

**Technical Report 11:
Follow-up Evaluation of
the Effects of Training
Primary Health Care Providers
in Huancavelica, Peru**

PRIME/Peru Project

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LIST OF ACRONYMS

FP	Family Planning
MINSA	Peruvian Ministry of Health
PASARE	Support Program in Reproductive Health
PRIME	Primary Provider's Training and Education in Reproductive Health Project
RH	Reproductive Health
USAID	United States Agency for International Development

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EXECUTIVE SUMMARY

This report presents results of a follow-up study of a PRIME/Peru training project for primary health care technicians (“técnicos”), conducted in remote regions of Huancavelica, Peru. The PRIME training was part of a joint initiative with the Support Program in Reproductive Health (PASARE) of USAID/Lima and Peruvian Ministry of Health (MINSa), designed to increase the access to and quality of priority reproductive health services provided by MINSa.

Using an adult learning approach the training of técnicos covered the following topics: prenatal care, reproductive risks, family planning counseling, and obstetric emergency management. In addition, the project included “supportive supervision,” which reinforces training techniques and concepts through feedback, based on pre-determined criteria.

The study followed-up 22 health technicians (técnicos) (49% of the eligible population) trained by PRIME, between May-July 1998. The study applied 4 evaluation instruments: 1) direct observations between client and provider; 2) interviews with providers; 3) objective testing; and 4) compilation of service statistics. Overall project results indicate PRIME/Peru has had a positive effect on the levels of clinical knowledge pre and post-test (9.6 versus 15.3, respectfully) and in provider satisfaction with the training. Moreover, among the study population, there was a 15% increase in new clients. Quality of care indicators were also positive. Direct client-provider observations indicated a majority of providers established good rapport with clients, offered appropriate methods, and demonstrated strong counseling skills.

The evaluation, however, found that some project areas needed strengthening. For example, while there is qualitative evidence suggesting that some of the trained health technicians were able to properly manage cases of obstetrical risk, knowledge outcomes in this area were low both at pre-test and at follow-up. Other possible barriers to project success include: a lack of understanding on how to integrate the cultural diversity of the region, lack of contraceptive supplies, and the need for a broader sexual and reproductive health perspective (e.g. discussion of gender issues, prevention/treatment of STI's).

In summary, given the difficulty of working in the region, PRIME/Peru has successfully initiated change in an area of the country rarely attended to, and with a great need for health services.

INTRODUCTION

Huancavelica is one of the poorest areas in Peru. The 1996 national demographic survey (ENDES III) noted that only 12.9% of women of reproductive age in the region use a modern family planning method. The child mortality rate in the region is 78 per 1,000 live births.

This study addresses some results of the recommendations from PRIME/INTRAH - Phase I Assessment in Peru. The assessment revealed that though health centers in this region contained adequate technology, drugs, contraceptive, and supplies, primary health service providers (técnicos) often lack basic skills and have little reproductive health knowledge with which to perform required tasks effectively. In 1997, PRIME/Peru conducted primary provider training designed to upgrade and improve care quality in the Huancavelica and Ayacucho regions of Peru. Training activities provided by PRIME afforded primary health providers skills that would give clients quality reproductive health care services with equity and efficiency. The importance of PRIME training is accentuated today by the need for integrated reproductive and sexual health services.

The PRIME/Peru project is administered locally, where the central activity of the project is to train MINSA health technicians at the primary level to improve the quality of service to clients. A total of 101 technicians in Huancavelica and Ayacucho were trained by PRIME between May and July 1997. (Phase II). The training workshops consisted of a 5-day integrated reproductive health curriculum that covers themes including prenatal care, reproductive risks, family planning counseling, family planning service delivery, and obstetric emergency management. In addition to training sessions, the project includes a “supportive supervision” component. Supportive supervision measures knowledge retention levels through standardized surveys and direct observation of health technicians. This technique reinforces training methodologies and concepts.

Purpose of Evaluation

PRIME initiated this evaluation to identify the strengths and weaknesses of health technician training and to establish recommendations for the next phase of program planning. The study objectives consisted of 5 evaluation components.

- Quality of training (content, methods, and approach)
- Knowledge and skill acquisition and retention
- Quality of supervision
- Health Posts assessment (facility and supplies)
- Service delivery outputs

METHODOLOGY

Sample Selection.

