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Memorandum

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Subject Foreign Trip Report (AID/RSSA): Nairobi, Kenya, February 16-March 7, 1982

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Director, Centers for Disease Control
Through: Horace G. Ogden
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SUMMARY

During the past several years, FPED/PEB developed a computerized patient flow analysis (PFA) technique with support from the Bureau of Community Health Services/Office for Family Planning. The technique has been used extensively in U.S. family planning clinics supported by federal funds. The system was presented to AID/POP officials in 1979, and subsequently several studies were conducted in developing countries with AID/POP support.

The Family Planning Association of Kenya (FPAK) learned of the technique through its contacts with the Pathfinder Fund, one of its supporters and an AID intermediary. FPAK requested that FPED/PEB conduct studies in Kenya to determine whether or not their recently experienced decline in the number of family planning users in their 10 clinics was related to problems of clinic management. As a result of this request, seven PFA studies were conducted in

the three FPAK clinics with the largest workloads located in Nairobi, Nyeri, and Mombasa. In addition to the basic PFA studies (which describe staff-client contacts in the clinic sessions), we added a component to evaluate the quality of services being provided to FPAK's clients. This quality evaluation was carried out through the use of clinic staff interviews, role-playing, client chart reviews, and an examination of FPAK policies related to clinic services.

Some of our major findings include:

1. Daily client loads vary randomly in all FPAK clinics and in the three clinics studied. Heaviest demand is during late morning hours, and almost no demand exists in late afternoon hours.

2. The clinic staffing pattern is not organized according to peak hours resulting in inefficient use of staff time.

3. The policies related to service delivery (e.g., contraindications to specific methods) are not necessarily clear and are not fully under-understood by the clinic staff. Service delivery is therefore inconsistent, and all clients do not receive all services that they should. For example, blood pressure is not always recorded in the client's medical chart for clients using orals or injectables.

4. Fees being charged are inconsistent, difficult to determine, and are discussed in an abrupt manner with clients.

5. There is inconsistency in the mix of methods used by the clients of the three clinics studied. We found that the clinic which made greatest use of the IUD had more than twice as many method changes and provided more than double the proportion of medical consultations when compared to the centers that relied more heavily on hormonal contraceptives. Our findings indicate that staff members or clients may be expressing consistent preference for a given method to their clients.

6. The client medical charts are deficient in that they do not contain all the information desired by the clinic staff, and they are cumbersome to use.

7. Appointments seem to be scheduled without regard to the desires of the client or the needs of the clinic personnel to maintain balanced workloads. The records indicate, however, that many clients make an effort to keep their appointments.

8. Staff skills are under-utilized.

9. The system for routing clients through the clinics is not as efficient as it could be.

During a final meeting with the FPAK Executive Director and her staff, the results of the studies were discussed, and plans for followup action were made.

Recommendations were made to improve all these (and others) areas of clinic operations as they detract from the efficiency of the clinics and may contribute to the decline in the number of persons seeking services from FPAK clinics. We also recommended that similar studies be conducted at other sites by the Research/Evaluation Officer who worked with us on these studies and learned how to use the methodologies employed.

A presentation of the PFA system was made to key Ministry of Health (MOH) officials who indicated that they would like assistance in conducting similar studies in their clinics. The FPAK Executive Director requested that we return to Kenya at a later date to discuss the recommendations and their implementation. We, therefore, plan to return to Kenya at an appropriate time to follow up the FPAK activities and initiate clinic evaluation studies in MOH clinics.

I. PLACES, DATES, AND PURPOSE OF TRAVEL

A. Places and Dates

Nairobi: February 17-23 and March 3-6, 1982
Nyeri: February 24-25, 1982
Mombasa: February 28-March 2, 1982

B. Purpose

The Family Planning Association of Kenya (FPAK) receives support from the Pathfinder Fund, an AID grantee. Pathfinder identified clinic management as a possible major obstacle to FPAK's delivery of family planning services in an efficient. To address this problem, they proposed to AID and FPAK that PEB/FPED/CDC conduct Patient Flow Analysis (PFA) studies in several FPAK clinics to determine if and how the management of these clinics could be improved. The proposal was accepted by both agencies, and FPED/CDC scheduled Jack Graves and Michael Dalmat to conduct the PFA studies in Kenya. They traveled to Kenya on the above dates. This travel was in accordance with the Resource Support Services Agreement (RSSA) between CDC/CHPE/FPED and AID/S&T/POP/FPS.

II. PRINCIPAL CONTACTS

A. U.S. Agency for International Development
1. Mr. Spencer Silberstein, Population Advisor, USAID/Nairobi
2. Dr. Anita Mackie, Health, Nutrition, and Agricultural Advisor, Regional Economic Development Support Office (REDSO)/East Africa
3. Ms. Barbara Kennedy, Population Advisor, REDSO/East Africa

B. Family Planning Association of Kenya (FPAK)
1. Mrs. Angela W. Gethi, Executive Director
2. Millicent Odera, Research/Evaluation Officer

3. Mr. E.M. Muteru, Administrative Officer
4. Dr. R.S. Nyanyi, Project Coordinator and Medical Officer
5. Ms. Nguru Kanywa, Information and Education Officer
6. G.M. Magiri, Training Officer and Assistant Information and Education Officer
7. Mr. P.K. Njuguna, Supplies Officer
8. Mr. Solomon Kuria, Accountant
9. Mr. Francis M. Ruhangi, Library Attendant
10 Mrs. F. Rach, Nursing Sister, Nairobi Clinic
11. Mrs. Maina, Nurse-Midwife, Nairobi Clinic
12. Mrs. Adembesa, Clerk, Nairobi Clinic
13. Mrs. J. Muigai, Nursing Sister, Nyeri Clinic
14. Mrs. D. Mukiri, Nurse-Midwife, Nyeri Clinic
15. Mrs. R. Mutuma, Nurse-Midwife, Nyeri Clinic
16. Mr. M. Nyage, Clerk, Nyeri Clinic
17. Mrs. R. Odindo, Nursing Sister, Mombasa Clinic
18. Mrs. G. Mbote, Nurse-Midwife, Mombasa Clinic
19. Mrs. H. Syria, Nurse-Midwife, Mombasa Clinic
20. Miss A. Makumi, Clerk, Mombasa Clinic

C. Ministry of Health

1. Dr. J. Kanani, Deputy Director for Medical Services and Director, National Family Welfare Centre (NFWC)
2. Dr. Irene Gathinji, Deputy Director, NFWC
3. Mr. Anderson Kahindi, Health Education Officer, NFWC
4. Mrs. Z.W. Giteu, Training Division, NFWC
5. Mrs. Margaret Mwiti, Clinical Services, NFWC
6. Mr. Norman M. Nzioka, NFWC
7. Mr. Jefwa Ngombo, Statistical Officer, NFWC
8. Mr. Alfred Ngerechi, Statistical Assistant, NFWC
9. Mr. Dominic Mutua, Senior Statistical Officer, NFWC
10. Mr. Iqbal Qureshi, Information and Education Advisor, NFWC

D. Other

1. Dr. Kigondu, Chairman, Medical Subcommittee (FPAK), Training Director, African Medical and Research Foundation ("Flying Doctors")
2. Professor J.K. Mati, Dean, Medical School, University of Nairobi
3. Dr. V.C. Aggarwal, Assistant Professor, Medical School, University of Nairobi

III. BACKGROUND

A. The Family Planning Association of Kenya (FPAK)

FPAK, which now operates 10 freestanding family planning clinics in towns and cities, began offering its services to clients in 1969. Initially, the thrust of FPAK's program was the provision of clinic-based family planning services to urban working women for a fee. The fees were intended to defray a significant portion of operating costs but were set below the cost of comparable services offered by private physicians. In addition to providing contraceptive services, FPAK promotes the acceptance of family planning in urban and

rural areas through its network of trained family life field educators and recently, lay educators. Over time, the FPAK clinics have attracted a substantial number of rural as well as urban women, reportedly of modest means. Within the last few months, this pattern has been accentuated by the work of mobile outreach teams that are enrolling primarily rural, relatively poor family planning acceptors.

The number of FPAK new acceptors and total visits peaked in 1980 at 5,500 and 44,000, respectively, but declined to 4,500 and 42,500, respectively, in 1981 (see Figure 1). Concern over this downturn prompted the Executive Director of FPAK, Mrs. Angela Gethi, to request CDC assistance in evaluating clinic operations.

B. Study Objectives

After an orientation session with Mr. Spencer Silberstein, USAID/Nairobi, on February 18, 1982, we participated in two planning sessions with the management of the FPAK (February 18-19, 1982). During the first session, the CDC consultants met with Mrs. Millicent Odera, Evaluation/Research Officer, who was assigned the responsibility of coordinating the Patient Flow Analysis/ Assessment of Quality of Service Study. During the second meeting, we met with the heads of FPAK departments and Mrs. Gethi. FPAK managers expressed the following as concerns and issues that the study should address (i.e., study objectives):

1. Decline in the Number of New Acceptors and Client Visits
   To determine what can be done to improve clinic operations that might increase the utilization of services. FPAK managers want to do whatever can be done to ensure that the performance of the clinics attracts new clients and satisfies the needs of active users so that they continue to use the clinics.

2. Effective Staffing of Clinics and Mobile Outreach Teams
   To plan the use of existing staff in order to increase the efficiency of services and to offer services through mobile outreach clinics (a relatively new activity) without jeopardizing the quality of service. To accomplish this, we were asked to help assess the over- or underutilization of staff.

3. Operation of Model Clinics
   To determine the characteristics of model clinics. FPAK is charged with the responsibility of operating "model family planning clinics" in Kenya. Recently, President Moi agreed to become the "patron" of FPAK. This has reinforced Mrs. Gethi's desire to define what to expect of a model clinic and to ensure that FPAK clinics meet these expectations.

4. Variation in Performance of Different Clinics
   To explain why some clinics have more clients and provide more services than other clinics, especially since all clinics are staffed in the same manner.

5. Adequacy of Information and Education
To determine if all major information and education (I&E) points in client counseling are being covered by the staff. To determine whether language barriers are constraining the effective communication of major I&E points.

During our planning session with Mrs. Gethi, we explained that not all of the study objectives would be achieved during this consultation. (We addressed objectives 1-3, and 5.) We explained that we would focus on the adaptation of a set of evalution techniques for use in Kenya to answer the study questions outlined above. We explained that we would also train Kenyan counterparts to use these techniques. In this way, FPAK evaluators would be able to collect information after our departure from the seven clinics that were not studied during this consultation.

Mrs. Gethi stressed that the purpose of evaluating the operations of the clinics was to look for ways to improve their efficiency and to ensure that declines in new acceptor rates or client continuation were not due to the management of the clinics. After identifying and implementing needed improvements in clinic management, we agreed that the same evaluation techniques used during this consultation could be used by FPAK staff with CDC assistance, if needed, to assess whether desired changes, in fact, took place.

