings, whether the client was asked to sit

Table 1 Definition of scores

Criterion	Score		
	3	2	1
<i>Accuracy</i> of information on FP methods, effectiveness, benefits, risks, or side effects	75% or more correct information.	50-75% correct information.	Less than 50% correct information.
<i>Completeness</i> of information on FP methods	Minimum of 5 modern FP methods mentioned; effectiveness, benefits, risks, and side effects of 3-5 methods discussed.	1-3 methods mentioned; limited discussion.	0-3 methods mentioned; no relevant discussion.
<i>Attitude</i> toward client	Courteous, friendly, attentive, concerned; treats client with respect, tries to help client understand.	Judgmental manner; little respect for client.	Authoritarian manner; rude, condescending, domineering.
<i>Bias</i>	Information presented impartially; no prejudice shown toward client.	FP information restricted or somewhat misleading; some evidence of prejudice.	FP information withheld or presented in distorted or exaggerated way; highly prejudiced.

down, addressed with polite forms of speech (e.g., *tapai* for "you"), asked questions to help formulate and explain particular circumstances and needs. The scoring also took into account whether the staff presented information carefully and simply so that it could be understood, encouraged the clients to ask questions, admitted not knowing the answer to a question, and tried to help the clients obtain information or service from another source when unable to provide it themselves. Low scores were given when staff tried to rush the clients, tried to dominate them, scolded them, made condescending or rude statements, and so forth. An interview containing the following statement by a clinic staff member received a score of 3 on attitude:

People who use family planning often believe that it is because of the family planning method that they are suffering from this or that disease, but in many cases they are mistaken . . . There are not really very many [troublesome] side effects. The important thing is that you come here for consultation before adopting a family planning method, and return every three months for a check-up. If you have any problems we will provide treatment.

Another interview, containing the following statements, received a score of 1:

You have not had the operation, and you are asking us many unnecessary things. We cannot spare so much time for you . . . Go now! Why should you concern yourselves with how to use one method or another, or what to take after the operation? Try it and see for yourselves what happens.

Bias scores took into account any evidence of prejudice against the simulated clients, the degree to which

a staff member appeared to withhold information, and biases for or against a particular family planning method. In some cases information was presented relatively freely, but certain aspects were distorted or withheld in order to steer a client in a particular direction. Often such bias seemed to result from the staff's low estimation of the client's intelligence; the staff assumed that an uneducated client would be too dull to grasp the information or too incompetent to use a particular method effectively. In some instances the staff seemed well-meaning, but failed to provide counseling in an objective manner because of biases related to experiences in their own lives or the lives of friends and relatives, or because they felt that the client should conform to social norms. Simulated clients with only one or two children, for example, were all but denied permanent sterilization, because the family planning staff felt they ought not take the risk of losing their only offspring, or only son.

A number of accounts revealed distortion of information and poor advice related to biases against particular methods, rather than against the clients per se. (Trussell, 1976 reports similar findings with regard to contraceptive counseling in the United States.) The simulated clients were told not to use condoms, for example, because "they are only 50 percent reliable and they break 15 percent of the time." The bias against less effective methods (condoms, withdrawal, abstinence) was so common that female clients in our study who said that they were more than a week into their menstrual cycle typically were not advised to use any of these as an interim method. They were told simply to go home and to come back on the fourth or fifth day of their next cycle for pills, IUD insertion, injectable

contraceptives, or sterilization. In the scoring system we employed, the degree of bias determined the score more than the particular form the bias took.

Family Planning Staff Response

On all four criteria the scores are positively related to the socioeconomic status of the client (Figure 1). Little difference was found in the accuracy of the information presented to Group A and Group B clients, but a substantial difference was noted between these two groups and Group C. The information presented was on average 76, 74, and 60 percent accurate for groups A, B, and C, respectively (average scores were 2.6, 2.5, and 2.0). In other words, only slightly more than half of the information that the Group C clients recalled being given was classified as correct. With regard to completeness the trend is similar, but there is a marked difference in the average scores of groups A (2.7) and B (2.2), as well as B and C (1.0).