A factor in the participant selection was the limited access across the region. Local analyses determined that many of the trained technician health posts were too isolated, and in some cases the territory would be dangerous to cross. Eliminating such health posts created a more convenient sample of health technicians for the evaluation. Even so, the observation group still averaged 30 to 40 hours of travel time to arrive at the health posts for training.

Other factors also determined the sample selection. Of the 101 available technicians only 71 were considered for the study. Technicians were included if they met the following requirements: (1) trained exclusively by PRIME; (2) pre-test data are available; and (3) received a supportive supervision visit. During the study, only the Huancavelica region had received supportive supervision visits and therefore the Ayacucho region was excluded from this follow-up.

The sample number (N) was based on the statistical calculations of the pre- and post-test results. Epi Info was used to determine what sample size was needed for an alpha=0.05 (p=0.05). This sample size gave a power of 84%. In order to obtain an alpha=0.05 and power of 84%, a sample of 22 people was needed. We worked with 71 technicians (N=71), located in the 6 provinces of Huancavelica (Acobamba, Angaraes, Castrovirreyna, Churcampa, Huaytara and Tayacaja). The Castrovirreyna province was excluded because of limited accessibility and the small number of technicians (total: 6). Three strata were formed from the remaining provinces: 1) Huaytara and Churcampa; 2) Tayacaja; 3) Acobamba and Angaraes. Ultimately, Tayacaja was isolated because of its slightly higher socio-economic characteristics.

The provinces in strata 1 and 3 were grouped together because of their similarity in geography, access, and pre- and post-test results. In each of the 3 strata, a province was selected at random, comprising 49% of the eligible population and 31% of the entire cohort. See Table 1 for details.

Table 1. Number of technicians selected by province

Selected Province	# of active technicians ^a	# of selected technicians
Angaraes	13	6
Tayacaja	20	10
Churcampa	12	6
Total	N= 45	n =22

^aTechnicians trained that met the study criteria and still work in the province

Data Collection Instruments.

The 4 evaluation instruments used for this study were validated by a group of technicians who had performed similar activities as the study personnel. Data were collected by 6 professional technicians with experience in reproductive health and qualitative data collection. Teams, consisting of 1 doctor and 1 social science expert, were formed. None of the teams were from the PRIME project. These teams participated in a 2-day training workshop during which the study instruments were reviewed, observation techniques discussed and the data collection training was conducted. Data were collected between May and July 1998 and processed between July and September. A brief description of the instruments used are as follows:

1. **Objective Test.** A questionnaire consisting of 25 close-ended questions was applied, evaluating theoretical knowledge about topics discussed in the workshops. The same instrument was applied before each training, allowing for comparisons of pre- and post-tests. This instrument compares 3 instances of learning and knowledge retention: Pre-test (base line); Post-test 1 (applied immediately after the workshop); and Post-test 2 (eight months after the training)
2. **Standardized Observation Guide.** Based on an instrument previously developed to conduct supportive supervision, the standard observation guide was used to evaluate the service quality offered by technicians. Two to three sessions of provider interaction by technicians were observed. If there were no clients at a visit, the observation team simulated a family planning consultation. The instrument consisted of 65 items in the following areas:
 - Reading of vital signs
 - Techniques for application of injectables
 - Reproductive risk factors
 - Prenatal care
 - Family planning counseling
 - Contraceptive methodology
 - Obstetric emergencies

The following table shows the distribution of observations, including the number of observed clients per region.

Table 2. Number Of PRIME/Peru Observations, By Type Of Client And Region

Observed Clients	Anagaraes	Churcampa	Tayacaja	TOTAL
New	5	2	3	10
Repeat/return Clients	10	10	14	34
Simulated	1	0	0	1
Total Observed Clients	16	12	17	45

3. **Provider Perceptions.** All the participants in the study were interviewed using a semi-structured guide. The interviews lasted approximately for 1 hour and were conducted by the *observer* with experience in social sciences. The interviews covered:
 - Service demand
 - Training usefulness
 - Role of supportive supervision
 - Community approach
 - Open comments

4. **Health Records and Evaluation of the Health Post.** The records for each technician were revised to determine the volume of service delivery in a year. Another form evaluated themes including physical aspects of the health post and the availability of contraceptive supplies and educational materials. It is important to note that determining a direct association between technician training and changes in the service volume is complex and requires the implementation of broader and more rigorous studies than the current one (Miller et al 1997). This data complements the information in instruments 1-3.