Two types of evaluation were undertaken during this trip. Minor adjustments were made to the Patient Flow Analysis (PFA)* methodology, which we used to assess the utilization of staff time, the number of clients served, and patient waiting time in addition to several other measures of clinic efficiency. We decided that it was necessary to make an Assessment of the Quality of Services in addition to the quantity of services provided by the staff. In this way, we would be able to (1) inform FPAK management about the extent to which client counseling and medical standards are reflected in the services provided, and (2) make recommendations about the capacity of clinics to serve more clients in relationship to the quality of services that are provided. The methods developed for the Assessment of the Quality of Services were pilot-tested during this consultation. While the use of these methods produced several useful results, through experience, we learned ways in which to improve the methods.

C. Methodology

We recommended that FPAK clinics that serve an average of 15 or more clients per day be selected for study. Patient flow patterns are readily discernible at this volume of service. With this guideline, we used service statistics based on monthly clinic reports in selecting the clinics to be studied. After reviewing the service statistics reported from all 10 clinics for October-December 1981 to determine average daily attendances, FPAK managers selected

*Graves JL, Hudgins AA, DeLung J, Burnett CA, Scanlon P, Orentlicher D. Computerized patient flow analysis of local family planning clinics. Family Planning Perspectives 13, No. 4, 164-170, 1981.

Nairobi, Nyeri, and Mombasa clinics (Table 1), three of five clinics with 15 or more clients per day.

We also used service statistics to assess seasonal variations in client loads during the year to determine if recurring monthly client attendance patterns existed and to check for consistency between reported client loads and client loads detected through Patient Flow Analysis. We found no significant seasonal variation in client attendance for any of the clinics. Reported service statistics were very consistent with PFA data from the three clinics studied. Patient Flow Analysis was conducted in each of seven full-day clinic sessions held in the three clinics: three in Nairobi Clinic (February 22-24, 1982), two in Nyeri Clinic (February 25 and March 1, 1982), and two in Mombasa Clinic (March 1-2, 1982).

To complement the PFA studies, we completed a record review from the client cards (or records, charts) of clients who attended the first clinic session for which a PFA was conducted at Nairobi, Nyeri, and Mombasa clinics (refer to Appendix A for a copy of the record review form used). A total of 83 client cards were abstracted:

21 - Nairobi Clinic
32 - Nyeri Clinic
30 - Mombasa Clinic
83 - TOTAL

We used role-playing in Nyeri and Mombasa clinics to (1) determine the movement of clients from one provider to the next; (2) assess the quality of client counseling and education, and to (3) test the technical knowledge of the staff. Three roles were assumed by the same CDC consultant in the following sequence: new acceptor uncertain of which method to use, IUD user with minor side effects seeking a yearly checkup, and user of oral contraceptives with complications coming for a medical visit. To the extent feasible, the staff members offered the consultant the full range of counseling and other services normally provided. The consultant and Mrs. Odera both took notes and refrained from correcting staff members on the spot.

Differences in the fees posted and explained were noted in each center. In addition, a layout of the physical space was sketched, and notes were taken regarding the posting of clinic hours and the physical appearance of each center.

IV. RESULTS

A. Patient Flow Analysis (PFA)

1. Staff and Client Time Utilization

Data on staff and client time utilization are found in Table 2. These data show that the mean time that clients spend in the clinics ranges from 17 to 36 minutes. We observed that, in most cases, clients entered the service stream within a few minutes of arrival at the clinic and that they moved through the

various points of service with few delays. Mean client time in contact with staff ranged from 9 to 16 minutes, and the percentage of client time in contact with staff members ranged from 41 to 70 percent with the exception of one clinic session. The ability to move clients through the clinics without delay was primarily because the percentage of staff time in client contact was very low, ranging from 16 percent to 34 percent as shown in Table 2. This indicates that staff are under-utilized relative to service demand. From these data, we estimate that the clinics could easily serve 50 or more clients per session if services are not changed and if the present staffing pattern is maintained (one clerk, one to two nurse-midwives, and one Nursing Sister*).

The under-utilization of staff time is reflected in the high direct personnel costs per client for conducting these clinic sessions as shown in Table 3. When Tables 2 and 3 are compared, a negative correlation between the utilization of staff time and the cost of service delivery can be seen; that is, the lower the percentage of staff time in contact with clients, the higher the cost per patient served.

2. Client Arrival Times

Data on client arrival patterns are presented in Figure 2. This graph is a representation of the aggregate pattern for all seven studies. We found little variation in this pattern among the sites studied. The graph shows that most clients come to the clinic during the mid-to-late morning hours with a secondary peak between 2:00 and 3:00 PM. In fact, approximately 50 percent of the client load arrives at the clinics during the first 3 hours of operation. Although the clinics remain open until 5:30 PM, we found that only 17 of the 200 clients included in the study arrived at the clinic after 3:00 PM, only two arrived after 4:00 PM, and none after 5:00 PM. It was not clear whether the small number of clients arriving after 3:00 PM was a result of client or staff preference.

3. Appointments

Appointments in the clinics studied are usually made for the day of the clinic. Only one clinic specifies the hour of the appointment. Staff are capable of influencing client arrivals by suggesting to clients that they should come to the clinic at a scheduled time; we could not determine if this was being practiced. Ideally, one would desire client arrivals to coincide with staff availability to provide services. For example, if the staff can serve five clients per hour, then the ideal arrival pattern would be one client every 12 minutes. This is obviously not happening in the clinics studied. The result is under-utilization of staff in the clinics, especially in the afternoon and particularly after 4:00 PM when almost no clients are seen.

4. Daily Client Loads

Another factor that influences clinic efficiency is consistency in daily client loads relative to staff availability. That is, if the clinic is to

*A Nursing Sister in Kenya is equivalent to a Family Planning Nurse Practitioner in the U.S.

maintain a consistent day-to-day staffing pattern, it should strive to have the same numbers of clients in attendance every day.

We collected data on daily client loads for the months of February and March 1982, for the three clinics studied and found serious inconsistencies in workloads. Nairobi and Mombasa have almost identical patterns of daily workload, largely from 10 to 19 clients per day while Nyeri has a much wider distribution, largely from 30 to 49 clients per day. Some of the factors that contribute to this variation reportedly are client preference for certain days, the weather, holidays, inadequate appointment systems, and staff preferences. One important factor in Mombasa is that when the clinic first opened, clinic sessions were held only on Monday, Wednesday, and Friday. A review of daily client attendance during the months of October 1981 to February 1982 shows that these days have the highest attendance. The staff's explanation was that their clients choose these days from habit. No clear patterns of day preference were obvious at the other sites.

In an effort to gain more insight into this problem, we studied some of the appointment data at Nyeri and Mombasa. As shown below, of the 68 clients served during the two PFA studies at Nyeri clinic, 42 (62 percent) were clients with appointments for the day of the study, 16 (23 percent) had appointments on other days, and 10 (15 percent) were clients without appointments.

Clients Served at Nyeri Clinic by Appointment Status

	No.	%
On appointed day	42	62
After appointed day	9	13
Before appointed day	7	10
Walk-in	10	15
TOTAL	68	100

Because the total number of appointments made per day were not recorded, we were not able to calculate the no-show rate. However, the Nyeri data presented above indicate that most clients in this predominantly rural area do keep their appointments.

When we looked at the proportion of appointments kept by users of specific methods for Nyeri clinic, we found that 78 percent of clients using injectable contraceptives came on the day of their appointments. The number of users of other methods are too small to report the percentages that came on schedule.

When we matched the names of Mombasa clients with appointments scheduled with those of clients who attended the clinic during the week of February 22, we found that only 35 percent kept their appointments with a daily range of 13 percent to 48 percent:

Percent of Appointments Kept at Mombasa Clinic

Date	Total No. Appointments	Appointments Kept	% of Total
2/22	15	2	13
2/23	18	8	44
2/24	21	10	48
2/25	11	3	27
2/26	19	6	32
TOTAL	84	29	35

From these observations it appears that if a system is instituted, clients will make and keep appointments such that the attendance and flow of clients can be better planned and, thus, provide services more efficiently from the points of view of both staff and clients.

B. Assessment of the Quality of Services

1. Introduction

Mrs. Gethi and Mrs. Odera stated a definite preference for studying three clinics instead of doing a more in-depth analysis of one clinic. As a result, we physically spent a day-and-a-half in each clinic, and we abstracted the records for only those clients who came to the clinic during the full-day clinic that we attended. This limited the total number of observations to 21 to 32 clients per clinic, and these clients are not necessarily representative of the clientele of the study clinics. Thus, the findings reportred below should be reviewed with these limitations in mind. We analyzed the data that we collected with the intent of testing the Assessment of the Quality of Services methodology and acquiring insights that would point the way for further investigations.

2. Characteristics of Clients

From the record review, we found that there were differences among the clients who attended the clinic sessions in Nairobi, Nyeri, and Mombasa (see Table 4). Clients in the Nyeri and Mombasa clinics tended to be older, higher parity women with less education. The majority of clients who came to all three clinics were married: 65 percent for Nairobi, 66 percent for Nyeri, and 80 percent for Mombasa. According to data on husband's occupation (for married women), women in the Nairobi clinic were of higher socioeconomic status than the clients of the two other clinics who were primarily of high or intermediate socioeconomic status.

3. Method Mix

Data on method mix from the record review were consistent with data from the PFA. Since the PFA data include clients from seven sessions as compared to three sessions from the record review, Table 5 was derived from the PFA printout. We found that twice as many Nairobi clinic clients were using the IUD (49 percent) as any other single method. By contrast, in Nyeri Clinic, which serves primarily less affluent rural women who travel long distances to come to the clinic, four times as many women were using injectable contraceptives (65 percent) as any other single method. Approximately twice as many

Mombasa clients were using injectable contraceptives (48 percent) as any other single method.

4. Method Changes and Preferences

Staff preferences for particular methods can strongly influence a client's choice of method and the overall method mix of a clinic. If these method preferences coincide with client preferences and/or do not result in side effects, one would not expect staff preferences to influence the continued use of contraceptives. If the converse is true, clients may become discouraged and stop using contraceptives altogether or seek family planning services elsewhere. Because of these possible problems for the women and potentially for FPAK, we addressed three questions that would indicate whether staff or client preferences exist and if they do, whether they pose a problem.

a) What proportion of client change methods and do these changes gravitate toward one particular method?

In Nairobi Clinic, 9 of 11 changes involved the IUD with a net gain of five IUD users out of 21 clients (23 percent). Fifty-two percent of clients had at least one method change. We also found that only 18 percent of 1980 clients returned for at least one visit in 1981. During the record review, the CDC consultant noted that women who began using oral contraceptives generally switched to the condom and/or foam for a short time and then began using an IUD. The consultant also noted that IUD users tended to have a series of infections for which they were treated. In contrast, only 23 percent of the clients from Nyeri Clinic had one or more method change (Table 6). Five out of six method changes involved injectable contraceptives with a net gain of three users of this method. Fifty percent of Nyeri clients in 1980 came for at least one visit in 1981. The CDC consultant detected a very few important side effects and no medical complications associated with the use of injectable contraceptives at Nyeri Clinic. Twenty-one of 32 clients (66 percent) that first adopted injectable contraceptives as their method of choice have never changed methods. Out of 10 method changes among clients from Mombasa Clinic, seven involved injectable contraceptives with a net gain of three users of this method. Forty percent of all users of injectable contraceptives at Mombasa had never switched from their initial method of choice, which may have contributed to the fact that only 33 percent had ever changed their methods. Mombasa Clinic had a client-return rate of 42 percent from 1980 to 1981. No medical complications or side effects were detected among users of injectable contraceptives.