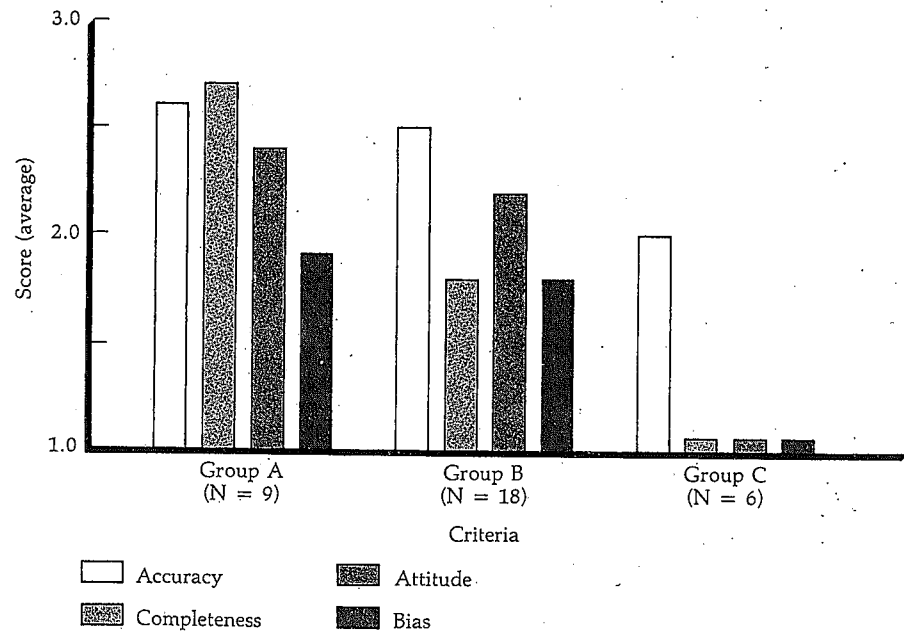
One explanation for these differences is that the interviews with Group C clients were too short for the staff to have conveyed much information, correct or incorrect. Family planning staff spent an average of over 30 minutes with Group A clients and conveyed, on average, 13.6 items of information per interview that the clients were able to recall; staff spent less than 10 minutes with Group C clients and conveyed an average of only

2.5 items of information that the clients could recall.

With regard to attitude and bias the pattern is similar. Average scores are positively related to the socioeconomic status of the client. Here, as with accuracy, the difference in the responses to Group A and Group B clients is only slight, but the scores drop dramatically for Group C clients. Although attitude and bias appear strongly related, they do not always covary. In some cases staff were very friendly and sincere in trying to help, but they allowed personal prejudices to interfere with their professional roles and tried to manipulate the clients "for their own good." In such cases the interview scored higher on attitude than on bias. When the two scores were not consistent it was most often the bias score that was lower. Hence, for clients from Groups A and B the average bias scores are lower overall than the average attitude scores. On all four criteria the Group C clients scored lowest. Disaggregating the scores by clinic and by individual client suggests that the patterns we observed cannot be attributed to idiosyncratic factors.

In summary, the scores indicate that the family planning information provided at most clinics is inadequate or incorrect in many cases. Generally, the clinics are capable of providing reasonably satisfactory services, but whether they do so depends upon the client. A clever, sophisticated, and personable client can get complete, objective information that is generally accu-

Figure 1 Response (average score) of family planning clinic staff to simulated clients, by clients' socioeconomic group



Note: Group A consisted of two high caste, urban couples; Group B consisted of two lower middle-class couples and two individual women; Group C consisted of two lower-class couples, one of which was also low caste.

N = total number of clinic visits made.

rate and presented in a courteous manner, but lower-class clients who lack the requisite characteristics and skills cannot. They are reluctant to use family planning services for good reason.