RESULTS

Quality of Training.

All the people interviewed expressed gratitude for having been selected to participate in the training and follow-up. Those interviewed said that the training was very helpful in their jobs as health technicians because they had learned a lot. The only inconvenience mentioned was the lack of physical space in the workshop. They also considered the workshops to be very dynamic and participatory. In many cases participants mentioned that because of its interactive design, they learned a lot more than in other workshops. The practical applications in the workshop also was mentioned as a very good learning instrument. One person noted "...it is not true that by watching one learns, we learn more by doing the exercises in a group."

A curriculum content analysis was undertaken to evaluate the appropriateness of the themes and methodology used. The 5-day curriculum, designed by local and RH regional consultants, focused on several themes. Obstetric emergency management was the longest training segment covered, followed by the family planning and the forms completion session. These themes coincide with the training objectives, indicated on Table 3 below. The forms completion theme was added to train providers how to use national form formats, per the request of MINSA.

Table 3. Themes of the PRIME/Peru Curriculum, By Number And Percentage Of Dedicated Time

THEMES	DEDICATED TIME #OF HOURS[♦]	%*
Obstetric Emergencies	5h, 15 min	17%
Family planning (counseling, update, side effects, rumors)	4h, 15min	14%
Forms completion (clinical history prenatal control card, HIS and SIS)	4h, 15 min	14%
Communication skills	3h, 45 min	10%
Orientation, practices and RH activities	3h	10%
Application of Injectables	2h, 45 min	8%
Newborn Care	2h	7%
Vital Signs	2h	7%
Prenatal Care	1h, 45 min	5%
Anatomy and Physiology	1h	3%
IEC activities in Reproductive Health	1h	3%
Prevention and monitoring of maternal mortality	30 min	1%
TOTAL	=30hours	100%

[♦] h= hours; min=minutes; * rounded amount

In addition to theme analysis, the techniques used during the trainings were examined. In all of the sections, participatory techniques on adult education were used. The effectiveness of this methodology was confirmed in interviews with providers, in which most of those interviewed mentioned that the techniques used created a good atmosphere conducive to maximum learning.

For many, the workshop had been the only opportunity to learn about reproductive health issues. One participant began to understand the role of reproductive health, where as "... before I did not consider it (RH) important because it was not part of the nursing area." Thus, the workshop also helped to enforce the RH program and the need to include this theme in patient management.

The interviewers were asked if the training had helped them to solve a difficult case. All the cases mentioned (8 total) referred to obstetric emergencies. The following 2 cases highlight the importance that the workshops had in preventing maternal mortality.

Case 1

"Yes, there was a patient with hemorrhage in Chonta and she was alone. She was bleeding heavily and was in a state of shock. We had referred her to the Churcampa Hospital, after I applied antibiotics, and the IV and all of the procedures to her. Then I drove her to Churcampa... The trainings were very helpful because I had not received any of these trainings before."

Case 2

"The training helped me a lot, that is why I have solved a case of hemorrhage, if I had not known, I wouldn't have applied an IV, I could have let her died, and this could have been a maternal mortality in my health post."

Other obstetric emergency examples included the placenta manipulation to expel it, and also the use of the "fishing" maneuver to remove the umbilical cord.

The themes covered in the workshops were adapted according to the principal roles of the technicians. The themes strengthened the technical skills of each provider. The theme "rumors", however, seemed to indicate that the curriculum needed to incorporate local belief systems. The inclusion of the rumors theme in the FP section suggests that local beliefs are wrong, consequently, providers are responsible for correcting the theoretical beliefs of the clients. This thematic use suggests that Huancavelican beliefs are irrelevant to their health care, and that providers should correct their beliefs with clinical explanations. A more fruitful approach would be to explore differences between local and biomedical beliefs and to incorporate them into future curricula.

Knowledge and Skill Acquisition and Retention.