These findings suggest that a provider and/or client preference for the IUD may exist at Nairobi Clinic. Given the low client-return rate of Nairobi Clinic and IUD-associated infections, we recommend that the Medical Supervisor systematically investigate (1) whether or not a staff or client preference for the IUD exists, (2) whether users of IUDs at Nairobi Clinic have normal or higher than normal infection rates, and (3) whether the proportion of IUD users that continue to use the services of Nairobi Clinic is comparable or lower than that found in other Kenyan clinics. While a staff or client preference may exist at Nyeri and Mombasa Clinics for injectable contraceptives, there is no evidence that it is contributing to complications or a low client return rate.

Based on a review of FPAK service statistics for 1980 and 1981, we found that among new acceptors there was a definite trend in all three clinics away from the use of injectable contraceptives (see Table 7). Staff members in Nyeri and Mombasa attributed this shift to the adverse publicity surrounding the method as reported in the newspapers. We also noted that there has been an increase in the acceptance of the IUD in Nairobi and Nyeri Clinics and an increase in the acceptance of oral contraceptives in Nyeri Clinic.

b) Do client records show any plausible reason why an alternative method was not used?

Generally, physicians recommend that older, higher parity women use the IUD and injectable contraceptives and that younger, low parity women use oral contraceptives*. From the record review data for each of the three clinics, we examined the age distribution of clients by type of contraceptive method both at the time when they adopted their first method provided by FPAK and again, at the time of the study. The number of clients for whom records were abstracted was too small to meaningfully report a method-specific age distribution for each clinic. However, to illustrate this type of analysis, we have combined users of each method under 30 and over 30 years of age from the three clinics (Tables 8 and 9).

We examined the recorded blood pressures and number of living children for women under 30 from the three clinics to see if either factor may have precluded the use of an alternative method to the contraceptive method first accepted (see Table 10).

Out of 40 women from the three clinics who are under 30 years of age, we found only four for whom high blood pressures were recorded. Of the 11 women under 30 years of age from Nairobi Clinic, six were using the IUD. Of these, two had high blood pressures, one was nulliparous, and the other had four or more children. It is likely that neither would have made a good candidate for either oral or injectable contraceptives. The four other users of an IUD who were under 30 years of age would not have been precluded from using a hormonal contraceptive based on their blood pressures. None of the 16 women under 30 years of age from Nyeri Clinic used an IUD or had high blood pressure. Among the 14 women from Mombasa Clinic under 30 years of age, six used an IUD and two had high blood pressures. One of these women used an IUD and had four more children, and the other was using an oral contraceptive and had four or more children. The user of oral contraceptives may be a better candidate for a different method, perhaps the IUD. The four IUD users for whom normal blood pressures were recorded would not have been precluded from using a hormonal contraceptive.

c) Did users of the predominant method experience more side effects or complications than those using other methods?

We did not systematically collect information about the frequency, type, management, and reoccurrence of side effects and complications by method. In the

*Hatcher RA, Stewart GK, Stewart F, Guest F, Josephs N, Dale J: Contraceptive technology 1982-1983, 11th revised edition. New York: Irvington Publishers, Inc., 1982.

absence of this information, we looked at the proportion of visits in each clinic that were made for medical reasons by contraceptive method (see Table 11).

There were too few users of all methods other than the principal method used in each clinic to analyze these data in a meaningful way. In Nairobi Clinic, 36 percent of IUD user visits were made for medical reasons. Nine percent of the visits made by users of injectable contraceptives from Nyeri Clinic were made for medical reasons as compared to 14 percent by users of the same method from Mombasa Clinic. While the number of clients included in the three analyses are limited and their selection was not random, Nairobi Clinic had more than twice the proportion of medical visits for all methods (27 percent) as did Nyeri Clinic (11 percent) and Mombasa Clinic (11 percent). However, there are serious difficulties in interpreting these findings: differences may be due to differences in the characteristics of the clients themselves, the service standards adhered to by different staff members, the method mix used by clients, the definition of a medical visit as compared to a resupply visit, or chance.

To assess whether users of one method are experiencing more side effects or complications than users of other methods, we recommend that a random sample of client cards be abstracted to examine method-specific complication rates and the management of these complications.

From this first experience with the PFA/Assessment of the Quality of Service (AQS) in FPAK clinics, we learned that two sets of client cards need to be reviewed. To begin with, the cards of all clients included in the PFA need to be reviewed. Client card numbers for these records can be used to link the PFA findings and AQS findings for individual clients. In this way, the amount of time spent in contact with different staff members can be assessed within the context of the services received. In addition, we recommend reviewing a randomly selected set of cards from among all clinic clients, those not in attendance and those who are in attendance. This will ensure that the study findings are representative of all clinic patients. Also, by increasing the number of client cards reviewed, we can make more meaningful analyses when comparing outcomes between users of different methods.

5. Other Indicators of Quality of Service
   a) Blood Pressure Readings and String Checks:

FPAK requires clinicians to take blood pressure readings for users of oral and injectable contraceptives during every visit made by the client (initial, resupply, annual checkup, medical). Similarly, FPAK requires that a client's IUD string be checked to make sure that the IUD is in situ during each clinic visit. Since blood pressure readings and string checks are recorded in the clients' cards (i.e., charts or records), we decided to assess the consistency with which these requirements are met as indicators of the quality of service provided.

As noted in Figure 3, differences in consistency were detected between clinics, not between methods. Mombasa Clinic staff were the most consistent in recording for the three methods: blood pressure readings were taken for 96 percent of all visits of users of oral contraceptives and 91 percent of all visits of users of injectable contraceptives, and string checks were recorded for 92 percent of all IUD user visits. Nyeri Clinic staff were the next most consistent in their recording of these events: blood pressures were taken during 74 percent of visits for users of oral contraceptives and 53 percent for injectable contraceptive users, and strings were checked during 50 percent of visits for IUD users. When comparing the recording for the three methods for Nairobi Clinic, string checks were most consistently recorded (66 percent of visits), followed by blood pressure readings for users of oral contraceptives (54 percent of visits) and users of injectable contraceptives (50 percent of visits).

b. Breast Examinations

FPAK clinicians are also expected to examine clients' breasts and to record the results at the time of a new acceptor's first visit. Based on role-playing and informal observations of client-provider interactions, we recommend that the Medical Supervisor satisfy himself that all clinical staff know how to examine a woman's breasts, can teach the woman to examine her own breasts, and are confident in their ability to explain the importance of breast examinations to clients. This recommendation is supported by the record review findings reported in Table 12. From this table, we note that for 30 percent of Nairobi Clinic client cards, 16 percent of Nyeri client cards and 84 percent for Mombasa client cards, no information about breast examinations was recorded.

c. Contraindications to the First Method Adopted

From the medical histories recorded in the client cards, we identified only six in which clinical abnormalities were noted. Since we are not certain which medical condition FPAK considers to be contraindications to the use of specific methods, we have included a brief case report for each of the six clients for FPAK's review in Appendix B. Even after repeated inquiries, we found no written list of contraindications to the use of specific methods. If such a list does not exist, it would be very desirable to develop one for the use of FPAK clinicians.*

d. Fees

Through role-playing, we learned that immediately after introducing themselves to a client and seating the client, clinic staff members ask clients if they brought a specified amount of money with them to pay for services. If the client has enough money with her, the staff member goes on to explain the schedule of fees. If the client does not have the full amount but does have an adequate portion (25-50 percent) of the specified amount with them, they will provide the required family planning services and make a note of the amount due. In the event that the client does not have enough money with her, she may be sent home and instructed to return when she has the money. This

*Hatcher RA, Stewart GK, Stewart F, Guest F, Josephs N, Dale J: Contraceptive technology 1982-1983, 11th revised edition. New York: Irvington Publishers, Inc., 1982.

approach may be associated with a decrease in new acceptors and may even contribute to the discontinuation of active users.

We compared the 23 fees charged by the three clinics depending upon the type of service provided. Comparisons were made within each clinic to detect discrepancies between the fees posted in the waiting room, in the examining room, and charged by the clerk. In addition, we searched for discrepancies in fees charged by the three clinics. We found discrepancies for 9 of the 23 fees charged as summarized in Table 13. . In Nyeri Clinic, we found five discrepancies between fees posted in the waiting room, fees explained by the nurse-midwife, and fees charged by the clerk. One discrepancy was found within Mombasa Clinic, and none were detected for Nairobi Clinic. We found discrepancies in the fees charged by the three clinics for six services.

We observed that the posted fee schedule lists each individual fee separately: e.g., membership fee, physical examination, pregnancy test, contraceptive method, IUD insertion, yearly checkup, IUD removal, etc. Also, fees were listed for services or methods that were not available at the time. This approach to listing fees can at best create confusion if not suspicion.

As an aside, to illustrate the lack of clarity, we asked FPAK managers to tell us how much a new IUD acceptor would pay during an initial visit. The range of the seven responses was from Ks45-105 for the Copper-7 and from Ks45-95 for the Lippes Loop. The actual fees are Ks198 for the Copper-7 and Ks110 for the Lippes Loop as presented in Table 14.

e. Client Counseling

Based on role-playing and client-provider observations, we suspect that there are deficiencies in the areas listed below. We urge the Information and Education Officer, together with the Medical Supervisor, to make their own independent assessment of these and other aspects of client counseling and to provide on-the-job training and technical supervision in order to rectify whatever weaknesses they detect.

1. The Nursing Sister at Nyeri Clinic sets the client at ease quite effectively while several others in the clinic studied do not appear to make an attempt.

2. It was not apparent that staff obtain a clear understanding of the clients' needs, fears, preferences, personal and economic constraints, and family planning objectives (e.g., desire for more children--how many and when).

3. From our observations, staff members do not explain the advantages and disadvantages of the methods available to the client based on their medical histories, needs, and personal constraints. It appeared as though staff members made the selection of a method for most clients.

4. Staff should thoroughly explain the use of the method of choice to the client. We assume this is consistently done.

5. Staff members do not routinely confirm that the client knows how to use the method they chose and when to seek help by asking her to explain both points to the staff member in her own words. This should be done after the other aspects of the service have been completed and before the client leaves the clinic. Any ambiguity or confusion should be clarified by the staff.

We found that some staff members did not clearly understand why certain medical conditions might contraindicate the use of specific methods or why certain socioeconomic factors might present barriers to their use. If they are not confident in their own knowledge, they will not be able to give factual replies to client questions.

f. Pregnancy Tests, Menses, and Timing of Use of Contraceptives

Pregnancy tests were not available in one of the three clinics. In two clinics, women had to be menstruating in order to demonstrate that they were not pregnant before they would be given oral contraceptives, an injection, or the IUD. Given the distances, costs, and inconveniences of a clinic visit to many clients, FPAK may wish to reconsider this de facto policy. This policy may limit new acceptors, contribute to dropout and even unwanted pregnancies. Alternatively, FPAK may want to reinforce the use of the slide test for pregnancy in all of its clinics.

