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DEPARTMENT OF HEALTH & HUMAN SERVICES IGN 13243

Public Health Service
Centers for Disease Control

Memorandum

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Subject Foreign Trip Report (AID/RSSA), Jamaica: Service Statistics System, March 7-19, 1982

To William H. Foege, M.D.
Director, Centers for Disease Control
Through: Horace G. Ogden
Director, CHPE

SUMMARY

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The National Family Planning Board (NFPB) coordinates all family planning services in Jamaica in both the public and private sectors, including clinic/hospital services, outreach programs, and the Commercial Distribution of Contraceptives (CDC) program.

For some years the NFPB has felt the need to develop a comprehensive national family planning service statistics system. Although the Ministry of Health (MOH) has developed, in collaboration with the U.S. Bureau of Census, a computerized "Monthly Clinic Summary Report" (MCSR) data system, which gathers maternal-child health/family planning service statistics from 385 MOH clinics (of which approximately 227 offer family planning services), the NFPB has concluded that the data provided by this system are inadequate for ongoing program management and for more long-term program evaluation and planning.

The writers were asked to provide technical assistance to help develop a comprehensive national family planning data system which would seek to improve the present MCSR-provided service statistics. The new system would have to provide more useful service statistics, sterilization data, supply data, as well as additional data which would be more effectively gathered from surveys.

In discussions with NFPB staff it was determined that in addition to the family planning service statistics on visits by new and previous acceptors already gathered by the MCSR system, there is a need for the following additional data:

(1) Ongoing standardized data from all NFPB-coordinated service providers, including more indepth data from the 15 proposed family planning clinics that the NFPB will directly manage in the 13 parish capitals and Kingston.

(2) An estimate of the current number of contraceptors (contraceptive prevalence).

(3) More detailed age-specific and method-specific data on contraceptive users, particularly adolescents.

(4) Data on the average age at first conception by year.

(5) Service statistics from outreach activities.

(6) Service statistics on male users.

(7) Sterilization data reporting.

(8) Data on supplies distributed.

The major recommendation made was that family planning data should be collected in three separate ways:

(1) The Monthly Clinic Summary Report (MCSR) System, which will provide improved routine service statistics based on a few simple suggested changes, should include data on supplies. Supply data would permit working estimates of contraceptive prevalence as well as information useful for supply management. A separate monthly family planning service statistics system apart from the MCSR is not recommended, since in the majority of smaller clinics where a small staff is responsible for keeping records for all nine health services provided, it would represent a burdensome addition to paper work, resulting in decreased reporting.

(2) Annual Records-Search Surveys for more detailed information not needed on a monthly basis. These surveys are to be conducted by the MOH Statistics Division with initial collaboration from the U.S. Bureau of Census. Funds are to be provided as part of the USAID project. To more effectively implement these surveys, it is recommended that an assistant be hired for the NFPB statistician assigned to the MOH.

(3) Contraceptive Prevalence Surveys every 3-5 years. Funds for these are also to be provided as part of the USAID project. They will be conducted by the Sociology Department of the University of the West Indies.

Further recommendations were made on gathering data on outreach activities and instituting formal followup activities in the 15 NFPB clinics.

A detailed sterilization recordkeeping and statistics system was developed together with the NFPB Medical Director. This system would standardize hospital records of all sterilizations done under the institutional reimbursement system. On a monthly basis, information abstracted from the chart on patient characteristics, surgical procedures, and complications would be reported on a monthly report form and entered into a computerized file. The file would provide data needed by the NFPB as well as produce any reports needed by other agencies.

I. PLACES, DATES, AND PURPOSE OF TRAVEL

Kingston, Jamaica, March 7-19, 1982, at the request of USAID/Jamaica, AID/S&T/POP/FPSD and the National Family Planning Board of Jamaica, to provide technical assistance in the area of national family planning service statistics. This travel was in accordance with the Resource Support Services Agreement between the Office of Population, AID, and CDC/CHPE/FPED.

II. PRINCIPAL CONTACTS

A. USAID/Jamaica
   (1) Mr. Terry Tiffany, Health, Nutrition, and Population Officer
   (2) Ms. Marlene Tomlinson, Population Officer
   (3) Ms. Francesca Nelson, Nutrition Officer

B. National Family Planning Board
   (1) Dr. David Thwaites, President
   (2) Mr. A. Burgess, Executive Director
   (3) Mrs. J. Ratray, Executive Secretary
   (4) Dr. O. McDonald, Medical Director
   (5) Mrs. P. Hamilton, Research Officer
   (6) Mrs. E. Radlein, Statistician

C. Ministry of Health
   (1) Dr. C. Moody, Director, Primary Health Care
   (2) Mr. Osmond Gordon, Acting Director, Statistics Division
   (3) Ms. Schwapp, Nursing Sister-in-Charge, Comprehensive Clinic
   (4) Ms. Cummings, Midwife-in-Charge, Cassava Piece Clinic
   (5) Matron Dann, Victoria Jubilee Clinic

D. Ministry of Youth and Community Development
   (1) Mrs. Doris Watts

E. Ministry of Agriculture
   (1) Mrs. N. Jones

F. YWCA
   (1) Mrs. Campbell
   (2) Nurse Edwards

G. Operation Friendship
(1) Nurse Ruth Brown, Coordinator, Health Programs
(2) Ms. K. Evering, Research Officer

H. University of the West Indies, Kingston
(1) Professor Dorian Powell, Chairman, Sociology Department

III. BACKGROUND

With the exception of services provided by private physicians, the National Family Planning Board (NFPB) coordinates all family planning services in Jamaica, including clinic/hospital services, outreach programs, and the Commercial Distribution of Contraceptives (CDC) program.

When first constituted in 1967, the NFPB operated on an autonomous basis. However, after a reorganization in 1974 all Board Members named were Ministry of Health (MOH) officials, and the NFPB's activities became "integrated" within the MOH. This change resulted in several problems, including a lesser emphasis on non-MOH family planning activities. Therefore, under a recent change in policy, the NFPB has once again been made a more autonomous body.

For some years the NFPB has felt the need to develop a comprehensive national family planning service statistics system. Although the MOH has developed, in collaboration with the U.S. Bureau of Census, a computerized "Monthly Clinic Summary Report" (MCSR) data system, which gathers maternal-child/family planning service statistics from 385 MOH clinics (of which approximately 227 offer family planning services), the NFPB has concluded that the data provided by this system are inadequate for ongoing family planning program management and for long-term program evaluation and planning.

IV. SCOPE OF WORK

USAID/Jamaica and the NFPB are presently finalizing a new Population and Family Planning Services Project (532-0069), which will include a number of new subprojects providing for increased family planning service delivery outside the MOH, a new voluntary sterilization program, and an expansion of clinic and outreach services directed to adolescents. We were asked to provide technical assistance to the NFPB in the development of a comprehensive national family planning data system which would improve the present MCSR-provided service statistics. The new system would have to provide more useful service statistics, including sterilization and supply data as well as data from the new subprojects.

The writers accomplished these assigned tasks. Detailed discussions were held with personnel providing family planning services in different size clinics and outreach services, NFPB and MOH staff as well as fellow consultants from the U.S. Census Bureau. NFPB data needs were identified and detailed recommendations were made which are included in this report.