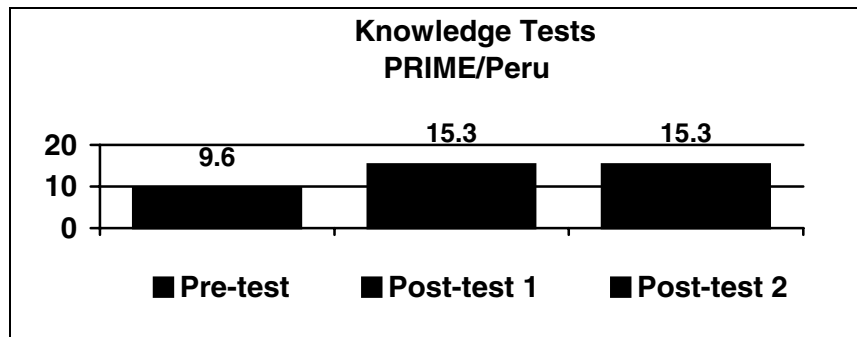
Knowledge Retention. The objective test, described previously, helped determine levels of knowledge retention in study participants. Graph 1, Levels of Learning and Knowledge Retention, PRIME/Peru 1997-8, represents the learning curve and knowledge retention between three events. The average of each measurement follows:

Table 4. Objective Test, Score and Standard Deviation

Test	Score	Standard Deviation
Pre-test	9.6	3.0
Post-test 1	15.3	2.95
Post-test 2	15.3	2.99

The increase in knowledge between the pre-test and post-test 1 and 2 are significant ($p < 0.05$; power of 84%). There was a 41% increase in knowledge acquisition between the pre-test and post-test 2. Fifty-five percent of the providers increased their scores, whereas the remaining 45% maintained the same level of demonstrated knowledge retention.

Graph 1. Levels of learning and knowledge retention, PRIME/Peru 1997-1998.



The objective test data was analyzed to determine any thematic differences in the learning levels. There was a significant increase between the pre-test and post-tests, based on the locally defined information on use of the pill, injectables, and quality of care.

The increase in knowledge however, was low in obstetric emergency management; 40% of the questions (10 of 25) were dedicated to this theme. Between the pre-test and post-test 1, there were positive significant changes in only 5 questions ($p < 0.05$). The participants demonstrated 50% retention of the information covered on obstetric emergency management. In the second post-test, participants showed knowledge retention of 40%.

Overall, the knowledge that was gained was retained and used at the work site 8 months after the training.

Skills. Standardized observation tools were used to evaluate the service quality of technicians.. The skill index is based on the total number of correct versus incorrect observations noted. It is important to note that the technicians were trained to provide basic health and reproductive health services only.

The most commonly observed service was general medicine (measurement of blood pressure, pulse, respiration and temperature), followed by counseling and provision of FP methods. During the observation of general medicine services, the health personnel showed high skill level in measuring vital signs. In only 8 cases did health personnel tell clients that their blood pressure would be taken, and the provider failed to complete it. In 1 observed case, the health personnel did not apply an adequate technique when measuring pulse rate.

Eight cases of prenatal care were observed. In all cases, the health technicians followed the indicated steps for prenatal control (measure of uterine height, weight control and warning signs). In 1 case, it was observed that the client was not informed about warning signs during pregnancy.

A great variety in the skills of the providers was found when observing family planning services. In all of the observed cases, the health personnel offered a cordial service, privacy and established good communication with the client. The clients were comfortable and confident in the provider.

Seventy-seven percent of providers did not impose personal preferences or barriers when offering contraceptive methods. In most of the observed cases the technician helped the client make an informed choice of family planning contraceptives by him/herself. However, in 4 cases (23%) the client was not informed about all the available contraceptive methods.

Following the family planning contraceptive choice, in 50%-60% of the cases observed, the provider did not confirm if the client understood the characteristics, use or side effects of the chosen method. These results were more evident with repeat/return users. In other words, less information was provided to clients and less asked of the clients who returned for supplies or control visits.

In 90% of the observed cases, the personnel did not ask in depth about the general health of the client. The personnel responded only to the service(s) requested by the client. In particular, the screening of the patient for possible reproductive risks, including gynecological cancer, was not explored. In most of the observed sessions, technicians did not inform clients about other available services in the health posts or other services they needed. Finally, providers did encourage the client to return to their follow-up visits or for any other reason.

Quality of Supervision.