In one clinic, women who are 2 weeks late for their injections are sent home with a barrier method and told to return during their menses. Evidence suggests that a 3-month injection of Depo-Provera is effective for a number of weeks beyond the 3 months. The Medical Subcommittee may want to reexamine the most current research literature and decide how it wants these situations handled.

g. Availability of Other Tests

As FPAK's mission requires it to offer exemplary services from "model clinics," the Medical Subcommittee may want to examine the costs, feasibility, and potential benefits, risks, and political liabilities associated with routine versus targeted screening.

V. CONCLUSIONS AND RECOMMENDATIONS

A. Introduction

Having completed a baseline PFA/AQS in three FPAK clinics, we recognize that each clinic is somewhat different. They vary in terms of the characteristics of their clients, the level of family planning experience, training, and knowledge of staff members within the same profession, the flow of clients, the organization of the clinic, the mix of methods used and in the consistency of care offered. In this section, we present a number of recommendations. Several of these recommendations are general, anticipating that they will be adapted to the circumstances and characteristics of each clinic and its clients. In these instances, we suggest needed changes and offer guidelines for making these changes. However, implementing these changes may require obtaining additional information about each clinic and should involve the participation of the clinic staff members.

The PFA/AQS Study is intended to be used as a management tool. That is, an initial study should point the way to introducing changes in the management of clinics, and subsequent studies should be used to determine if the improvements had their desired effect on the quality and quantity of services offered as well as on the efficiency and effectiveness of the clinics. For these reasons, we have attempted to make the data collection instruments employed in the study easy to use, and the analysis and interpretation of the results straightforward.

This initial effort succeeded in achieving the following:

1) FPAK staff and management feel comfortable with the methodology, know how to use it, and have expressed interest in using it to periodically assess the performance of their program, and to identify needed management improvements.

2) Results from the study suggest both specific management improvements that are needed and a general approach to introducing these changes.

As stated earlier, FPAK is committed to providing quality services in "model" clinics. We were asked by FPAK to define what a model clinic should be. Our response is that FPAK and that FPAK can arrive at its own definition by establishing certain quality standards and by experimenting with certain management improvements until it is satisfied with the service outcomes (e.g., new acceptor rates, percentage of clients who actively plan their families, method-specific complication rates, cost per visit, and cost per active user served per year).

We have developed a draft "Observer Checklist" to be used by FPAK clinic supervisors to assess the quality of services offered to individual clients, including deficiencies in the skills or knowledge of staff as well as in the availability of equipment and supplies (see Appendix C). The checklist implies a "model" approach to providing services. It must be revised to reflect FPAK standards, once defined, before it is used by FPAK supervisors.

B. Patient Flow Analysis

1. Appointment System

In planning a medical outpatient clinic, several factors are important; consistency is related to all of them. First, the clinic should be planned to provide a consistent quantity of services. Usually the services to be provided are combined into tasks which are assigned to qualified individuals on the staff. The time required to perform each task must be known so that the proper amount of staff time can be scheduled for the expected workload.

One way to achieve consistency in workload is to establish an appointment system which specifies the day and time for each client to come to the clinic. Clients will be more likely to honor their appointments if they are set at times convenient to the client and if the clinic is able to provide prompt services of high quality. The client can thus obtain her services without long

waiting times and with the assurance that the services provided are consistent with her needs. Other factors involved are pleasant surroundings and sympathetic staff. Clients may drop out of the program if they feel that staff members are arrogant or otherwise unpleasant, if waiting rooms and service areas are unattractive and/or do not provide sufficient privacy, and if clients are given appointments at times not convenient to their schedules.

We, therefore, recommend that an appointment system be established at all locations. This system should include scheduling appointments by date and time to the nearest hour. In scheduling appointments, every effort should be made to allow the client to specify the time and date of the appointment. Also, the system should be designed so that the appointments are scheduled at times when sufficient staff are available to ensure prompt service. For example, fewer appointments should be scheduled around the noon hour when staff are taking their lunch breaks. If it is found that clients seem to prefer morning hours, then more staff can work these hours and fewer in the afternoon. If few or no clients desire appointments after 4:00 PM, then consideration should be given to closing the clinics earlier.

[illegible] in factors influence appointment schedules. These are: (1) the number o[illegible]ients who come to the clinic without appointments (walk-ins) and (2) the number who break their appointments (no-shows). When these two are equal, then the clinic should appoint the number of clients that they can reasonably expect to serve. On the other hand, if the no-show rate is greater than the walk-in rate, a correspondingly greater number of appointments should be scheduled. In any event, the clinic manager must monitor these rates continuously as they are known to change; this is particularly true after improvements in management and services are instituted. As mentioned above, when services and schedules are more in tune with clients' desires, one would expect that clients would keep their appointments on time and the no-show rate decrease. If management neglects monitoring these rates, the clinic could become overloaded and the quality of services deteriorate.

2. Staffing and Client Routing

While a good appointment system can contribute to consistency in workload, the clinic must be properly staffed to ensure high quality and efficient service. When the appointment system is established, the demand for services will become apparent. One goal of family planning organizations is to ensure that family planning services are available to all who need and want them. Since FPAK is involved in both motivational activities and the provision of family planning services through their model clinics, they want to be able to serve as many clients as their resources will allow. As those services improve, one might expect the demand for services to increase. This poses a serious staffing problem. It is not desirable to maintain staff for clinic services beyond the demand, especially when there are other tasks to be performed which are related to other activities of the organization. On the other hand, if an increase in demand is anticipated, it is better to tolerate a small degree of inefficiency through overstaffing than to have clients turned away or having to experience long waiting times due to understaffing.

The basic staff at FPAK clinics at the present time is one clerk, one-to-two nurse-midwives (NM), and one Nursing Sister (NS). We recommend that this staffing pattern be maintained until workloads have stabilized.

Since the NM and NS have similar training, either of them can perform most of the services provided by the FPAK clinics. Efficiency might be improved if some sort of triage system could be established so that clients could be directed to the proper service provider without delay. The use of one system would require the NM and NS to be stationed in full view of the reception area. The would alternate serving clients as they enter the clinic. They could then serve their clients, call on each other for assistance as needed, and direct the clients to the clerk for payment after services have been completed. Another system might call on the clerk to make the initial contact with all clients, determine the clients' needs, and then direct the clients to the proper service provider, either the NM or the NS. During the initial contact, the clerk could explain clinic fees, take the client's card from the file, enter some of the information required in the record, and perform other services according to the needs of the client and the skills of the clerk. After receiving services from the NM or NS, the client could return to the clerk for payment of fees. Either of these two systems would require two examining rooms where only one exists at the present time in Nairobi and Mombasa. The NM office in Nyeri Clinic could be equipped to serve as a second examining room. Rearrangement of space would be required in Nairobi and Mombasa to accommodate an additional examining room in their clinics.

At the present time, it is difficult to estimate staffing needs because the clinics are currently under-utilized, and the time required for providing services might change when service standards are documented and put into practice in the clinics. Also, any change in basic client flow patterns could affect the amount of time required from any staff member.

We recommend that as soon as possible an appointment system, service standards, and a triage system be established. Once established, additional PFA studies can be conducted to determine staff-patient contact time requirements for each staff member.

C. Assessment of Quality of Services

1) Contraceptive Methods

We recommend that FPAK clarify or establish contraindications for the use of specific methods (medical and social).

We recommend that the client cards be modified to reflect FPAK policies on methods once established or clarified, and that clinicians learn to use the cards as a tool in selecting the best method in discussion with a client. In so doing, the choice of method may more closely fit the needs and characteristics of individual users rather than staff preferences.

We also suggest that FPAK establish or clarify which services should be received during an initial visit, resupply visit, or yearly checkup visit, by

type of method. Once this is done, an observer checklist can be completed for each type of visit to assess adequacy in techniques, equipment, supplies, knowledge, communication skills, and organization. These checklists could be used by the clinic supervisor to systematically identify and solve the problems of family planning workers through additional on-the-job training or other means.

We recommend that FPAK review its policies regarding when a client can begin using the IUD, oral, and injectable contraceptives. Use of pregnancy tests to confirm that a woman is not pregnant could eliminate the need for her to be menstruating in order to be given or start using a method. This may increase new acceptor rates and client continuation by not requiring women to make more than one visit to begin using an effective contraceptive or to be resupplied.

In keeping with FPAK's emphasis on "model" clinics, some FPAK staff members are considering giving greater emphasis to screening for cervical cancer (use of pap smears), breast cancer (teaching women to do self-administered breast exams), anemia (hematocrits), and diabetes (urine analysis). The prevalence of these problems, the sensitivity and costs associated with the tests, the ability to treat patients if problems are found, and the feasibility of using these tests for outreach clinic clients (which may pose ethical and/or political questions), need to be taken into consideration when making these decisions.

Once all of these policy decisions are made, FPAK should incorporate them into modularized training materials and guidelines for clinic staff. As the clinic supervisor identifies deficiencies within each clinic, these materials can be used to complement the hands-on, practical aspects of on-the-job training.

We recommend that the FPAK's Research/Evaluation Officer assist the Clinic Supervisor in monitoring or periodically assessing client drop-out rates and medical visits by method in order to check whether methods selected are having a negative effect on the health of clients and the performance of clinics. This can be done by screening the tear sheets from the client cards and/or by periodically conducting a randomized record review.

2. Client Counseling

We recommend that new emphasis be given to upgrading clinic staff members' communications and counseling skills when they are found to be deficient by their Supervisors. We found that these skills varied by individual within clinics and between clinics. Deficiencies should be diagnosed on an individual basis through the use of observer checklists, tape recordings, or other methods. On-the-job training should be practical (not theoretical) and should never jeopardize the client-clinician relationship by publically disclosing a clinician's weaknesses.

Areas of communications and counseling that need improvement include:

a) setting the client at ease immediately upon contact;

b) ascertaining the client's needs, fears, preferences, personal and economic constraints and family planning objectives in an empathetic, non-threatening manner;

c) after having narrowed down the selection of methods based on b) above and the client's medical history and physical examination, discussing the advantages and disadvantages of those methods available to the client so that the choice of method is made together; and

d) confirming that the client understands how to use the method of choice and when to seek help by asking the client to explain both points prior to her departure (and clarifying any misunderstandings that may exist).

3. Fees

We recommend that FPAK reevaluate its policies on fees, taking into consideration recent changes in its clientele. These policies include, but may not be limited to the following:

1) whether to use a fixed schedule of fees, have a sliding scale based on the client's economic situation, or whether to adjust a fixed or sliding fee schedule to the clientele of each clinic;

2) the extent to which fees are intended to defray operating expenses; and

3) whether to post fees for individual services or to group them by type of method and visit (e.g., visit of users of orals, injectables, or the IUD for initial resupply, medical or yearly checkup).

Given what we observed in the three clinics studied, we recommend that FPAK consider (1) listing a single method-specific fee by type of visit as indicated below; (2) adopt one set fee for each type of visit (independent of the method used); or (3) charge one standard fee for all visits and methods.

	First Visit	Resupply	Annual Checkup	Medical Consultation
IUD				
Pill				
Injection				
Condom/Foam				

Once these decisions are made, clearly presented wall charts should be prepared and explained to clinic staff. Staff members should be taught how and when to discuss fees as part of their training in client counseling.