The Perspective of the Staff

The responses of family planning staff to several of the questions asked in interviews at four of the clinics add an interesting dimension to the accounts of the simulated clients. All four of the staff interviewed were people who dealt with clients, though we had no way to determine whether they were the same people who counseled the clients we had sent. Three of the staff were women, including a midwife and two staff nurses in charge at government clinics, and one was a male "motivator" at a FPAN clinic. The midwife and the male motivator worked in large clinics in densely populated areas of the city; one of the nurses worked in a smaller urban branch clinic and the other nurse worked in a small branch clinic in a rural area a few miles outside the city.⁷

The male motivator and the nurse from the urban clinic told the interviewer that it was easiest to deal with educated people. The nurse from the rural clinic noted that almost all of her clients were illiterate, and the midwife said:

Rural people are easy to deal with. They do not have many questions and they readily believe what we say.

Two of the female staff members remarked that they found Jyapu (a farming caste) women particularly difficult to influence, a situation that they seemed to find perplexing. The male clinic worker said that he found uneducated people difficult to "motivate," by which the interviewer understood him to mean that it is difficult to persuade uneducated clients to change their minds. Three of the respondents said that clients rarely ask questions, and only one of them viewed this negatively. The fourth said nothing on this point.

The four staff members we interviewed shared a low estimation of their uneducated clients' intelligence; they sent them away without much information regardless of whether they considered dealing with them easy or difficult. One of them explained:

It is very difficult for us to provide information so that uneducated people can understand it. Even educated people generally can't understand it very well. Everything has to be explained three or four times, and some people still do not understand. But they can be *convinced* [respondent's emphasis] by repeated explanations. . . . You can't explain complicated things so that uneducated people will understand. One can only "motivate" such people.

In most of the clinics visited the staff attempted to dominate the simulated clients, at least those from groups B and C. When asked, however, whether it was

their job to decide which method is best for each client, only one nurse stated unambiguously that it was:

Often clients come here determined to use a particular method, but sometimes we feel compelled, for their own sake, to tell them to use something else. . . . We consider each individual case and then guide the client in making a decision. For example, we never advise a woman to use Depo-Provera unless one of her children is at least five years old. *But some people will lie to get the method they want!* [respondent's emphasis] They will simply say that they have a child over five. And in fact most of them do not follow our advice. They go to get what they want from another clinic, and complain [about ours]. There is a lack of communication between the central family planning office and the branches. . . . If we reject [a client] they should do likewise!

"Talking down" to clients and trying to dominate them "for their own good" were situations frequently encountered in the transcripts. The nurse who was just quoted above admitted that her advice often drives people away from the clinic.

To further probe the preconceptions behind the advice that the family planning staff gave the simulated clients, we asked which family planning method would be best for various types of clients (responses are summarized in Table 2). For a low caste, uneducated client, three out of four of the respondents said an IUD would be best, but two of them added that such people generally will not agree to this because they are afraid of having something inserted inside them. The fourth said only that he would not recommend condoms.

The data from the simulated client interviews suggest that, in practice, IUDs and other temporary methods are rarely recommended to uneducated, low caste clients. The low caste Group C couple was advised to use a temporary method in only one of the four clinics they visited, and at that clinic sterilization was recommended with equal emphasis. At a second clinic the staff jeered at them, told them that they could just as well use nothing, and that they could go ahead and have ten children and it would not make any difference. When our simulated clients persisted, the staff mentioned permanent sterilization and pills and then dismissed them before they could ask another question. At the other two clinics this couple was told in no uncertain terms to have permanent sterilization.

We will not give you anything to take by mouth. You have to have an operation. It will be good for you.

At the other clinic, the following exchange took place:

Clients: Are there no other medicines [methods]?

Staff: There are, but they would not be good for you. Only the operation is good for you. *Do it!* [speaker's emphasis]

For a couple with several daughters but no son, all four respondents said they would not recommend per-

Table 2 Comparison of staff responses to the question "Which birth control method do you think is best?"