Role of supportive supervision. From the beginning of the project, a different system of supervision for trained technicians was incorporated into the Phase II training design by PRIME staff and local counterparts. Usually, midwives are responsible for supervising technicians within their geographical area. The supervisions tend to be extensive (without specific defined criteria) and with very little feedback. In this project, a new system was adopted and called “supportive supervision” for health technicians by midwives. The supportive supervision system is a technique where supervisors observe personnel performance, measure personnel knowledge of family planning (e.g., side effects, appropriate use, etc.), and critiques the health technician in dealing directly with clients. This system reinforces concepts and training techniques to motivate the provider.

All study participants were subject to supportive supervision visits. When we asked a participant about the supervision he had received, he asked if we referred to the “previous” or to the “new” supervision, the new one being the one used by PRIME.

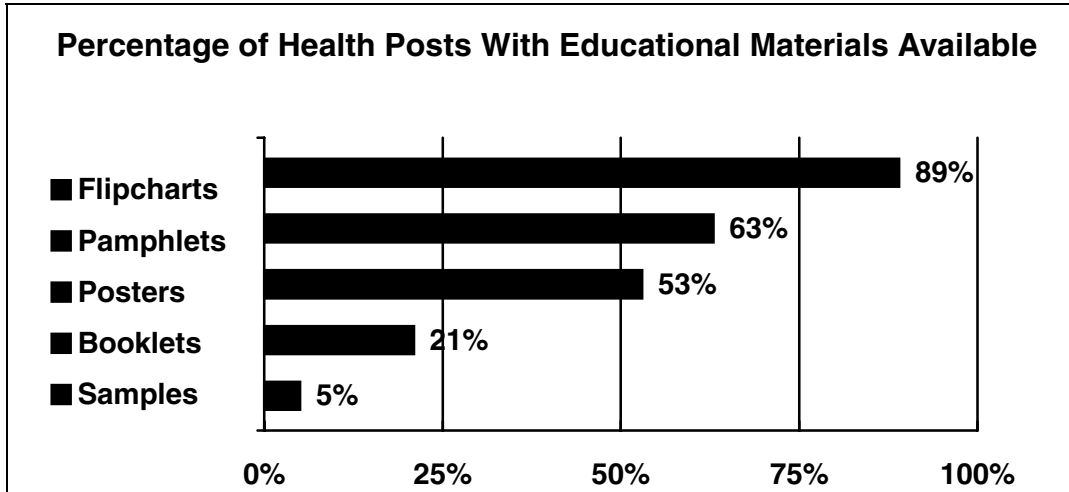
The interviews demonstrated a good relationship between supervisors and providers. Most of the providers said they did not feel threatened by supervision visits since these visits helped them to improve their performance. One person commented that “Supervisors tell us what we are doing fine and what we are doing wrong {without yelling}. The supervisor has a pleasant manner....she treat us like people (she respects us).”

However, when this study was conducted, technicians had only received 1 supervision visit in 8 months. The project coordinator indicated that clear criteria had not been established for the number of visits that should be conducted and that this technique needs to be integrated in the Ministry of Health. Once this technique is integrated, criteria could be established and the midwives could be more encouraged to conduct their visits.

Health Post Assessment (facility and supplies).

Work Environment. As indicated in Graph 2, all the health posts had educational material available (only 19 health posts were evaluated). The material covered family planning, breast feeding, pregnancy control and prevention of STD/AIDS.

Graph 2. Percentage of Health Posts with Educational Materials Available



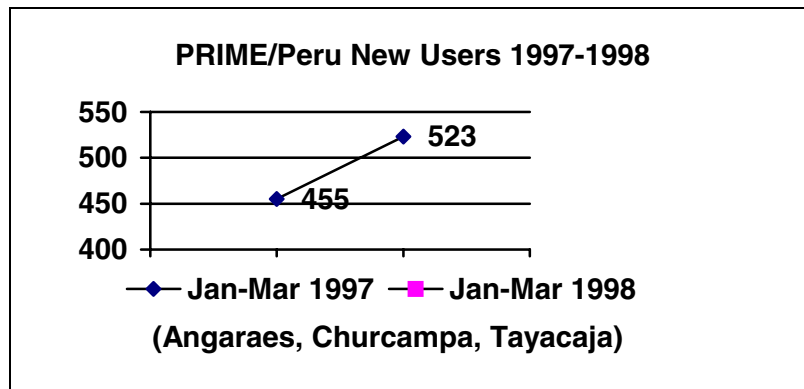
With regard to the availability of contraceptive methods, several technicians mentioned that in many cases they could not offer complete FP services because of the lack of supplies, especially of Depo Provera®. According to the technicians, a national policy has been established that does not allow offering this method to new users. Also, when there are not supplies, the technicians have to suggest the pill.