4. Client Card

There are a number of modifications that could be made to enhance the usefulness of the card to clinicians and to program evaluators and managers. We recommend that any changes in the card await completion of an initial PFA/Quality of Service Study of Ministry of Health clinics. In this way, all changes will reflect what is useful to both settings--i.e., the National Family Planning Program.

Client cards should reflect FPAK policies about the use of specific methods. That is to say that the layout of the card should make it clear that if a client has condition "X," then she should not use method "B" or "D." In this way, the card becomes a constant reminder of FPAK standards and a work tool (see Appendix D).

The format should be changed to make it easy for a clinician to glance at the card and observe patterns in weight, blood pressure, complications, or other important factors.

Given our knowledge of FPAK clinics, we recommend the following changes in content:

a) Client Background

1) Physical address (to facilitate followup).
2) Disposition of client to receiving home visits (no problem or forbidden).
3) Tribe or community should be eliminated (unless this category can be clarified for staff so meaningful information is recorded).
4) Client's occupation. Currently, there is no information about the economic status of single clients.
5) Record of pregnancies (date, outcome) since becoming a member of FPAK.
6) Type and place of births.
7) Desire for additional children (how many, when).

b) Medical History/general and Pelvic Exams

8) The focus of the medical history should be on absolute contraindications.
9) Symptomatology of absolute contraindications should be printed on the form (not medical terminology) to enhance communication with the client and the accuracy of the information.
10) The format for printing the symptomatology should relate to specific methods so that it is obvious which methods cannot be used if certain conditions exist(ed) (see Appendix D for an illustration).
11) Questions about the examination of the breasts, uterus, adnexa, and cervix need to be explicit and made dichotomous. For example:

	Yes	No	Comments
Tears			
Infection			
Discharge			
Swollen glands			

c) Method Adopted

12) For the condom/foam, need to record the type and quantity received.

d) Record of Subsequent Visits

(Several of these are already included, however, in order to give a clearer picture of the entire section, all factors are listed below.)

13) Date

14) Purpose of visit (resupply, test results, medical, information, annual, other).
15) Method used at the time of this visit.
16) Clinical findings:
    - weight
    - blood pressure
    - string check (IUD in situ)
    - pregnancy test results
    - urine test results for diabetes
    - results from hematocrits tests
    - side effects, complications, or complaints.
17) Treatment and/or referral
18) Change in method or termination and reason.
19) Supplies received (type and quantity).
20) Return date (appointment) and purpose.
21) Clinician code number.

VI. FOLLOWUP ACTIVITIES

A. FPAK

The studies described in this report cover only three of FPAK's 10 locations. As such, all of the conclusions might not be applicable to the other seven. Although some of the other locations are new and, at present, are providing services to only a few clients, it might be productive to conduct additional modified studies at the other sites. The FPAK Research/Evaluation Officer worked with us during our entire stay in Kenya and has learned the techniques used in this study. She could conduct other studies as deemed appropriate by FPAK management. The results of any additional studies should be submitted to the Medical Subcommittee and other FPAK managers for use in setting service standards, deciding on staffing and in making other needed improvements.

Followup studies should be conducted to measure and evaluate the effects of any changes implemented. CDC consultants would be happy to assist FPAK in the interpretation of any new or followup studies and to further train FPAK personnel in the use of these types of evaluations. We are also available to assist in implementing changes in the management of FPAK clinics.

B. Ministry of Health (MOH)

During our stay in Kenya, we made a presentation on the PFA techniques to a number of MOH officials. They expressed interest in conducting similar studies in MOH clinics and in learning these new evaluation methods. CDC would be happy to assist the MOH family planning program in conducting similar studies and in training their personnel in the use of PFA.

C. Methodology

This was the first attempt to tie quality of service to the quantitative PFA system. We intend to pursue this further, since we feel that the two aspects are inseparable. We will further streamline methods for evaluating quality so that future studies can be easily conducted and more meaningfully interpreted.

Jack L. Graves, M.P.H.

Michael E. Dalmat, Dr.Ph.

FIGURE 1

Client Visits to Family Planning Association of Kenya Clinics - 1975-1981

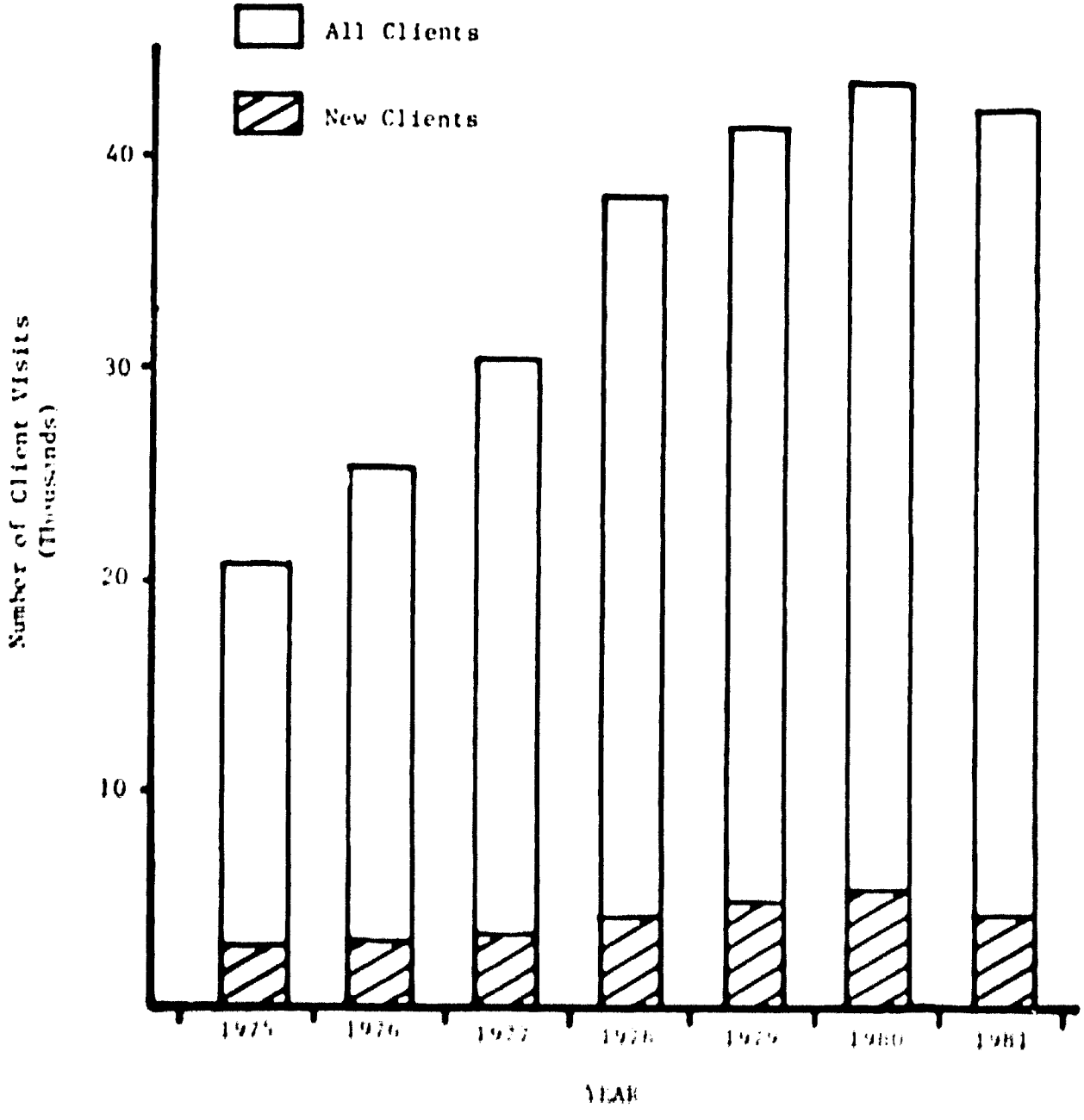


TABLE 1

Patient Load by Center (1981)

	Patient Visits Served				Average Daily Attendance				% of Clients from 1980 Returning to Clinic in 1981
	Oct.	Nov.	Dec.	TOTAL	Oct.	Nov.	Dec.	TOTAL	
Mombasa	489	424	397	1310	21	18	18	19	42
Nyeri	663	877	822	2362	28	38	38	35	50
Nairobi	538	520	418	1476	23	23	19	22	18
Eldoret	278	249	303	830	12	11	14	12	46
Embu	394	415	422	1231	17	18	20	18	42
Nakuru	373	395	411	1179	16	17	19	17	35
Kisumu	189	169	194	552	8	7	9	8	39
Kakamega	170	161	139	440	6	7	6	6	65
Thika*	265	260	266	792	11	11	12	12	*
Meru*	104	139	124	367	4	6	6	5	*
TOTAL	3434	3609	3496	10539	146	157	162	155	

*Thicka and Meru clinics began providing family planning services in 1981.

TABLE 2

Utilization of Client and Staff Time in Seven Patient Flow Analysis Studies, Family Planning Association of Kenya
February-March 1982
(Time in Minutes)

	Location and Study Number						
	Nairobi			Nyeri		Mombasa	
PFA Indicators	183011	183021	183031	115011	115041	171011	171(
Number of clients served	32	27	28	33	36	30	1(
Mean client time in the clinic	17	29	25	26	36	23	2!
Mean client time in contact with staff	12	16	15	11	9	12	1:
Percent of client time in contact with staff	70	56	62	41	20	52	4(
Staff time available per client served	39	47	46	54	42	49	7!
Mean staff time in contact with clients	12	16	15	11	9	14	1!
Percent of staff time in contact with clients	30	34	34	20	22	29	1(

TABLE 3

Summary of Average Direct Personnel Costs
From Seven Patient Flow Analysis Studies
Family Planning Association of Kenya
February-March 1982

(Cost in Kenya Shillings; US $1.00 = KS 10.58)

Type of Client Visit	Location and Study Number						
	Nairobi			Nyeri		Mombasa	
	183011	183021	183031	115011	115041	171011	171021
	No./Cost	No./Cost	No./Cost	No./Cost	No./Cost	No./Cost	No./Cost
Initial	3/20.75	3/17.36	4/18.66	4/30.07	2/15.42	2/22.60	2/51.03
Annual	2/35.10	6/28.58	3/25.82	-	2/12.08	5/20.86	1/54.96
Medical	3/15.87	8/14.35	6/11.97	4/23.74	4/11.04	2/13.40	3/17.81
Resupply	14/10.75	7/ 8.52	11/15.66	25/16.34	26/ 7.92	20/12.72	8/13.27
Preg. Test	1/ 4.37	-	-	-	-	-	-
Counseling	9/ 8.7	3/ 5.67	4/ 4.97	-	2/18.48	1/ 3.85	-
All	32/12.76	27/15.37	28/14.86	33/18.90	36/ 9.50	30/14.48	14/22.62

FIGURE 2

Pattern of Client Arrivals in Seven Patient Flow Analysis Studies-Family Planning Association of Kenya; Nairobi, Mombasa and Nyeri Clinics-February-March, 1982
Clinic Hours of Operation, 8:00 AM-5:30 PM