V. IDENTIFICATION OF NFPB DATA NEEDS

On the Monthly Clinic Summary Reporting Form (MCSR Form) shown in Figure 1, the MOH gathers family planning service statistics from approximately 227 of its own clinics as well as clinics of Operation Friendship and the Jamaica Family Planning Association. Data collected include:

(1) Total Number of New Acceptors by Method
(2) Total Number of Visits Made by Previous Acceptors by Method
(3) Total Number of New Acceptors Under Age 20
(4) Total Number of Mothers Who Become New Acceptors at Postnatal Visit
(5) Total Number of Family Planning Visits

The NFPB has identified a need for the following additional data.

(1) Ongoing standardized data from all NFPB-coordinated service providers, including more in-depth data from the 15 proposed family planning clinics the NFPB will directly manage in the 13 parish capitals and Kingston.

(2) An estimate of the current number of active contraceptors (contraceptive prevalence). A program goal of the NFPB is to increase the contraceptive prevalence of women presently in union from 58 percent to 70 percent by 1983.

(3) More detailed age-specific data on contraceptive users, particularly adolescents. This would include a breakdown by method.

(4) Annual data on the average age at first conception in order to estimate whether the program is meeting its objective of preventing unplanned adolescent fertility.

(5) Service statistics from outreach activities.

(6) Service statistics on male users.

(7) Sterilization reporting.

(8) Data on supplies distributed.

VI. RECOMMENDATIONS

A. General

Family Planning data should be collected in three separate ways:

(1) The MCSR System, which will provide improved routine service statistics based on a few simple suggested changes to be set forth in detail in section VI B of this report. A separate monthly family planning service statistics system apart from the MCSR is not recommended, since in the majority of smaller clinics where a small staff is responsible for all nine health services recordkeeping, it would represent a burdensome addition to paperwork, probably resulting in lower quality and/or less complete reporting.

(2) Annual records-search surveys for more detailed information not needed on a monthly basis using clinic records as a sampling frame. These surveys are to be conducted by the MOH Statistics Division with initial collaboration from the U.S. Bureau of Census. Funds are to be provided as part of the USAID Project.

(3) Contraceptive Prevalence Surveys (CPS) every 3-5 years. Funds for a CPS are also to be provided as part of the USAID Project. These surveys will be conducted by the sociology department of the University of the West Indies, who conducted the 1979 CPS.

B. MCSR-Service Statistics Recommendations

At the present time all family planning clinics, both MOH and others, keep track of clients on a standard client record form, which records medical information gathered at the time of a first visit on one side and line lists the details of subsequent visits on the reverse side. In collaboration with the U.S. Bureau of Census, the MOH is in the process of modifying these forms, although the basic format will remain as described above (this form will be described in Section IV C).

At the end of each clinic session, the client record forms are gathered in piles and separated by method into new and previous acceptors. The forms representing new acceptors under 20 are noted, and all forms are then counted. The information gathered is then entered on the Tally Sheet-Family Planning Services (Figure 2). At the end of each month the figures on the Tally Sheet are totalled, and these figures are then entered on the MCSR form (Figure 1), which is then sent to the MOH Statistics Division to be entered into its computer. All clinics also keep a daily chronological log book (register) which line lists basic information on all patients seen, including supplies distributed.

(1) At the suggestion of colleagues from the U.S. Bureau of Census who have been acting as consultants to the MCSR system, the most important change recommended is that Section 16 no longer record "Total Number of Visits Made by Previous Acceptors by Method." This section should instead record "Total Number of Units of Supplies Distributed to All Family Planning Program Acceptors by Method."

This change will serve three purposes:

(a) A working estimate can be made of contraceptive prevalence based on Couple-Years Protection (CYP) methodology, using standard annual quantities of each contraceptive method distributed. These quantities would be:

Pill--13 cycles
Injection--4
IUD--0.4 (an IUD is considered to remain in place 2.5 years)
Diaphragm--to be based on one unit of accompanying cream (Coramex) lasting 3 months, 4 units of cream per year.
Condoms--192 (16 per Month)
Spermicidals--8 tubes (of 20 tablets)

The data would be best used in any given month by taking a total of quantities distributed for the past 12 months and dividing this figure by the standard annual quantity distributed for each method. For example, for any given clinic, the data at the end of a given month could be:

Method	Amount Distributed Past 12 Months A	Standard Annual Distribution B	Working Estimate of Active Users (CYP) (A-B)
Pill	3,900 cycles	13	300
Injection	1,000 injections	4	250
IUD	40 units	0.4	100
Diaphragm	100 units of Coramex cream	4 units of Coramex cream	25
Condom	38,400 units	192	200
Spermicidal	800 tubes of 20 tablets	8 tubes of 20 tablets	100
TOTAL			975

(b) The second purpose is that accurate data on supplies distributed, by facility, would be available in order to more effectively manage the contraceptive supply and logistics system. The NFPB distributes contraceptives based on requisitions from the field. According to the NFPB Executive Secretary, these requisitions are frequently too large or too small, and clinic managers rarely furnish justification by entering on their requisition form the amounts of previous use of supplies and present stock.

(c) USAID/Jamaica would have more accurate estimates to complete its quarterly report to AID/Washington "Family Planning Services." This report requires data on "New Acceptors," "Prevalence of Use by Method" and "Flow of Contraceptives." USAID/Jamaica will also be able to more easily complete the annual Contraceptive Procurement Tables needed to order yearly supplies of contraceptives for Jamaica.

The MCSR System will continue to gather, as before, data on sterilization referrals, total family planning visits (for all methods), new acceptors by method, and the number of new acceptors under age 20.

(2) The second change recommended to the MCSR system is that in the future, it include data from all family planning service providers, both clinic and outreach, including the activities of the Ministry of Agriculture, the Ministry of Youth and Community Development, the Teen Scene Project, the Women's Centre Project, the YWCA, and any others who will distribute contraceptives. Furthermore, once the change is implemented to record supplies distributed, instead of visits by previous acceptors the quantity of supplies distributed by the Commercial Distribution of Contraceptives Program (CDC) can be included also. The data system would then provide a very comprehensive monthly working estimate of active users and supply use.

(3) A third recommended change to the MCSR form is that it henceforth record data on visits by male users in a separate category under Family Planning Visits-Section 1 (d). This category will be divided into two sub-sections: "Visits--Men" and "Visits--Women."

In order to implement the above changes, minor modifications must be made to the MCSR Form and the Tally Sheet. The changes necessary to the MCSR form, shown in Figure 3, are as follows:

(a) Since the MOH Statistics Division has decided that the information on "Sessions" in Section 1 "General Clinic Information" is to be eliminated because of problems of definition, category 1 (d), computer code 12, can become "Visits--Men" with space for three digits.

Categor 1(d), computer code 13, can become "Visits--Women" without changing the present four-digit space.

(b) In Section 4 15, Category (e) will become "Condoms" only. Category (f), "Sterilization (referral)," will become "Spermicidals." "Sterilization (referrals)" will be separated from New Acceptors, since sterilizaton referrals for both new and previous acceptors will now be totalled together.

A new category, 4-18 "Total No. of Sterilization Referrals" will therefore be created and placed on the MCSR form just to the right of Category 4-17, "Total No. of New Family Planning Acceptors Under Age 20."

(c) Section 4 16 will henceforth be "Total No. of Supplies Distributed to all Family Planning Program Acceptors by Method". In this section, category (e) will become "Condoms" only and category (b) "Sterilization (referrals)" will be changed to "Spermicidals." Category (g) "None" will be eliminated. Finally, in order to accomodate the large quantities of supplies presently distributed by large clinics and the CDC program (over 100,000 condoms per month), as well as allowing for future expansion, the number of computer coding boxes for codes 67-72 will be increased to six in each row in order to accomodate 6-digit numbers.