Service Delivery Outputs and Issues.

Volume of Services. During the evaluation visit, the observation team asked to see the statistical reports with patient information/records. The service figures from January 1997 (period before the project) to March 1998 were reviewed. Since the evaluation was conducted during May and June the only completed data available to be compared were between January-March 1997 and January-March 1998.

Graph 3 shows that there was a 15% increase in the number of new clients between those periods. Of note here is that the 1998 figures only include the first quarter of the year. Service volume is expected to be much higher by the end of the year. Because of difficulties in the field, it was not possible to select a group of technicians for a comparison or “control” group.

Graph 3. Number of new users before and after trainings, 1997 – 1998.



Community Approach. Most of the técnicos interviewed noted they had a high level of acceptance within the community. They use their position in the community to

conduct home visits and in this way promote health services. When asked how they could get more involved in the community, several answered that it was necessary to involve community promoters. These personnel also provide basic health care, but do not have any technical medical training.

Continuing Issues

The role of health promoters was seen as “the link with the community.” Although they are very involved and supportive in the community, “they receive nothing in return” for their efforts.

In terms of service demand, the health personnel mentioned that most of the services offered are maternal, prenatal and general medicine. Most of the people who receive services are women, followed by children and less by men. In particular, the personnel take care of many respiratory illness cases. Family planning also is a common service, however, many people do not utilize the resources at the health posts. When technicians were asked why more people do not attend their health posts, several of them explained that there is a belief in “Chacho” in the community. “Chacho” is a theoretical belief referring to illnesses that formal/clinical medicine cannot cure. Various technicians illustrated sensitivity to this barrier in the community. One technician affirmed that “we [the providers]do not face this barrier openly, we integrate ourselves into this belief system,” thus demonstrating the importance of this cultural understanding.

Some technicians described experimental situations that they have conducted in their communities to promote changes in health behaviors. These experiments varied between health campaigns to setting fines if families did not attend to preventive services, such as prenatal check-ups or vaccinations for children. Upon further exploration, the providers explained that these penalties were not used in practice.

The dominant role that men have in family planning decision-making was mentioned in 5 of 22 cases. One person noted that “the rejection is produced because of the chauvinism of men who prevent their wives from using contraceptive methods to avoid cases of ‘infidelity’.”

In the latter part of the interviews participants were asked to give open comments/suggestions. Some of these include:

- Participants asked to continue providing interactive training that includes practical applications/exercises
- Participants asked to support health promoters
- Technicians requested supplies and material for collecting and presenting data
- Technicians requested field work equipment: backpack, boots, jackets, raincoats, etc..., to ensure quality performance

DISCUSSION AND CONCLUSIONS

The project appears to have had positive effects for trainees. The high satisfaction with the training workshops was due to the use of adult education theory. Each session included participatory and dynamic techniques that included role play, group practice and feedback. Even more importantly, the themes discussed were based on the knowledge and experiences of the participants.

The evaluation found that only a single theme included in the curriculum could have been better designed. One session in the curriculum was dedicated to exploring “rumors” on family planning. Other studies have found that the simple use of this word negates local beliefs and their importance in the search for services. One study analyzed the use of the term “rumors” in family planning, and found that this term impedes the understanding and experience of the population and makes users afraid to ask questions (mentioned in Simmons and Elias 1994). The importance of exploring this reality in the context of the regions of influence of the project would be important.

The general results of the objective tests indicated that there was a very significant statistical increase between the pre and post-tests, and that retention of knowledge was steady between post-test 1 and 2. An increase in knowledge is an important factor for good job performance and responding to client needs. However, when the knowledge levels by theme were analyzed, learning retention in emergency obstetrics was lower in comparison with other areas. This could be due to poor management of the theme in the workshop or because of the small number of cases that the technician sees and can therefore apply his/her knowledge in practice. Other studies have found that there is a good and statistically significant relationship between skills learned and how often they are applied, regardless of how many months until the provider is evaluated (Valadez J, et al. 1997). In other words, the time that has passed since a skill was learned is not as relevant as how often it is applied/put into practice.