Client and situation	Response			
	Clinic 1	Clinic 2	Clinic 3	Clinic 4
Couple in their late 30s to early 40s with several grown children.	Sterilize if woman is under age 40; otherwise nothing is necessary.	Sterilize if woman is under 40; otherwise use a temporary method.	Sterilize.	Sterilize if woman is under 40; otherwise use a temporary method.
Newly married couple who want to delay first child.	Condoms.	Condoms.	Condoms (never pills or Depo-Provera).	IUD.
Low caste, uneducated couple.	No specific method (not condoms).	IUD (but clients usually refuse).	IUD (but clients usually refuse).	IUD.
Couple with 2-4 daughters and no son.	No specific method (never sterilize).	No specific method (never sterilize).	Depo-Provera (never sterilize).	IUD or pills (never sterilize).
Educated couple with 1-2 small children, who say they definitely don't want and can't afford another child.	Sterilize if youngest is over 5 years old.	Sterilize if youngest is over 5 and couple has at least one son.	Sterilize if youngest is over 5.	Sterilize if youngest is over 5.

manent sterilization. This is consistent with the advice received at four of the six clinics visited by one of the Group B clients, who represented herself as the mother of four daughters. Although she had said nothing about wanting a son, the staff at each of these four clinics insisted that she must have one. At one clinic she was told:

What, then! Is not a son necessary? You should have a son. You must conform to society; everyone waits to have a son. You have delivered only four daughters and you have come for family planning?

The staff person seemed irritated, according to our client. At another clinic the staff counseled:

Though it is a matter of fate, still you must wait for a son, even if you bear seven or eight daughters. You must satisfy your husband by making him the father of a son. Go on having babies until you produce a son.

While low scores on attitude and bias in many instances reflected indifference on the part of family planning staff, the opposite was true regarding the issue of bearing sons. In the above case, for example, the family planning staff attempted to dominate the client because of a sincere concern for her. Often a personal tragedy or the pitiable plight of a friend or relative can influence the type of information and advice provided by family planning staff. For example:

Client: For me, daughters are just like sons.

Staff: We women think so, but husbands do not agree. My case was similar to yours, and when I failed to bear a son my husband took a second wife. She bore him a son. You should not use family planning; you must have a son!

Her husband's attitude is not unusual. One of the four family planning staff interviewed, a young man, explained:

A son is essential . . . If my wife fails to bear a son I will get another wife. . . . I personally would not suggest sterilization [for someone who does not have a son] because I myself want a son.

In addition to the biases illustrated above, the responses indicate that many family planning staff do not believe that a woman over 40 years of age, even if regularly menstruating, is at risk of pregnancy. For young couples who want to postpone their first child, clinic staff tend to recommend only condoms, for fear of jeopardizing the couple's fertility. Pronatalism surfaces as well with regard to permanent sterilization. The interviews point to a tendency to not recommend sterilization to couples with fewer than three or even four children.

Summary and Policy Implications

Directly and indirectly, the study revealed a number of barriers to provision and effective use of family planning services in the urban areas of Nepal. First, it appears that a significant proportion of the family planning information provided by the clinics is either incorrect or inadequate. Second, the manner in which this information is presented is apt to drive clients away. Third, the quality of the services is positively related to the socioeconomic status of the client. Unsophisticated lower-class clients are likely to receive scantier, less accurate information and less courteous treatment than educated middle-class clients. Clients who lack the req-

uisite social status and skills to elicit useful information from the staff in family planning clinics are apt to leave without sufficient information to make an appropriate decision, or with an inadequate understanding of the method they adopt, and they are unlikely to return for follow-up. Their negative perceptions of family planning and family planning clinics probably become disseminated among their friends and neighbors.

The problems we had in encouraging lower-class simulated clients to visit the clinics and engage in dialogues with family planning staff are the same problems that service providers face. In some areas upgrading of technical knowledge may be called for, but the more complicated problem is how to improve the interaction and exchange of information between family planning staff and client.

The hierarchy that underlies day-to-day social relations in Nepali society came to the foreground in the setting of the urban family planning clinics. The staff was made up of strangers and the setting was unfamiliar, and traditional patterns of behavior soon took over. The simulated clients became deferent and submissive. Even in the debriefing sessions it was difficult to persuade them to articulate their real feelings about the way they had been treated. They simply reported what had been said and we did not press them further, fearing that if we showed disproportionate interest in a particular aspect of what they reported they might begin to exaggerate or embellish that aspect. After their last clinic visit we finally did persuade the low caste couple to express their real reactions to the treatment they received at one of the clinics. The man did an imitation of the staff person and then lapsed into profanities.