The necessary minor changes to the Tally Sheet for Family Planning Services are similar. They are shown in Figure 4, as follows:

(1) Columns 2 and 3 will be changed from "Sessions" and "Total Visits" to "Visits--Men" and "Visits--Women."

(2) Column 4e will become "Condoms" only and Column 4f will be changed to "Spermicidals." Since sterilization referrals for new and previous acceptors will now be totalled together, a new Column 7 "Total No. of Sterilization Referrals" will be placed at the extreme right-hand side of the page.

(3) Column 5 will be titled, "Total No. of Supplies Distributed to All Family Planning Program Acceptors by Method." Column 5e will become "Condoms" only and Column 5f will be changed to "Spermicidals." Column 5g will be eliminated.

Furthermore, in order to standardize definitions, the unit of supply to be counted will be printed directly under each method distributed. These are Pill (cycle), Injection (each person), IUD (units), Diaphragm (units of cream), Condon (units), and Spermicidal (tubes or jars). Condoms should not be counted by "strips" of four.

In order to implement these MCSR changes to the MCSR system, no modifications need be made to patient recordkeeping systems already in use as described earlier, since clinics and outreach programs already keep records on supply distribution.

A simple client record system for male users can easily be established. Male clients should be served by the clerk/receptionist near the door of a clinic. All that need be tallied on a daily basis using a simple form are the number of visits by men and the total amount of supplies distributed to them.

We were told that henceforth all proposed changes to the MCSR system will be discussed at an Annual Workshop in July or August for implementation the following calendar year. We recommend that the changes proposed in this report be discussed in depth at that time for implementation in 1983. Follow-up technical assistance could be made available at the proposed July/August 1982 Workshop.

C. Annual Records-Search

These surveys, using clinic records as a sampling frame, would be best handled by the MOH Statistics Division with initial technical assistance from the U.S. Bureau of Census and would provide data on all components of health services, including family planning. Budgetary provision for this type of survey has been made in the USAID project paper as part of "Interim Evaluations." The Statistics Division will implement these surveys using its own staff as well as those staff members working under its direction who are seconded from the NFPB. The MOH plans to employ a Mathematical Statistician (and four other staff members), who will be trained by the U.S. Bureau of Census to be specifically responsible for the methodology of these surveys. Professor Dorian Powell, Chairman, Sociology Department, University of the West Indies who has extensive survey experience, has indicated that she would be willing to provide technical advice and assistance in the design and implementation of these surveys.

We recommend that an additional statistician be hired with NFPB funds at the PMA-2 or MSA-1 level as an assistant to Mrs. Ellen Radlein, who can then concentrate on family planning statistics analysis. This new person, who should have a strong statistical background as well as Mrs. Radlein, should remain at the MOH Statistics Division as their principal work location in order to have the necessary ongoing access to other clerical and professional staff in the

Division. Their duties should be formalized with written job descriptions, which would delineate their responsibilities to the NFPB on one hand and the MOH on the other. We suggest that the formal job descriptions and responsibilities to the NFPB of these two persons be based on the following outline:

(1) Qualifications: University level training in statistics or related field with professional level job experience in statistics. Positions should be at PMA-2 or MSA-1 levels or higher.

(2) Responsibilities to NFPB

(a) Processing and analysis of MCSR data related to family planning activities.

(b) Development of family planning related information to be collected from annual patient records search surveys to be conducted by MOH Statistics Division; collaboration in development of sampling and data analysis plans of these surveys; provision of assistance in implementation of the surveys.

(c) Collaboration with Sociology Department, University of the West Indies (UWI), in development of information to be collected in contraceptive prevalence surveys to be conducted every 3-5 years. Provision of any technical assistance required by UWI in areas of sampling, data processing and data analysis when implementing CPS surveys.

(d) Implementation of any other small-scale research projects required by the NFPB, including population projections on a regular basis.

(3) Lines of Authority: Reporting should be through Mrs. Ellen Radlein to the Executive Director of the NFPB. At the same time, a close collaborative relationship must exist with the Director of the MOH Statistics Division which is where their office will be located.

The draft MOH medical records system being developed with the technical assistance of the U.S. Bureau of Census will be field-tested in April-May for implementation later in 1982. Based on this form the MOH Statistics Division will be able to organize annual records-search sample surveys to provide estimates of the following family planning data:

(a) Data on the number of New and Previous Acceptors specific for age, method, and parity. In particular, the NFPB Medical Director is interested in determining the number of women over 35 using the pill and the number of teenagers who have less than two living children who use Depo-Provera. This type of survey will provide a more accurate estimate of contraceptive prevalence by method than the MCSR system. On the other hand, it is doubtful if this type of survey will gather meaningful

data on male clients, since few Jamaican health professionals with whom we discussed this issue felt male contraceptors who were in a clinic only to obtain a contraceptive method would be willing to supply detailed medical record-type information on themselves.

(b) The average age of women at first conception. The goal of the NFPB would be to raise this age over time through family planning activities. An indicator for this variable can be gathered for the present year from records of women pregnant for the first time in the Antenatal, Delivery and Puerperal Record section of the medical form. The age of first birth for previous years can be gathered for women who have given birth in previous years from the pregnancy data section of the form.

Similar but simpler records-search surveys could be performed using the records of outreach activities conducted by the Ministry of Agriculture, the Ministry of Youth and Community Development, the YWCA, and others. To facilitate this, and for the purpose of standardizing more routine recordkeeping, it is suggested that those agencies who have not adopted a client record card be encouraged to adopt one similar to that shown in Figure 5. These could be filed in alphabetical order, by number or by date of next appointment if followup activities have been programmed.

Computerized Patient Flow Analysis studies could be carried out concurrently with record reviews to obtain supplemental clinic management information. CDC would be willing to collaborate in this effort as has been done in Brazil, El Salvador, Mexico, and Kenya. Information on Patient Flow Analysis has been forwarded to USAID/Jamaica.

D. Contraceptive Prevalence Surveys

Since many categories of family planning-related data do not change rapidly from year to year and/or are difficult or impossible to gather as part of routine service, statistics, or annual records search surveys, they are best gathered in Contraceptive Prevalence Surveys (CPS) conducted every 3-5 years. Program evaluation variables included in the CPS would include population-based estimates of contraceptive prevalence, data on source of contraception and planning status of pregnancies as well as an estimate of the number of women "in need" of family planning services. Detailed data on non-users would be collected including reasons for non-use, knowledge of availability of services, and method preference for those couples wanting to use contraception.

The expertise for conducting this type of survey already exists in Jamaica, since a CPS was successfully conducted by the Sociology Department of the University of the West Indies in 1979. For a second CPS in the USAID Project Paper, $100,000 has been budgeted for 1983. Professor Dorian Powell, the Chairman of the Sociology Department, informed us that she would welcome CDC assistance in developing the sampling design and questionnaire content of the survey. A CDC consultant can be made available in late 1982.

E. Service Statistics for 15 NFPB Model Clinics

The NFPB is planning to establish 15 model clinics in 13 parish capitals and the Kingston urban area. These clinics will engage exclusively in family planning activities. The NFPB feels they should serve as model clinics for the delivery of family planning services.