Because the supervisors form part of the administrative system of the Ministry of Health, it is expected that their support will provide continuity to the skills learned in the trainings. At the time, the supportive supervision system had not been formalized. Concrete administrative efforts are needed to assure that the investment in the training workshops is sustainable. The lack of established norms/guidelines for the supervision role could limit future achievements of the project.

This study used select indicators to evaluate the quality of care (see Appendix A). The results show that in general the providers offer good quality services (there are no baseline data). Most of the technicians establish good dialogue with users, offer all the appropriate methods and demonstrate good counseling technique. That the information provided to repeat/return users and the information about their

satisfaction with the method is limited has implications for the continuity of method use. For example, for users of Depo Provera®, a method that in many cases causes side effects, this could result in the user discontinuing the method or not identifying possible contraindications. This finding also coincides with a lack of exploring information about the life stage of the user and a broader perspective of reproductive and sexual health.

Finally, the increase in the number of new users suggest that the technicians are making a greater effort to promote contraceptive methods. The increase in new users indicates that at least access has increased. This is important given the context in which the technicians work. Moreover, the evaluation only considered data from the first quarter of the year and we expect that the volume of services will increase even more in the coming months. A possible obstacle to this is the lack of supplies in the region. Several technicians specifically indicated that many times they cannot satisfy the demand for Depo Provera®. In some cases, the supplies do not arrive on time or there is limited availability. This obviously has repercussions in the coverage of the population and in the choice of methods.

RECOMMENDATIONS

1. The continued use of participatory techniques in the workshops. This plays a very important role in the satisfaction of the participants and in the level of learning.
2. The incorporation of broader themes of sexuality and reproductive health in the design of the workshops. In particular, it is important to include themes on the prevention of STI/AIDS and in the involvement of men in reproductive health. Discussing broader themes in reproductive health would reinforce the courses funded by MINSAs.
3. The area of obstetric emergency needs to be strengthened. We recommended implementing a learning technique during the workshop to allow a better understanding and retention of knowledge in the area of obstetric emergencies. At the same time, it would be necessary to strengthen support in emergency obstetrics during the supportive supervision visits. This could be done through presentations of cases in which the technician is asked to delineate measures to take.
4. The workshops should emphasize the importance of **integrated** counseling for users. For example, ask the general health of the client and not just their family planning needs. The counseling should be a process where there is dialogue between providers and clients to help clients to define their needs, their sexual and reproductive risk and steps to improve their health.
5. Formalizing the supportive supervision system. This could be done by:
 - incorporating supportive supervision within the local health system. This could be established through agreements and formal meetings to present the supportive supervision system and reach an agreement on its use;
 - develop a guide for supervisors that describes their role as supervisors, supervision norms, frequency of visits, analysis and use of data and feedback to technicians and local authorities;
 - establish criteria to score and determine “good” performance (could be total score, passing of certain questions, or individual analysis of the questions);
 - use only 1 observation instrument that is complete, but flexible.
6. It is important to explore how to strengthen the logistics of method supply system in the region. PRIME has worked with other countries in this area.
7. The workshops should cover the theme of indigenous identity and its implications in the work of the providers.

8. To strengthen the learning process, the workshops should determine if technicians understand the medical language used. This would determine how the questions are written in the objective tests

Other (this is not part of the study):

PRIME should develop and field test the project instruments with an evaluation specialist. This would assure that the instruments are consistent with the curriculum, state the objectives to be measured, can be readily processed and are appropriate for the population.

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APPENDIX A

Selected quality of care indicators:

- Number/percent of technicians competent 8 months post-training (competence as measured by pre/post tests and observations)
- Provider establishes rapport with client
- Provider offers all appropriate methods
- Provider demonstrates good counseling skills (providing information, eliciting information, answering questions)
- Provider encourages clients to return as needed
- Provider gives accurate and relevant (new vs. continuing users) on method accepted:
 - how to use
 - advantages and disadvantages
 - side effects
 - contraindications
 - complications

Source: Handbook of Indicators for Family Planning Program Evaluation