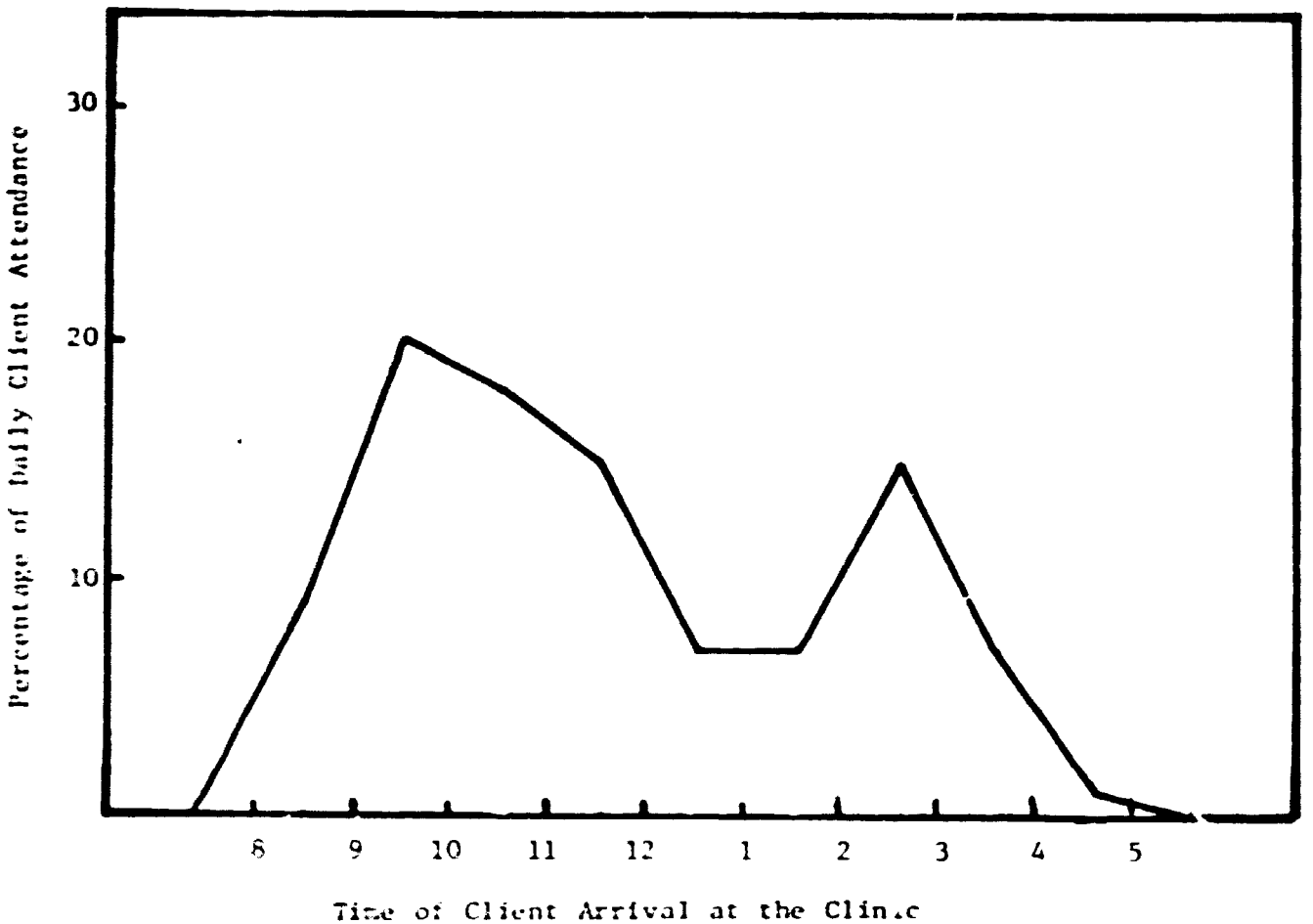


TABLE 4

Characteristics of FPAK Users: Nairobi Clinic (February 22-24, 1982), Nyeri Clinic (February 25 and March 1, 1982), Mombasa Clinic (March 1-2, 1982)

	Nairobi		Nyeri		Mombasa	
Age	No.	%	No.	%	No.	%
20-29	13	62	11	34	8	27
30-39	7	33	14	44	17	57
40+	1	5	7	22	5	17
TOTAL	21	100	32	100	30	100
Marital Status						
Married	13	65	21	66	24	80
Single	6	30	7	22	1	3
Divorced/Widowed	1	5	4	12	5	17
TOTAL	20*	100	32	100	30	100
No. of Living Children						
0-2	11	52	7	22	4	14
3-5	9	43	12	38	13	43
6+	1	5	13	40	13	43
TOTAL	21	100	32	100	30	100
Education						
None	0	0	5	16	6	22
Standard	3	15	24	75	10	37
Form	13	65	3	9	11	41
Higher	4	20	0	0	0	0
Unknown	1	0	0	0	3	0
TOTAL	20*	100	32	100	27	100
Economic Status of Clients (Determined by husbands' occupations)**						
High (functionary, self-employed businessman, farmer owning own land)	12	100	14	58	16	64
Intermediate (skilled laborer, driver, craftsman)	0	0	4	17	6	24
Low (farm laborer, unskilled laborer)	0	0	6	25	3	12
TOTAL	12**	100	24**	100	25**	100
No. of Clients	21		32		30	

*Information was not recorded for one client

**This definition cannot be used for single clients or divorced/widowed clients that did not report the occupation of their ex- or deceased spouses. This accounts for the nine clients excluded for Nairobi Clinic, 8 for Nyeri, and 5 for Mombasa.

TABLE 5

Methods Used by Clients of FPAK Clinics on Days of PFA Studies

Method	Nairobi (2/22-24/82) No.	Nairobi (2/22-24/82) %	Nyeri (2/25, 3/1/82) No.	Nyeri (2/25, 3/1/82) %	Mombasa (3/1-2/82) No.	Mombasa (3/1-2/82) %
IUD	42	*49*	10	*14*	10	*23*
Orals	20	*23*	10	*14*	11	*25*
Injectables	1	*1*	45	*65*	21	*48*
Condom/Foam	16	*19*	1	*1*	2	*5*
Sterilization	0	*0*	2	*3*	0	*0*
None/Unknown	7	*8*	1	*1*	0	*0*
TOTAL	86	*100*	69	*100*	44	*100*

TABLE 6

Most Recent Method Changes

Nairobi Clinic: February 22, 1982 (n=21)

		FROM.....					
		IUD	Orals	Injectables	Condom/F	TOTAL*	Net**
To...	IUD	(4)	3	0	4	+ 7	+ 5
	Orals	0	(2)	0	0	-	- 5
	Injectables	0	0	0	0	-	-
	Condom/Foam	1	2	0	(4)	+ 3	- 1
	Termination	1	0	0	0	+ 1	+ 1
	TOTAL	- 2	- 5	0	- 4		

Changes = 11
No Changes = 10
52% Changing

Nyeri Clinic: February 25, 1982 (n=32)

		FROM.....					
To...	IUD	0	1	0	0	+ 1	0
	Orals	0	(5)	1	0	+ 1	- 1
	Injectables	1	1	(21)	2	+ 4	+ 3
	Condom/F	0	0	0	0		
	TOTAL	- 1	- 2	- 1	- 2		

Changes = 6
No Changes = 26
23% Changing

66% staying with injection

Mombasa Clinic: March 1, 1982 (n=30)

		FROM.....					
To...	IUD	(2)	1	2	0	+ 3	+ 1
	Orals	2	(4)	1	0	+ 3	- 1
	Injectables	0	3	(12)	1	+ 4	+ 1
	Condom/F	0	0	0	(2)	-	-
	TOTAL	- 2	- 4	- 3	- 1		

Changes = 10
No Changes = 20
33% Changing
44% staying with injection

*Total = total number of clients changing from a former method to this particular method.

**Net = the net change, that is the total number of clients switching to a particular method minus the number who changed from the same method to a different method.

TABLE 7

Percent Change in the Number of Users of Pills, Depo-Provera, and IUD, 1980 to 1981

NEW ACCEPTORS ONLY

Method	All Clinics	Nairobi	Nyeri	Mombasa
Orals	- 6	-21	+73	-15
Injectables	-12	-45	-12	-22
IUD	+17	+ 4	+ 1	-29

TABLE 8

Age by Method First Used at FPAK Clinics
Among Clients Included in the Study

Age		IUD No.	IUD %	Oral No.	Oral %	Inject. No.	Inject. %	Condom/F No.	Condom/F %	Total No.	Total %
20-29:	Nairobi	6		5		0		5		16	
	Nyeri	0		5		11		0		16	
	Mombasa	6		4		4		1		15	
	Subtotal	12	75	14	70	15	38	6	*	47	57
30+:	Nairobi	3		1		0		1		5	
	Nyeri	0		2		14		0		16	
	Mombasa	1		3		10		1		15	
	Subtotal	4	25	6	30	24	62	2*	*	36	43
TOTAL		16	100	20	100	39	100	8	100	83	100

*Numbers are too small to be statistically meaningful.

TABLE 9

Age by Method of Current Use Among
Clients Included in FPAK Study

Age		IUD No.	IUD %	Oral No.	Oral %	Inject. No.	Inject. %	Condom/F No.	Condom/F %	Total No.	Total %
20-29:	Nairobi	3		2		0		5		10	
	Nyeri	1		4		6		0		11	
	Mombasa	1		3		3		1		8	
	Subtotal	5	33	9	56	9	21	6*	*	29	35
30+	Nairobi	8		0		0		2		10	
	Nyeri	0		2		18		1		21	
	Mombasa	2		5		15		0		22	
	Subtotal	10	67	7	44	33	79	3*	*	53	65
TOTAL		15	100	16	100	42	100	9	100	82	100

*One IUD user from Nairobi Clinic terminated use of contraceptives.