In general, these clinics should use the same system for clinical record-keeping and monthly reporting as described earlier for MOH clinics. Monthly services statistics should be tallied and reported on the MCSR forms described in part IV B. Client medical records should be kept on the form designed by the MOH in collaboration with the U.S. Bureau of Census. However, since the NFPB clinics will engage exclusively in family planning activities, we suggest that the portions of these forms relevant to family planning be printed separately on two pages, front and back, for NFPB clinic use. This will include the two page "Family Planning Record," the "Females Past Puberty" section, the "Pregnancy Data" section, and the relevant parts of the "Individual Health Profile" as designated by Dr. MacDonald (see Figures 6a-6c). Retaining the same format of the MOH records will permit integration of NFPB clinic data with MOH clinic data for monthly reports and annual record surveys. It has generally been agreed that this detailed record system should be used for female clients only and that service statistics for males be handled as described in section IVB of this report.

At present most MOH clinics do not have sufficient staff and/or a record-keeping system which would permit active followup of family planning clients who discontinue use. We feel that an important service which the NFPB clinics should provide is establishing a scheme within the 15 model clinics for active followup of clients. This system would serve as a prototype for other MOH clinics to follow when followup activities are established. The NFPB clinics could, in fact, extend the system in the near future to assist nearby MOH clinics in following up their family planning clients.

The followup system we propose is manual and will not change any existing clinical or recordkeeping procedures. Individual sociodemographic information, the client's medical history, and a record of all subsequent visits will be recorded on the clinic medical record as described above. The record will then be filed in a horizontal position in an open file box according to the month of the next clinic appointment. There will be file dividers between each month (see Figure 7). At the end of each month, a count will be made by method of the records of all clients in succeeding months whose next appointment has not yet fallen due. These clients will be considered "active;" that is, they have a contraceptive method in their possession, are presumably using it, and have an appointment for a subsequent visit. These records will be filed by the month of the next visit in the front part of the box behind a large separator labeled "ACTIVE."

At the same time, a count will be made of all records remaining in the file under the month which has just ended. These are women who have not kept their scheduled appointment during the previous month and are now considered to "NEED FOLLOWUP," for program purposes, since they have presumably run out of their supply of contraceptives (not strictly true for IUD clients). These

records will be removed and placed in the rear part of the same file box by month of missed visit, behind a large divider labled "NEED FOLLOWUP." These clients can then be followed up by means of home visits to ascertain the reason for their failure to return to the clinic. At that time, they could be motivated to resume contraceptive use. Once followup activities are begun, additional forms to monitor these activities can be designed.

As a special case, women who are found to be pregnant at the time of a kept appointment will be referred to a MOH clinic for antenatal care and given an appointment to return in the month when the birth is due. Their record will be kept in the active file under the month of this appointment. Although this will overstate the number of active clients, it will facilitate postpartum followup. If it is learned that the client has permanently transferred to another clinic, died, become menopausal, or been sterilized, the card will be permanently removed from the active file.

The division between active and inactive clients will have two purposes: (1) to provide an accurate estimate of the number of active users, and (2) to count and identify those clients who have discontinued use and are in need of followup. It could also be used as a basis to estimate a ratio of continuing to discontinue clients.

We recommend that each clinic hire a clerk/receptionist to handle all record-keeping and management of the followup system. As described earlier this person would also be responsible for distribution of contraceptives to males.

We feel the most important activity clinic staff should be doing, in addition to delivering the standard family planning clinic services, is developing and executing the system for client followup. However, if more frequent or detailed service statistics are felt desirable or necessary by the NFPB, the clerk/receptionist and other available clinic staff could compile such data by doing record surveys more often than once per year, e.g., quarterly or semi-annually. This type of simple records survey should be designed by NFPB statistical staff.

F. Sterilization Data

1. Background

At present, there is no standardized reporting of sterilization data to NFPB or the MOH. Some data have been collected by Mrs. Radlein at the MOH through telephone surveys of hospitals performing surgical contraception. In addition, the NFPB has required certan kinds of information on clients sterilized under the institutional reimbursement program. According to the Ministry of Health, a total of 2,805 female sterilizations were performed in public hospitals in 1980. Shown in Table 1 are 11 hospitals with data available for both 1980 and 1981. In 1980 these have accounted for 65 percent of all sterilizations. Assuming that sterilizations done at these hospitals represent the same proportion of all sterilizations the following year, we estimate that about 3,200 female sterilizations were performed in public hospitals in 1981. (It is not known how many sterilizations were done by the private sector.) From conversations with the NFPB Medical Director, we estimate that 20-25 percent of these procedures were laparoscopic using either

silastic bands or electrocaudery, and 10 percent were done via minilaparotomy. These procedures were done at the larger institutions which performed 300 or more sterilizations per year. The remainder, representing the majority of sterilizations done in Jamaica, were postpartum tubal ligations done via laparotomy.

TABLE 1

Number of Female Sterilizations Performed
At Selected Public Hospitals by Year
Jamaica, 1980-1981

Hospital	1980[1]	1981[2]
Victoria Jubilee	116	250
Glen Vincent	261	310
University	645	715
Princess Margaret	120	156*
Port Antonio	111	107
Nod Holmes	35	35
Savanna-La-Mar	20	41
May Pen	23	89
Lionel Town	39	63
Spanish Town	390	337**
Linstead	54	11
Total	1,814	2,114

[1]Source: Statistics Division, Ministry of Health
[2]Source: National Family Planning Board
*Estimate based on 9 months of reporting
**Hospital-supplied data

However, these data are inadequate to meet the program evaluation and planning needs of the NFPB. In addition, they are inadequate to meet the sterilization reporting requirements under a proposed Association for Voluntary Sterilizaton (AVS) grant to expand sterilization activities to 22 medical facilities in Jamaica. The AVS grant requires the following data:

(a) Numbers of sterilization procedures by timing, approach, and method of sterilization.

(b) Numbers of major complications.

(c) Numbers of sterilizations refused for medical or other reasons.

(d) Numbers of sterilizations which were not completed.

(e) Numbers of sterilizations by age and parity of client.

(f) Detailed case reports of sterilization complications.

In addition to the above, Dr. Olivia MacDonald, NFPB Medical Director, identified the need for the following information for program evaluation and planning:

(a) More detailed clinical data, past medical history, physical examination, and laboratory data.

(b) Type of facility performing sterilization.

(c) Medical staff performing procedures (e.g. surgeon, nurse, anesthesiologist, anesthetist).

(d) Client counseling, operative and post-operative.

Dr. MacDonald and Mrs. Radlein also identified the following operational problems:

(a) Data from hospital charts and medical records are not readily available to medical staff for summary reporting and are difficult to tabulate.

(b) Data reported to the NFPB reimbursement system is not easily accessible to the statistical staff who are located in a separate MOH office.

2. Recommendations

(1) A standardized NFPB Sterilization Patient Record, Form ST-1 (see Figure 8), should be used to record clinical data on each patient and should be a permanent part of the patient's chart. In general, this form will be filled out by the physician(s) responsible for doing the sterilization. This document will be the basic instrument for data collection and will be used to complete monthly reports as well as permit annual record surveys. If Item F is positive, then a complication report is also completed (see Paragraph 2.(4) below).

(2) In place of the monthly summary presently being submitted to the NFPB, a NFPB Monthly Sterilization Report, Form ST-2 (see Figure 9) listing individual sterilizations, would be filled out along with two carbon copies. This form can be filled out on a daily or monthly basis by a clerk or other trained person using the data taken directly from Form ST-1. A copy would be retained in the records of the hospital and two copies would be sent to the NFPB, who will forward one copy to the Accounts Department for reimbursement and one copy to the MOH Statistics Division. Mr. Osmond Gordon of the Statistics Division has suggested that this data could be keypunched into a computer, and tabulations could be reported at monthly, quarterly, and/or yearly intervals.