It is interesting that the high caste, upper middle-class, urban, university-educated research assistants in the larger study described earlier (Goldstein, 1984) overcame the cultural barriers with relative ease when working with low caste and lower-class families. As these research assistants became known in the neighborhoods, their rapport with clients increased. People gave extremely personal information about sexual matters and family conflicts and tragedies, and in many cases asked for advice and assistance with health, family planning, and other matters. Clearly, in face-to-face relations between individuals it is possible to break through the hierarchical modes of interaction that prevail in more impersonal contexts.

Perhaps, then, situations need to be created in which clients and family planning service providers can relate to one another as individuals. The findings of this study suggest that a neighborhood-based program would be more effective than the clinic-based system as it now functions. With the clinics providing medical services and technical backup, a community-based program could utilize workers with minimal technical training. An alternative or complementary program might focus on upgrading the communication skills of

family planning staff within the clinics. Transcripts of the simulated clients' accounts could be used in staff training, and the study could be repeated to evaluate the effectiveness of the training program.

The simulated client methodology described in this article provides a relatively quick, low-cost technique for evaluating family planning counseling. In contrast to direct observation by a researcher, it does not yield a verbatim account of the dialogue between client and clinic staff. In fact, the information is likely to be distorted by the simulated clients if they are unable to understand what they have been told. Since information a client does not understand is useless to him or her, this "weakness" of the methodology may in fact be a strength. Compared with direct observation, it is more likely to reveal the correct and incorrect information and impressions that clients take with them when they leave a family planning clinic. A more systematic evaluation of methodologies for studying provision of family planning services from the client's perspective could be made by employing direct observation, exit interviews with clients, and a simulated client study in a single clinic, and then comparing the findings.

Notes

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- 1 Total fertility rate is defined as the expected number of children a woman would have, under the assumption that the current age-specific fertility rates hold throughout her reproductive life span.
- 2 See Tuladhar and Stoeckel (1982) for additional details.
- 3 The study was sponsored by the Nepal FP/MCH Project under the direction of Badri R. Pande and funded by a grant from the Integrated Rural Health/Family Planning Services Project (AID No. 367-0135) and the John Snow Public Health Group.
- 4 The two high caste, middle-class client couples and one of the lower middle-class women had been employed by two of the authors as research assistants for periods of 3-12 months, and had heard many accounts of experiences in FP clinics in collecting reproductive and contraceptive histories. The low caste and lower-class clients were recruited by the research assistants from among their own acquaintances.

The two high caste couples made one and eight clinic visits, respectively (the first couple was then given the job of training and debriefing other simulated clients); the two

lower middle-class women each visited six clinics and the lower middle-class couples visited one and five clinics, respectively (one dropped out after a single visit); the low caste couple visited four clinics and the lower-class couple visited only two (they were scheduled to visit more, but procrastinated). In addition, one lower-class woman and two couples (one low caste) were recruited but did not visit clinics because they were too fearful. We tried but failed to find a low caste or lower-class woman who would dare to visit a clinic alone.

- 5 After initial discussions in which the project was explained, training consisted of one to two sessions of two to three hours duration, with reinforcement during debriefing sessions.
- 6 The following procedure was used to assign scores to each interaction on the basis of the client's account. First, the two authors conducting the study independently read the accounts of the 33 clinic visits (reconstructed from the taped debriefing sessions). The first reading was to determine the general character and content of the interactions, the extent of variation in the interviews with regard to the range of information discussed, the degree of accuracy of the information presented, and the specific ways in which the attitudes and biases of the FP staff were manifested. The accounts revealed considerable variation in the quality of the interactions. In some instances the staff was very courteous and friendly. They treated the clients with respect and seemed to be presenting FP information in detail and in an objective way, to help the clients make a decision. In other instances the staff was blatantly rude and sarcastic; they either withheld information or distorted it, cutting short the interview and attempting to push the client into a particular course of action. It was relatively easy to identify the "best" and "worst" interactions, and on this point there was no disagreement between the two authors. With respect to each of the four criteria, the "best" and "worst" interviews received scores of 3 and 1, respectively. Using these two interviews as indices, definitions were developed for the three possible scores for each criterion (Table 1), and the remaining interviews were reread and scored. One coder was a physician and the other a social anthropologist. The few cases in which the two coders assigned different scores were discussed and traced to (1) inadvertent mixing of dimensions by one or the other, (2) misunderstanding of the rough English translation by the physician, and (3) inadequate technical knowledge about reliability and side effects of contraceptive methods in the case of the anthropologist.
- 7 The four clinics and staff were chosen to represent the range of clinics and staff included in the study. Time constraints prevented more extensive interviews with staff.