TABLE 10

Number of Living Children and Blood Pressure of Women Under 30 Years of Age from the Three Clinics Included in the Study at the Time They First Accepted a Method from FPAK

Clinic	Method	Number of Living Children				
		0	1	2	3	4+
Nairobi	IUD	120/60 120/70 130/90		130/80		110/55 140/100
	Orals		100/70 110/70	120/70	120/80 120/80	
Nyeri	Orals		110/70 120/80 100/70 110/70	100/60		
	Injectables			100/60 Unknown	Unknown	120/80 120/70 100/60 100/60 100/60 130/75 Unknown Unknown
Mombasa	IUD		110/70	Unknown	120/80 110/70	150/80 110/70
	Orals	110/70		110/70 120/70		130/90
	Injectables				120/80	100/60 120/80 130/80

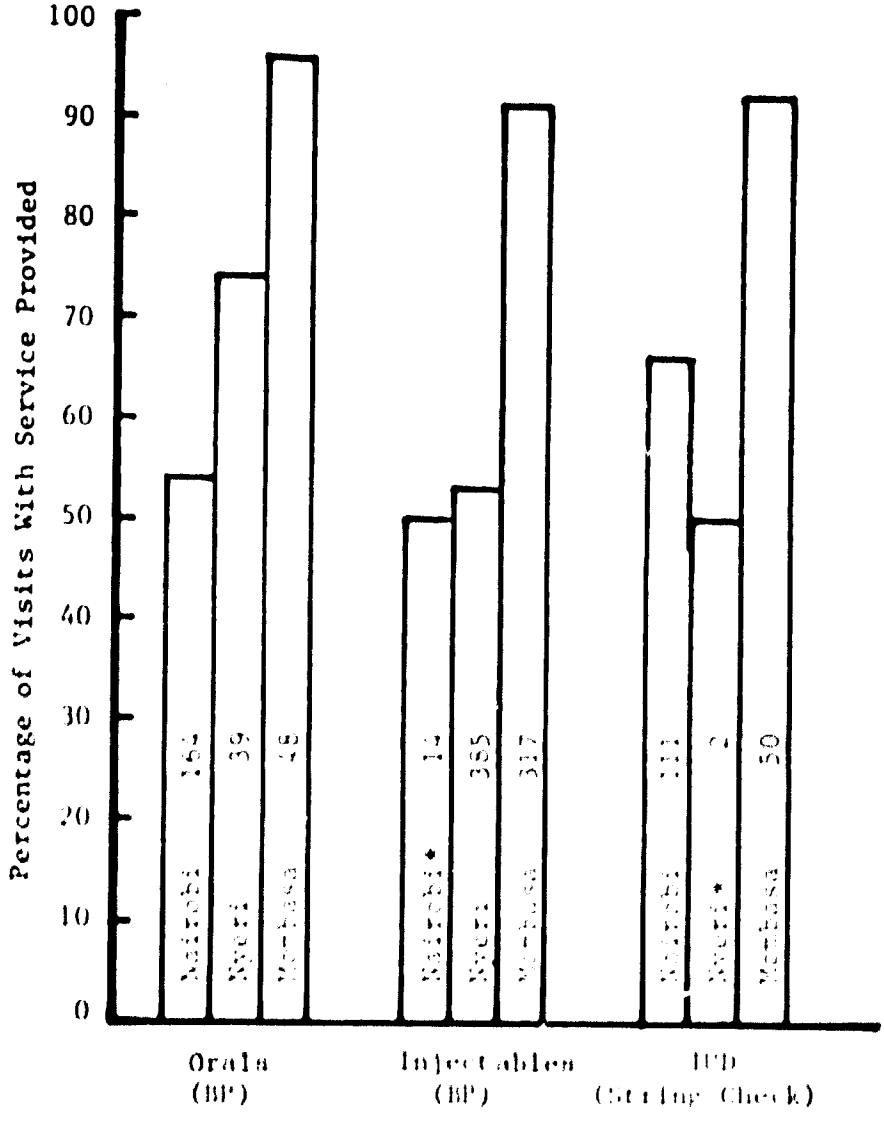
TABLE 11

Distribution of Visits by Type of Service Received by FPAK Clients Included in the Study

	Initial		Resupply		Annual		Medical		Other		Total	
Nairobi: 2/22-24/82 (n=63)	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
IUD	1	3	13	36	6	17	13	36	3	8	36	100
Orals	2	*	4	*	1	*	5	*	*	*	12	100
Injectables	0	*	0	*	1	*	0	*	0	*	1	100
Condom/Foam	6	*	2	*	3	*	1	*	0	*	12	100
Sterilization	0	*	0	*	0	*	0	*	2	*	2	100
Subtotal	9	14	21	33	11	17	17	27	5	8	63	100
Nyeri: 2/25/82 (n=36)												
IUD	0	*	2	*							2	100
Orals	2	*	3	*	1	*	1	*	0	*	7	100
Injectables	0	*	20	87	1	4	2	9	0	*	23	100
Condom/Foam	0	*	1	*	0	*	0	*	0	*	1	100
Natural	0	*	0	*	0	*	1	*	0	*	1	100
Sterilization	0	*	0	*	0	*	0	*	2	*	2	100
Subtotal	2	6	26	72	2	6	4	11	2	6	36	100
Mombasa: 3/1-2/82 (n=44)												
IUD	2	*	5	*	1	*	2	*	0	*	10	100
Orals	0	*	8	*	3	*	0	*	0	*	11	100
Injectables	1	5	14	67	2	10	3	14	1	*	21	100
Condom/F	1	*	1	*	0	*	0	*	0	*	2	100
Subtotal	4	9	28	64	6	14	5	11	1	2	44	100

FIGURE 3

Consistency of Blood Pressure Readings for Pill and Injection Users, and String Checks for IUD Users During FPAK Clinic Visits to Nairobi, Nyeri, and Mombasa Clinics



*These numbers are too small to be statistically meaningful.

TABLE 12

Completion of Breast Examination for New Acceptors: Nairobi (February 22, 1982), Nyeri (February 25, 1982), Mombasa (March 1, 1982)

	Nairobi		Nyeri		Mombasa	
	No.	%	No.	%	No.	%
Breast exam completed:						
Normal	13	65	27	84	4	13
Abnormal	1	5	0		1	3
No information recorded	6	30	5	16	26	84
TOTAL	20	100	32	100	31	100

TABLE 13

Variations in Fees Charged in Clinics
(9 of 23 fees, 39 percent)

Fee Category	Nairobi	Nyeri (1)	Nyeri (2)	Nyeri (3)	Mombasa	
1. Examination-new	30	30	40	30	30	
2. Loop	0	10	10	0	0	
3. Copper 7	160	138	88	88	88	
4. Copper T	0	50	55	0	0	
5. Novat	160		N/A		N/A	
6. Diaphragm	N/A		N/A		10	
7. Pregnancy test	45	30	45	45	45	
8. Pap smear	35		N/A	10	N/A	
					(2)	(3)
9. Yearly checkup	20	20	20	45	40	20

(1) Posted and explained by nurse-midwife
(2) Posted in waiting room
(3) Charged by clerk

TABLE 14

New Acceptor Fees (Kenyan Schillings*) for Initial Visit

	Copper 7	Loop	Orals	Injectables
New member	10	10	10	10
Examination (new)	30	30	30	30
Urine test	10	10	10	10
Pregnancy test	45	45	45	45
Insertion	15	15	--	--
Copper 7	88	--	--	--
	198	110	95	95

*Kenyan Schillings 9.1 - U.S. $1-

APPENDICES A-B-C-D

APPENDIX A

FPAK RECORD REVIEW FORM

Client's study number: __ __ (1-2) Date of study visit: _____ (5-10)

Family planning clinic: _____ (3-4) Date of initial visit: _____ (11-16)

CLIENT CHARACTERISTICS

1. Marital status: (1) married (2) single (3) divorced or widowed (9) no response __ (17)

2. Husband's occupation: (1) functionary (2) self-employed (shopkeeper, artisan, etc.) (3) farmer (own land) (4) skilled laborer (craftsman, driver, etc.) (5) laborer (farm, other) (6) other, specify: _____ (8) not applicable, single (9) no response __ (18)

3. Educational level: (0) none (1) standard (2) form (3) higher (9) no response __ (19)

4. Age at first registration: __ __ (20-21)

5. Age at study visit: __ __ (22-23)

6. Age at first marriage: 88 = not applicable, single __ __ (24-25)

7. Number of living children at time of study: 0-6 7=7+ 9=no response __ (26)

8. Number of children who have died: 0-6 7=7+ 9=no response __ (27)

9. Number of abortions __ (28)

10. Date last pregnancy terminated: __ __ __ __ __ __ __ __ (29-34)

MEDICAL HISTORY

(0) no (1) yes (9) no response/left blank

12. Inflammation of veins __ (35)

13. Diabetes __ (36)

14. Liver disease __ (37)

15. Epilepsy __ (38)

16. Venereal disease __ (39)

17. Heart disease __ (40)

18. Renal disease __ (41)

19. Tuberculosis __ (42)

GENERAL EXAMINATION (Skip to Question 22 if not a pill user)

20. Breasts: (0) normal (1) abnormal, specify: _____ (9) no response _____ __ (43)

21. Blood pressure at time of first visit: __ __ __/__ __ __ __ (44-45)

PELVIC EXAMINATION

22. Uterus: (1) anteverted (2) mid-position (3) retroverted (9) no response __ (46)

23. Uterus: (1) mobile (2) fixed (9) no response __ (47)

24. Uterus: (0) normal (1) abnormal, specify:_____ __ (48)

25. Adnexa: (0) normal (1) abnormal, specify:_____ __ (49)

26. Cervix: (0) normal (1) abnormal, specify:_____ __ (50)

27. Vaginal discharge: (0) none (1) reported (9) left blank __ (51)

FAMILY PLANNING CLINIC HISTORY

28. Method used before coming to clinic: (0) none (1) IUD (2) Pill (3) injection (4) condom (5) other, specify:_____ (6) method used but not specified __ (52)

29. Total number of visits completed: __ __ (53-54)

30. List all methods used since coming to this clinic in order of use (first to current): (1) after first visit (2) after second visit (3) after third visit, etc. (9) current visit (0) never used as primary method at this clinic

- o IUD __ __ __ __ __ __ (55-60)
- o Pill __ __ __ __ __ __ (61-65)
- o Injection __ __ __ __ __ __ (66-71)
- o Condom __ __ __ __ __ __ (72-77)
- o Other, specify: _____ __ __ __ __ __ __ (78-83)
- o None

31. Termination: (0) has not terminated (1) terminated because of husband's objections (2) because wants to become pregnant (3) because is pregnant (4) because cannot follow instructions (5) because of medical reasons (7) other, specify:_____ (9) terminated without explanation __ (84)

32. Pill users only: total number of visits while using the pill __ __ (85-86)
88 = not applicable

Number of visits while using the pill during which blood pressure was recorded __ __ (87-88)
88 = not applicable

33. IUD users only: total number of visits following IUD insertion __ __ (89-90)
88 = not applicable

Number of visits while wearing IUD during which strings were reportedly checked (does not include insertion visit) __ __ (91-92)
88 = not applicable

34. Depo-Provera users only: Number visits __ __ (93-94)

Number of visits during which blood pressure was recorded. __ __ (95-96)

APPENDIX B

CASE HISTORIES

Nairobi Clinic

Case 1: Inflammation of veins
29 = age at first examination
7 living children, 0 dead, 1 abortion
BP = 140/100 at first examination
Pill user prior to coming to clinic
Total of 12 visits over 8 years (age 36)

	Method	Visits	Comments
(string check 6 of 9 visits)	IUD	1-5	Expelled
	Condom	6	
	Injection	7	
	IUD	8-10	Expelled, conceived at age 35
	Condom	11-12	

Case 2: Inflammation of veins
30 = age at first examination
3 living children, 1 dead, 0 abortions
BP 120/70
Pill user prior to coming to clinic
Total of 6 visits during 1 year.

	Method	Visits	Comments
(string check 1 of 6 visits)	IUD	1-6	Infections repeatedly with Rx (wanted IUD herself)

Case 3: Inflammation of veins, abnormal breast exam
31 = age at first examination
3 living children, 0 dead, 0 abortions
BP = 130/80
Used a method before coming to clinic but method unknown
Total of 9 visits over 2 years

	Method	Visits	Comments
(string check 6 of 9 visits)	IUD	1-9	

Case 4: Vaginal discharge
26 = age at first examination
1 living child, 0 dead, 0 abortions
BP = 100/70
No method used before coming to clinic
Total of 7 visits over 5 months

	Method	Visits
(BP 3 of 7 visits)	Pill	1-7

Mombasa Clinic

Case 1: VD
39 = age at first examination
8 living children, 8 dead, 0 abortion
BP = 100/60
Total of 8 visits over 19 months

	Method	Visits	Comments
BP 7 of 8	Injection	1-8	Rx?