(3) The AVS requires grantees to complete a quarterly AVS statistical report for female acceptors, SF-1 (Figure 10) and a similar report for male acceptors, SM-1.

Instead of preparing SF-1 and SM-1 by hand at the hospital or the NFPB, MOH Statistical Services should produce a tabulation in a comparable format using a simple computer program. A copy of this report should be forwarded to AVS on a quarterly basis.

(4) Complications resulting from sterilizations should be noted on the NFPB sterilization patient record (Form ST-1). In addition, a detailed AVS complication report (Form C, Figures 11a and 11b) will be filled out by NFPB medical staff when they investigate the case.

(5) The following additions to Form C are suggested (see figure 11a):

(a) The patient number from ST-1 should be entered to allow complications information to be linked by hand or computer with information on the monthly report (ST-2).

(b) Under question 10 regarding type of anesthesia, a question to be numbered 10b regarding the level of training of the person administering the anesthesia should be added. Question 10 will be renumbered 10a.

(c) It is further recommended that the NFPB sterilizaton record and the NFPB monthly sterilization report (Figures 8 and 9) be field-tested in the three facilities in Kingston which will be performing sterilizations. Dr. MacDonald and Osmond Gordon, or their representatives, should meet to make any final modifications to the system prior to full implementation. It is also recommended that prior to full implementation, Dr. MacDonald write out directions for surgeons and other medical staff on how to fill out these report forms. This could be presented during visits to the medical facilities or at brief meetings at NFPB headquarters. If the NFPB feels it necessary, Dr. Liang will be happy to assist with field testing and/or instructing of hospital staff on the report forms.

VII. OTHER ACTIVITIES--VISIT TO OPERATION FRIENDSHIP

We visited Operation Friendship (OF) to discuss the implementation of the recordkeeping and service statistics system designed for that organization in January 1981. (See Friedman CDC/AID RSSA reports of April 5, 1981 and July 1, 1981.) The system has been successfully implemented, and the statistics generated have been permitted an evaluation by the OF Research Officer. The following is a summary of her report:

Within the clinic setting the pill is the most popular method followed by injectables (Depo Provera) (Table 2).

TABLE 2
Number of New Acceptors,
Operation Friendship Family Planning Clinic,
by Age and Method

Age Group in Years	Total	Total Family Planning Methods			
		Pill	Injectables	IUD	Spermicides Condom
Total	722	299	200	4	219
10-14	160	30	1	0	129
15-19	269	168	65	4	32
Adults (20 & over)	293	101	134	0	58

Because of the problems in obtaining age, parity, and addresses from male clients in the outreach program, spermicidals and condom distribution in the outreach program is not included in the table shown above.. Other records show that there were 9,726 female clients using spermicidals and/or condoms. In addition, 7,066 male clients were using condoms in the outreach program.

In Table 3 the data in Table 2 is broken down by parity.

TABLE 3
Number of New Acceptors of Family Planning
Clinic by Age, Method, and Parity
A. Parity 0

Age Groups (Years)	Total	Pill	Depo-Provera	IUD	Spermicides and/or Condom
Total	79	50	1	1	27
10-14	20	8	1	0	11
15-19	48	38	0	1	9
Adults	11	4	0	0	7

B. Parity 1-2

Age Group (Years)	Total	Pill	Depo-Provera	IUD	Spermicides and/or Condom
Total	458	148	119	3	188
10-14	140	22	0	0	118
15-19	142	75	44	3	20
Adults	176	51	75	0	50

C. Parity 3 and Over

Age Groups	Total	Pill	Depo-Provera	IUD	Spermicides and/or Condom
Total	185	101	80	0	4
10-14	0	0	0	0	0
15-19	79	55	21	0	3
Adults	106	46	59	0	1

At parity 0, the pill is the most popular method within the clinic setting, followed by spermicides and/or condoms.

For those women with parity 1-2, the spermicides and/or condoms are definitely the most popular method followed by the pill. Clinic personnel feel that spermicidal cream in the 10-14 group is favored because of the erratic nature of their sexual activity and the need for discretion in any method chosen, both in terms of their parents and consorts discovering the method. The 15-19 age group with this parity prefer the pill, and injectables (Depo-Provera) is the most used adult option. There were no adolescents in the 10-14 age group with parity 3 and over. In this group

the pill was most popular, and injectables again was preferred by adults with parity 3 and over. There were no acceptors of the intra-uterine device in the parity 3 and over for all age groups. It is reported that many persons in the area believe that this contraceptive initiates or at least perpetuates pelvic inflamatory disease.

This information was gathered from a more detailed OF report. It is encouraging to see that OF is using the data system set up in collaboration with CDC in January 1981.

Jay S. Friedman, M.A.

Arthur P. Liang, M.D.

FIGURE 1

MINISTRY OF HEALTH AND ENVIRONMENTAL CONTROL
MONTHLY CLINIC SUMMARY REPORTING FORM

(Please print, press down on copy and write numbers legibly)

Parish .....

Health Centre .....

Report for Month/Year .....

(1) Parish (2) H.C

(3) Month (4) Year

GENERAL CLINIC INFORMATION

1 Total No. of H.C. Sessions held and visits made by patients, by type of Service Offered

		Sessions	Visits		Sessions	Visits
(a)	Antenatal			(d) Family Planning		
(b)	Postnatal			(e) Multi-Purpose		
(c)	Child Health					

2 Home Visits (a) No. of Babies Weighed ..... (b) No. of Deliveries ..... (c) No. of Puerperal Examinations .....

ANTENATAL

3 Total No. of Women *Receiving* Antenatal Services at Health Centre for the *First Time* this Pregnancy by Length of Pregnancy

(a) Less than 16 weeks .....

(b) 16-28 weeks .....

(c) More than 28 weeks .....

4 Total No. of Pregnant Women (New & Old Patients) *Completely Immunized* or Detected to be *Completely Immunized* against *Tetanus* this month .....

5 Total No. of Pregnant *First Visit* Patients who before becoming Pregnant were using *Family Planning Methods* by reason for discontinuing use of methods

(a) Planned Birth .....

(b) Method Failure .....

(c) Method Misuse .....

(d) Method Dissatisfaction .....

(e) Supplies not Available .....

(f) Dissatisfaction with F.P. Services .....

(g) Social Pressure .....

(h) Other .....

POSTNATAL

6 Total No. of Postnatal Examinations *Performed* at Health Centre on:

(a) Mothers .....

(b) Babies .....

7 Total No. of Mothers/Babies *Referred to Base Hospital/Maternity Practitioner* due to complications

(a) Mothers .....

(b) Babies .....

8 Total No. of Deliveries by Place of Delivery (regardless of Outcome)

(a) Hospital .....

(b) R.M.C. .....

(c) Home (Midwife) .....

(d) Nursing Home .....

(e) Other .....

9 Total No. of Mothers who became *New Family Planning Programme Acceptors* at Postnatal visit .....

10 Total No. of *Babies being fully breastfed* .....

CHILD HEALTH

11 Total No. of Children *Receiving Child Health Services* at Health Centre for the *First Time* by age

(a) Under 6 months .....

(b) 6 months - 2 years .....

(c) Over 2 years .....

12 Total No. of children *Receiving Child Health Services* at Health Centre *Detected* to be in

(a) Gomez Normal & Above Normal .....

(b) Gomez I .....

(c) Gomez II .....

(d) Gomez III .....

13 Total No. of Visits by Children with

(a) Measles .....

(b) Gastroenteritis .....

(c) Respiratory Tract Infection .....

(d) Skin Infection .....