Bibliography

- Bailey, Jerald. 1971. "Contraceptive education and the Colombian druggists." Unpublished Ph.D. dissertation, University of Michigan, Ann Arbor.
- . 1972. "Contraceptive education and the Colombian druggists." *Studies in Family Planning* 3, no. 11 (November):273-276.
- Carlos Michelson T. & Co. 1984. "Marketing social sobre población, inmunización y rehidratación oral en el Perú: Análisis de la opinión de 25 expertos utilizando el método delphi" ("Social marketing of family planning, immunization, and oral rehydration in Peru: A focus group approach"). Report prepared for the US Agency for International Development.
- Forberg, Lynn. 1971. "Development of methodology for evaluating the quality of interpersonal interaction between clinic staff and family planning clients." Unpublished manuscript (available at Columbia University Center for Family Health, New York, NY).
- Gay, Jill. 1980. "A literature review of the client-provider interface in maternal and child health and family planning clinics in Latin America." Paper prepared for the Pan-American Health Organization/World Health Organization.
- Goldstein, Melvyn, S. Schuler, and J. Ross. 1983. "From a mountain-rural to a plains-urban society: Implications of the 1981 Nepal census." *Mountain Research and Development* 3, no. 1 (February):61-64.
- . 1984. "Contraceptive use and fertility in urban Nepal: The beginnings of a demographic transition." Unpublished manuscript.
- His Majesty's Government (HMG) Ministry of Health, Family Planning and Maternal-Child Health Project. 1976. *Nepal Fertility Survey*. Kathmandu: HMG Ministry of Health.
- . 1981. *Contraceptive Prevalence Survey Report*. Kathmandu: HMG Ministry of Health.
- Katz, Elihu, M. Gerevitch, T. Peled, and B. Danet. 1969. "Doctor-patient exchanges: A diagnostic approach to organizations and professions." *Human Relations* 22, no. 4 (August):309-324.
- Pridham, K. and M. Hansen. 1980. "An observation methodology for the study of interactive clinical problem-solving behavior in primary care settings." *Medical Care* 18, no. 4 (April).
- Schuler, Sidney R., M.C. Goldstein, and J.L. Ross. Forthcoming. "Family planning from the user's and nonuser's perspectives." *Studies in Family Planning*.
- Stiles, W., S. Putnam, M. Wolf, and J. Sherman. 1979. "Interaction exchange structure and patient satisfaction with medical interviews." *Medical Care* 17, no. 6 (June):667-681.
- Trussell, James, Ruth Fadden, and Robert Hatcher. 1976. "Efficacy information in contraceptive counseling: Those little white lies." *American Journal of Public Health* 66, no. 8 (August):761-767.
- Tuladhar, J.M. and J. Stoeckel. 1982. "The relative impacts of vertical and integrated FP/MCH programs in rural Nepal." *Studies in Family Planning* 13, no. 10 (October):275-286.
- Udry, Richard and L. Clark. 1972. "Preliminary results of the study of respectful treatment for patients." *Family Planning Evaluation Project Report 18*. Chapel Hill: University of North Carolina School of Public Health.
- Whyman, Andrew. (n.d.) *The Thread of Decency: A Sociological Interpretation of the Respect Dimension in FP Clinics*. Mimeo. New York: Columbia University Center for Population and Family Health.