Case 2: Inflammation of veins
32 = age at first examination
7 living children, 0 dead, 2 abortions
BP = 110/70
No method used before coming to clinic
Total of four visits over 7 months

	Method	Visits	Comments
BP 3 of 4	Injection	1-4	

APPENDIX C

OBSERVER CHECKLIST

(Draft)

CLINIC OBSERVER CHECKLIST

INITIAL VISIT, FAMILY PLANNING ONLY

(Nursing Sister or Nurse Midwife)

Supervisor: _____

1. Staff Member: _____

2. Staff Member: _____

3. Staff Member: _____

Assessment: 2 = adequate
1 = needs improvement
0 = not being done

Date: _____

Clinic: _____

Client No.: _____

SEQ. FOL.	STAFF MEMB.	ASPECTS OF SERVICE	QUALITY INDICATORS	ASSESSMENT OBSERVATIONS
		1. Initial greeting of client.	1.1 Clear vision of persons entering.	
			1.2 Initiate contact w/o waiting for client to approach.	
			1.3 Give clear instructions for next step.	
			1.4 Culturally standard greeting that is comfortable to staff and client as well.	

2. Preparation for clinic contact.	2.1 Establish reason for visit. 2.2 Menstrual history or possible pregnancy is not cause for rescheduling. 2.3 Initiate chart for new acceptor and retrieve chart for rejoin. 2.4 Record demographic information. 2.5 Based on established criteria, clients with obvious medical problems are put first in line to see the Nursing Sister or are asked to wait their turn. 2.6 Other clients are asked to wait their turn for the Midwife.
3. Waiting for clinical service.	3.1 Urine specimens are taken or water is given to clients who are unable to urinate. --explain how to give the urine sample --label container. --provide container. --explain where to place filled container. 3.2 Attractive, bright posters that reinforce health benefits of family planning, breastfeeding, infant immunization, women in the work force, method choices, etc. are posted. Appropriate symbols, use of language, and cultural sensitivity is reflected in all posters.

3.3 Unambiguous signs explaining clinic hours and service fees are posted.

3.4 Bathrooms are clearly labeled with signs leading from waiting room.

Bathrooms are clean.

3.5 Waiting room has adequate ventilation, lighting, and seating such that clients do not wait outside of the facility and can see the posters.

4. Clinical contact

4.1 Clinician greeting

--uses client's name and introduces self.

--client is seated.

--word choice avoids highly technical language as well as offensive terms.

4.2 Statement of reason for visit

--determine reason for visit from chart and from discussion with client.

4.3 History of family planning (HPI)

--number of living children.

--number of desired children.

--past family planning method used, if any.

--current breastfeeding.

--current use of contraceptive method.

--problems with methods used to date.

--method preferences.

--defer detailed discussion of alternative methods until after examination, reassuring client that all her questions will be answered at that time.

--currently sexually active.

--problems or questions related to sexual activity.

4.4 Past medical history of client (PMH)

--serious illnesses, past and present conditions, plus hospitalization.

--specific conditions: heart disease, diabetes, malaria, sickle cell anemia, tuberculosis, venereal disease, etc.

--current medications and allergies to medications.

4.5 Family history (FH)

--serious illnesses in mother, father, siblings, children, and spouse.

--deaths among the above and causes of death.

--specific conditions among above: diabetes, cancer, heart disease, etc.

4.6 Social history (SH)

--spouse's and own occupation (proportion of year together)

--smoking, alcohol and drug use.

4.7 Review of systems (ROS)

a. Nervous system

--blurred vision, loss of vision

--dizziness

--severe headaches

--fainting

--convulsions

b. Respiratory-heart

--frequent chest pains

--shortness of breath

--coughing or spitting blood

--palpitations

c. Gastro-intestinal

--nausea

--vomiting

--abdominal pain

--constipation, diarrhea, painful bowel movements

--change in color of stools

d. Genito-urinary

--pain, burning, frequency of urination

--leakage of urine

e. Extremities

--muscle pains

--calf pain or tenderness

f. Gynecological

--last menstrual period (LMP)

--cycle length and duration of menstrual bleeding, regular (?), inter-menstrual bleeding (?), painful menses (?)

--pregnancy history: date outcome

--history and treatment of PID

--history of any other gynecological treatments.

--douching, use of any substance in vagina

--pain on intercourse

--vaginal discharge

4.8 Physical examination (direct PE to ROS problems)

a. vital statistics and signs

--height, weight (scale)

--blood pressure (BP cuff, stethoscope)

--heart rate

b. head, ears, eyes, nose, and throat (check thyroid)

c. chest

--listen to heart and lungs

--breast examination, by staff and self administered

d. abdomen (examination table)

--check for masses, tenderness, and enlarged liver or spleen

--check for bladder tenderness and groin nodes

--check for CVA (kidney) tenderness

e. pelvic (light, speculum, cotton swabs on sticks)

--patient in stirrups

--inspect vulva for soars, ulcerations, discharge, warts, scarring

--inspect and palpate labia, Bartholin's glands, urethra, and clitoris

--introduce clean, warm speculum of the proper size

--inspect cervix and vagina for lesions, discharge, or signs of pregnancy - (remove speculum)

--bi-manual exam with two fingers in vagina and other hand on lower abdomen, palpate uterus and adnexa to estimate size, position, shape, consistency, and tenderness.

--recto-vaginal exam with index finger in vagina and middle finger in rectum, examine septum for masses or lesions.

4.9 If client has questions or if there are method options to discuss:

a. answer specific questions.

b. determine method options based on absolute and relative contraindications.

c. present options available to client (include benefits

d. If patient is prepared to make a decision, go ahead and provide method.

e. If patient is undecided, ask if there are areas of confusion that you can help to clarify. If she wants to discuss the decision with her spouse or others, remind her that she may get pregnant any time and to please use a barrier method until and if she chooses another method.

4.10 If a method is agreed upon:

a. Instruct the patient in the proper use of the method and reinforce her decision (i.e., review the benefits, anecdotes of successful users; anticipate difficulties and encourage questions and consultation).

1. OC—patient can tell you when she will start with OCs, when she will come back for more, what to do if she has a problem (side effects, complications, or in use of method).

2. IUD—patient understands reason and importance of the string check, can check string, and knows what to do if she has a problem (side effects, complications, or problems with IUD).

3. Injectable—patient knows when to return for her next injection, knows side effects, including irregular bleeding or no periods.

b. Explain problems that require medical treatment and discuss when and where to obtain care.

c. Have patient explain how she will use the method, when she will return to clinic, and what she will

do if she needs immediate attention. If patient is uncertain or confused about any aspect of the use of her method, clarify and recheck her understanding.

d. Schedule appointment with the patient:

1. Calculate the latest date that she should return.
2. Discuss most convenient day and time of day for her return.
3. Record appointment on her chart and on her membership card and record reason for next visit on the chart.

--OC-first revisit in 3 months if individual appears to fully under4stand use of OCs. If not, RTC in 1 month.

--IUD-first revisit in 1 month.

--Injectable-first revisit in 3 months.

5. Pay cashier:

6.1 List fees by total services to be received.

6.2 Review the fee to be paid for this visit with the patient.

APPENDIX D

PHYSICAL EXAM

REASON FOR VISIT

Visit Date ___/___/___ Mo. Da Yr.

SUBJECTIVE DATA BASE

	None	Oral	IUD	Shot	Ster	Other		Phone We Can Call
Desired Contraceptive Method (s)								
Current Contraceptive Used (s)								
Previous Contraceptive Used (s)								

MEDICAL HISTORY

Comment if "yes"	No Ans	Oral	IUD	Shot	Ster	Other	HISTORY COMMENT Interviewer	HISTORY COMMENT Clinician
Diabetes								
Heart Disease								
Asthma								
Serious Complications of Pregnancy								
Breast tumor/fibroids/Cancer								
Gallbladder Disease								
Surgery or Serious Illness last year								
Family history of Diabetes								
Family history High Blood Pressure								
Family history of Anemia								
Family history of Breast Cancer								
High Blood Pressure								
Inflammation of veins								
Varicose veins								
Anemia								
Complete examination of bowel disturbances								
Breast Lump or Discharge								
Current or recent liver Problems								
Seizures								
Severe Depression								
Allergies (especially drugs, rubber)								
Current complaint of itching or pelvic pain								
Irregular periods								
Scanty or very heavy or very light periods								
Missed periods								
Bleeding between periods (more than 2 weeks)								
Symptoms of Pregnancy (nausea, breast tenderness, weight gain)								
Painful intercourse								
Frequent or painful urination/bladder problems								
Surgery (operations, biopsies) since last visit								

COMMENT: Interviewer or Clinician

1. Regular self breast exam? Yes ☐ No ☐
2. Questions or problems about sex? Yes ☐ No ☐
3. Does patient smoke? Yes ☐ No ☐

Interviewer Sign

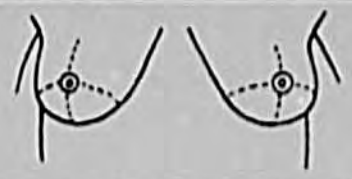
OBJECTIVE DATA BASE

1. First Pelvic Yes ☐ No ☐
2. Age Periods started _____
3. First day of last menstrual period ___/___/___ Mo. Da. Yr.
4. F P A L ___ ___ ___ ___
5. Date most recent pregnancy ended ___/___/___ Mo. Da. Yr.

PHYSICAL EXAM

Connect line if abnormal

		Oral	IUD	Shot	Ster	Other	ABNORMAL
WEIGHT Abnormal if appears obese							
BLOOD PRESSURE							
CHLOASMA							
JAUNDICE							
BREASTS							
CARDIORESP In detail if indicated by Hx							
NEUROLOGIC In detail if indicated by Hx							
ABDOMEN							
LOWER EXTREMITIES							
EXTERNAL GENITALIA							
VAGINA							
CERVIX							
UTERUS							
ADNEXAE							
RECTOVAGINAL							
OTHER FINDINGS x=contraindication							



LABORATORY

		TODAY RESULTS COMMENTS
URINE PREGNANCY TEST		☐ ☐
HEMATOCRIT		____ %
URINE LABSTIX		
PAP SMEAR		
GC CULTURE		☐ ☐ ☐
SYPHILIS SEROLOGY		
OTHER		

MOST RECENT LAB RESULTS FROM CHART ☐ Chart not available

ASSESSMENT

Contraindications	Oral	IUD	Shot	Ster	Other	EXPLANATION
	Yes	Yes	Yes	Yes	Yes	
	No	No	No	No	No	

PLAN

Diagnostic, Therapeutic and Educational

Contraception at Discharge		GIVEN TODAY			
ORALS					
IUD					
SHOT					
DIAPHRAGM					
FOAM					
CONDOMS					

OTHER PROBLEMS	TREATMENT/REFERRAL

RETURN IN _____

Patient's chart ☐ was ☐ was not available.

Clinician Signature

GMH Number