14 Total No. of Children *Completing Immunization* Series this month by Age and Vaccine

		1 Yr. & Under	Over 1 Yr.
(a)	BCG		
(b)	DPT		
(c)	Measles		
(d)	Polio		

FAMILY PLANNING

15 Total No. of *New Family Planning Programme Acceptors* by Method

(a) Pill .....

(b) Injection .....

(c) IUD .....

(d) Diaphragm .....

(e) Condom/Spermicides .....

(f) Sterilization (referral) .....

16 Total No. of visits made by *Previous Family Planning Programme Acceptors* by Method after visit

(a) Pill .....

(b) Injection .....

(c) IUD .....

(d) Diaphragm .....

(e) Condom/Spermicides .....

(f) Sterilization (referral) .....

(g) None .....

17 Total No. of *New Family Planning Programme Acceptors, Under Age 20* .....

Comments (include supervisory/technical support desired and/or supplies required) .....

Corrective Action taken (Please give details) .....

Completed by: ..... Status: .....

Date Completed ..... Date Mailed .....

Received by –

Parish ..... Date .....

MOHEC/Statistics ..... Date .....

NOTE: Form to be completed in triplicate (original sent to MOHEC/STATISTICS, first copy to parish and second copy for clinic records)

FIGURE 2

TALLY SHEET – FAMILY PLANNING SERVICES

MONTH OF: .....

HEALTH CENTRE: .....

PARISH: .....

1	2	3	4						5							6
Day of Month	Sessions	Total Visits	Total No. of *New* Family Planning Programme *Acceptors* by Method.						Total No. of Visits made by *Previous* Family Planning Programme *Acceptors* by Method *after* visit							Total No of *New* Family Planning Programme *Acceptors Under Age 20*
			a Pill	b Injection	c IUD	d Diaphragm	e Condom/ Spermicidal	f Sterilization Referrals	a Pill	b Injection	c IUD	d Diaphragm	e Condom/	f Sterilization Referrals	#	
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2																
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27																
28																
29																
30																
31																
TOTAL																

FIGURE 3

MINISTRY OF HEALTH AND ENVIRONMENTAL CONTROL

MONTHLY CLINIC SUMMARY REPORTING FORM

(Please print, press down on copy and write numbers legibly)

Parish .....

Health Centre: .....

Report for Month/Year: .....

(1) Parish (2) H C

(3) Month (4) Year

GENERAL CLINIC INFORMATION

1 Total No of H C Sessions held and visits made by patients, by type of Service Offered

		Sessions	Visits		Visits-male	Visits - female
(a)	Antenatal			(d) Family Planning		
(b)	Postnatal			(e) Multi-Purpose		
(c)	Child Health					

2 Home Visits (a) No of Babies Weighed (b) No of Deliveries (c) No of Puerperal Examinations

ANTENATAL

3 Total No of Women *Receiving* Antenatal Services at Health Centre for the *First Time* this Pregnancy by Length of Pregnancy

(a) Less than 16 weeks

(b) 16 28 weeks

(c) More than 28 weeks

4 Total No of Pregnant Women (New & Old Patients) *Completely Immunized* or Detected to be *Completely Immunized* against *Tetanus* this month

5 Total No of Pregnant *First Visit* Patients who before becoming Pregnant were using *Family Planning Methods* by reason for discontinuing use of methods

(a)	Planned Birth	23
(b)	Method Failure	24
(c)	Method Misuse	25
(d)	Method Dissatisfaction	26
(e)	Supplies not Available	27
(f)	Dissatisfaction with F P Services	28
(g)	Social Pressure	29
(h)	Other	30

POSTNATAL

6 Total No of Postnatal *Examinations Performed* at Health Centre on

(a)	Mothers	31
(b)	Babies	32

7 Total No of Mothers/Babies *Referred to Doctor/Hospital/Nurse Practitioner* due to Complications

(a)	Mothers	33
(b)	Babies	34

8 Total No of Deliveries by Place of Delivery (regardless of outcome)

(a)	Hospital	35
(b)	R M C	36
(c)	Home (Midwife)	37
(d)	Nursing Home	38
(e)	Other	39

9 Total No of Mothers who became *New* Family Planning Programme *Acceptors* at Postnatal visit 40

10 Total No of *Babies* being *fully* breastfed 41

CHILD HEALTH

11 Total No of Children *Receiving* Child Health Services at Health Centre for the *First Time* by age

(a)	Under 6 months	42
(b)	6 months - 2 years	43
(c)	Over 2 years	44

12 Total No of children *Receiving* Child Health Services at Health Centre *Detected* to be in

(a)	Games Normal & Above Normal	45
(b)	Games I	46
(c)	Games II	47
(d)	Games III	48

13 Total No of *Visits* by Children with

(a)	Measles	49
(b)	Gastroenteritis	50
(c)	Respiratory Tract Infection	51
(d)	Skin Infection	52

14 Total No of Children *Completing Immunization* Series *this month* by Age and Vaccine

		1 Yr & Under	Over 1 Yr
(a)	BCG	53	54
(b)	DPT	55	56
(c)	Measles	57	58
(d)	Polio	59	60

FAMILY PLANNING

15 Total No of *New* Family Planning Programme *Acceptors* by Method

(a)	Pill	61
(b)	Injection	62
(c)	IUD	63
(d)	Diaphragm	64
(e)	Condom	65
(f)	Spermicidals	66

16 Total No of Supplies Distributed to All Family planning Programme Acceptors by Method:

(a)	Pill	67
(b)	Injection	68
(c)	IUD	69
(d)	Diaphragm	70
(e)	Condom	71
(f)	Spermicidals	72

17 Total No of *New* Family Planning Programme *Acceptors Under Age 20* 74

18. Total No. of Sterilization Referrals

Comments (include supervisory/technical support desired and/or supplies required) .....

Corrective Action taken (Please give details) .....

Completed by: ..... Status: .....

Date Completed: ..... Date Mailed: .....

Received by -

Parish: ..... Date: .....

MOHEC/Statistics: ..... Date: .....

NOTE: Form to be completed in triplicate (original sent to MOHEC/STATISTICS, first copy to parish and second copy for clinic records).

FIGURE 4

TALLY SHEET – FAMILY PLANNING SERVICES

MONTH OF .....

HEALTH CENTRE .....

PARISH .....

1	2	3	4						5						6	7
Day of Month	Total Visits MEN	Total Visits WOMEN	Total No of New Family Planning Programme *Acceptors* by Method						Total No. of Supplies Distributed to All Family Planning Programme Acceptors by Method:						Total No. of New Family Planning Programme Acceptors Under Age 20	Sterilisation Referrals
			a Pill	b Injection	c IUD	d Diaphragm	e Condom	f Spermicidal	a Pill Cycles	b Injection Each Period	c IUD Units	d Diaphragm Units	e Condom Units	f Spermicidal Units		
1																
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30																
31																
TOTAL																

FIGURE 5

FAMILY PLANNING NON-CLINIC CLIENT CARD NO._____

NAME_____ADDRESS_____

AGE:_____ Today's Date:_____Date of Birth:_____

PREGNANCIES_____ABORTIONS_____STILLBIRTHS_____DECEASED CHILDREN____LIVING CHILDREN____

VISITS

DATE	UNITS SUPPLIED	Method	B.P.	DATE L.M.P.	Weight	REMARKS	DATE OF NEXT APPT.

FIGURE 6a

INDIVIDUAL HEALTH PROFILE

Health Record number _____

Health Centre _____

Surname	Middle	Middle
Pet name	Maiden names	Telephone

Sex (tick one)	Age
1. Male	1. years
2. Female	2. months
	3. days

Home Address Landmark

Date of Birth

day month year

Blood Group	Drug allergies
Sicle cell	

Union Status
1 single
2 common law
3 married
4 separated
5 divorced
6 widowed

Socioeconomic Data
Occupation of Individual
Parent

Is this person presently employed?
1 No
2 Yes

Can this person read?
1 No
2 Yes

FEMALES PAST PUBERTY

Are you using a method of contraception No Yes
If yes specify How long
Oral contraceptives _____
IUD
barria methods (condom) _____
(diaphragm) _____
Spermicides (foam cream) _____
(jelly etc.) _____
Injection
Other (specify) _____ _____
Unknown

Reasons for Change?

ASK FOR BOTH MALE and FEMAL CLIENTS

How did you find out about our Family Planning services?
1 Mass Media 4 Relative
2 Councelling 5 Nurse/Doctor
3 Friend 6 Other

Total no. of Children living _____
If 3 or more discuss availability of Surgical Contraception

FAMILY HISTORY (tick which is applicable)

NO	YES	
1	2	Asthma
1	2	Cancer
1	2	Diabetes
1	2	Epilepsy
1	2	Heart Disease
1	2	High Blood Pressure
1	2	Stroke
1	2	Mental illness
1	2	Other (specify)

_____

INDIVIDUAL HISTORY (first visit)

NO	YES	
1	2	Asthma
1	2	Cancer
1	2	Diabetes
1	2	Epilepsy
1	2	Heart Disease
1	2	High Blood Pressure
1	2	Stroke
1	2	Embolism
1	2	Mental Illness
1	2	Monilia
1	2	Trichomonas
1	2	Gonorrhoea
1	2	Syphilis
1	2	Jaundice
1	2	Other (specify)

PREGNANCY DATA

Total No. of Pregnancies no. Live Births no. Stillbirths no. Abortion no. Now Alive no. Dead

PREGNANCY DATA

Total No. of Pregnancies	Live Births	Stillbirths	Abortions	Now Alive	Dead	Date last preg. Terminated day month year

FEMALE PHYSICAL EXAMINATIONS AND LABORATORY INVESTIGATIONS
(Record Weight, Blood Pressure and L M P on Reverse Side)

Date of Exam	Breast	Vagina	Cervix	Varicosity	Papsmear	Urine	DP	Wt.	Initials
1 day mth yr									
2 day mth yr									
3 day mth yr									
4 day mth yr									
5 day mth yr									

Name of Health worker completing this form

FIGURE 6b

FAMILY PLANNING VISITS RECORD
(Make Sure That The Reverse Side is Complete)

Year_____ Date of Visit Day	Month	Method Coming in to Clinic	Weight in lbs.	Blood Pressure	Last Menstrual Period Day	Month	Method When Leaving	Units Dispensed	Reasons for Change of Method Problems, etc.	Date of Next Appointment Day	Month

FIGURE 7

FOLLOWUP SYSTEM
MONTHLY SEPARATORS FOR CLIENT FILES

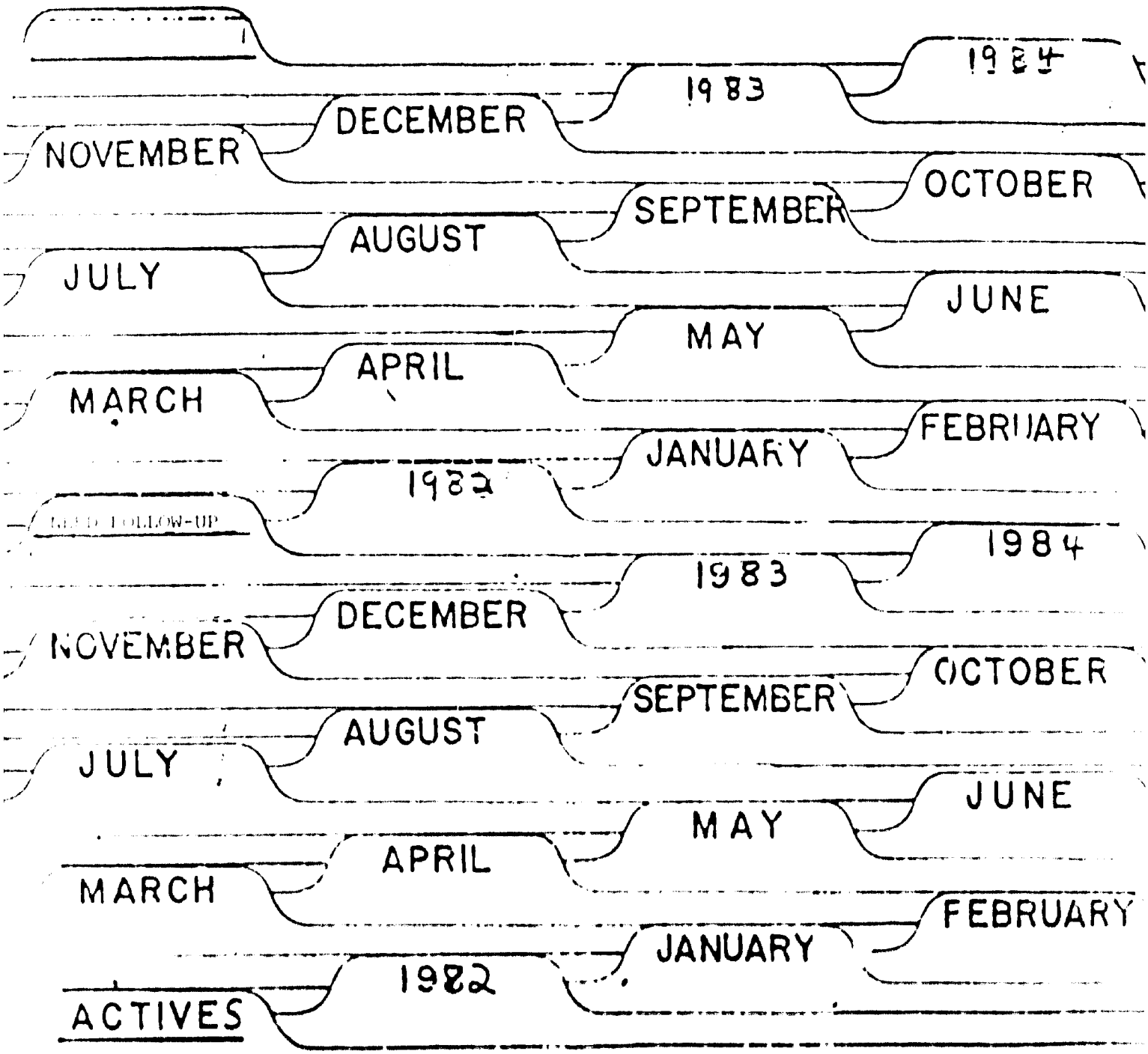

FIGURE 8

FORM ST-1 NFPB STERILIZATION PATIENT RECORD

NAME_____ ADDRESS_____

PATIENT NUMBER_____ NEXT OF KIN_____

AGE IN YEARS_____

TOTAL NUMBER OF PREGNANCIES_____

NUMBER OF LIVING CHILDREN_____

WAS PATIENT COUNSELLED? ( )

PRE-OP_____

POST-OP_____

NONE_____

PREVIOUS MEDICAL HISTORY

CONVULSIVE DISORDERS_____

ASTHMA_____

HEART DISEASE_____

DIABETES_____

HYPERTENSION_____

OTHER (specify)_____

PHYSICAL EXAMINATION

BREAST_____

HEART_____

LUNGS_____

PELVIC EXAM_____

_____

OTHER (specify)_____

LAB TESTS

NONE

HAEMOGLOBIN_____

URINE ANALYSIS: SUGAR_____PROTEIN_____

OUTPATIENT_____( )

INPATIENT (number of days)_____

A. Previous Method(s) of Contraception Ever Used
Circle number that applies.

1 None
2 Oral contraceptives
3 IUD
4 Barrier methods (condoms, diaphragm)
5 Germicides (foams, cream, jelly, etc.)
6 Injection
7 Other (specify in comments column)
8 More than one (specify in comments column)
9 Unknown

B. Timing of the Sterilization

1 Post partum (within 1 week)
2 With cesarean section
3 Post abortion (within 1 week)
4 Interval (not preg-assoc)
5 Operation not performed due to medical contra-indications
6 Unknown

C. Approach

1 Laparotomy
2 Minilaparotomy (incision 5 cm. or less interval or post-pregnancy)
3 Laparoscopy
4 Vaginal (colpotomy or culdoscopy)
5 Other (specify in comments)
6 N/A (vasectomy)
7 Unknown

D. Method of Tubal Sterilization

1 Electrocoagulation (specify unicolor, bipolar in comments)
2 Fallope ring
3 Clip
4 Pomeroy, fimbriostony, salpingectomy, or other surgical tubal occulsion
5 Other (specify in comments)
6 Operation not completed
7 Unknown

E. Anesthesia

1 General
2 Regional (spinal, epedural caudal)
3 Local
4 Unknown

F. Complications

NO_____ Circle appropriate number
YES_____ fill out complication report form C and forward to NFPB

1 anesthetic complication
2 bladder injury
3 bowel injury
4 uterine perforation
5 accidental burn
6 hemorrhage
7 infection
8 other

G. Names of Operators

1 Surgeon_____
2 Anesthetist_____
3 Nurse_____

FIGURE 9

Form ST-2

NATIONAL FAMILY PLANNING BOARD

Monthly Report of Sterilization (Male & Female) Procedures Performed

Medical Facility: _____ ☐☐

Type of facility:

1__ Hospital

2__ Non-hospital clinic

3__ Other, specify _____ ☐

Does this facility have: Emergency ventilation equipment 1 No 2 Yes ☐

Blood transfusion facilities 1 no 2 yes ☐

Facilities for surgical management of operative complications 1 no 2 yes ☐

Date Day/Mth/Yr	Patient Name	Patient Number	Patient Age (yrs)	SEX M=1 F=2	Total # of Pregs	No. of Living Children	Clinical Information (Use Codes from back) A	B	C	D	E	F	G	Names of Operators Surgeon	Anesthetist	Nurses
/ /																
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FIGURE 10

Date _____

Sub-Grant No. _____

STATISTICAL REPORT FOR FEMALE ACCEPTORS

NAME AND ADDRESS OF INSTITUTION WHERE SERVICE TOOK PLACE: _____

_____

Note: A separate Statistical Report must be completed for every place providing female sterilizations during the reporting period.

Reporting Period: From _____ **19**____ **to** _____ **19**____

1. In the space provided, indicate the number of female sterilizations performed during the reporting period according to type of surgical procedure, if it was done post-partum, and if it was a ring procedure.

	Falope	Non-Falope Ring
Mini-Laparotomy (Post-partum)	_____	_____
Mini-Laparotomy (Interval)	_____	_____
Laparotomy (Post-partum)	_____	_____
Laparotomy (Interval)	_____	_____
Colpotomy	_____	_____
Culdoscopy	_____	_____
Laparoscopy	_____	_____
Other: _____ (Please specify)	_____	_____
Totals:	_____	_____

Grand Total: _____

2. How many major complications were there during this reporting period?* _____

3. During this reporting period, approximately how many women were refused a sterilization procedure for either health or other reasons? _____

4. During this reporting period, how many sterilization procedures were attempted but for some reason could not be completed? _____

5. In the boxes below indicate the number of female sterilizations performed during the reporting period according to the age and number of living children of the acceptors.

AGE OF FEMALE PATIENTS

NUMBER OF LIVING CHILDREN	24 or less	25-29	30-34	35-39	40 or more	Unknown	Total
0							
1							
2							
3							
4							
5							
6 +							
Unknown							
Total							

*A Complication Report (Form C-1) must be completed separately for every patient who experienced a major complication.

FORM SF 1
11/78

FIGURE 11a

PATIENT NUMBER: _____ Date _____

Sub-Grant No. _____

COMPLICATION REPORT

Major Complications of Voluntary Sterilization Procedures

A major complication is defined as any problem occurring during or after surgery necessitating surgical intervention, hospitalization, or medical treatment that is above and beyond that normally provided in conjunction with a sterilization procedure. Pregnancies following surgical sterilization are also considered major complications. This form should be completed by the Project Director.

1. Date of sterilization: _____

2. Date when complication occurred: _____

3. Date of complete recovery: _____

4. Age of patient: _____

5. Sex of patient: _____

6. Number of living children: _____

7. (For women only)

Total number of pregnancies _____

Total number of abortions _____

Number of children ever born _____

Please indicate your answer by checking (✓) the appropriate response

8a. By whom was the sterilization procedure performed? ( ) Staff Physician ( ) Trainee

8b. What was the qualification of the person performing the sterilization procedure?

( ) General Practitioner ( ) Ob/Gyn ( ) Surgeon ( ) Other: (Specify)_____

9. Please specify with a check mark (✓) the type of procedure performed.

( ) Laparoscopy ( ) Colpotomy ( ) Culdoscopy

( ) Mini-Laparotomy—interval ( ) Mini-Laparotomy—post-partum ( ) Laparotomy—interval

( ) Vasectomy

10. What type of anesthesia did you use? ( ) Local ( ) Regional ( ) General

10. b. Anesthetist: Anesthesiologist ( ) M.D. ( ) Nurse ( )

11. What type of complications did you have? (Please check *all* relevant answers).

A. Complications related to Anesthesia

( ) Respiratory arrest/depression

( ) Cardiac arrest

( ) Convulsions

( ) Other: (specify) _____

B. Unintended Trauma

( ) Injury to bladder

( ) Injury to bowel

( ) Uterine perforation

( ) Electrocoagulation of any organ other than the fallopian tubes

Other: (specify)_____

→

FIGURE 11b

COMPLICATION REPORT (*Continued*)

C.(1) Hemorrhage

( ) Epigastric vessels
( ) Fallopian tubes
( ) Hematoma (requiring hospitalization)
( ) Other: (specify)_____

C.(2) Did the patient receive blood transfusion?

Yes ( ) No ( )

D. Infection

( ) Wound abcess
( ) Wound disruption
( ) Epididymitis or epididymo-orchitis requiring hospitalization
( ) Other: (specify) _____

E. Pregnancy

( ) Intrauterine ( ) Ectopic

F. Other complications not mentioned above

(specify)_____

12. Was the patient hospitalized? No ( ) Yes ( ) If yes, for how long? _____

13. Please describe the type of treatment administered. _____

_____

_____

14. What was the final outcome of the complication?

( ) Patient completely recovered with no permanent physiological damage.
( ) Patient recovered but with permanent physiological damage.
( ) Patient died. (Please provide a *detailed* report of exactly what happened, *in addition* to this form).

_____

(Signature of Project Director)

FORM C-2
11/78