

PN-ABN-699
ISN 81645

**SEVENTH DAY ADVENTIST RURAL
HEALTH SERVICES MIS ASSESSMENT**

MAY, 1992

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FAMILY PLANNING MANAGEMENT DEVELOPMENT

**Project No.: 936-3055
Contract No.: DPE-3055-Q-00-0052-00
Task Order No.: TAI 94 KE**

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Kenya S.D.A. Rural Health Services

Background:

The Kenya Seventh Day Adventist Rural Health Services (SDARHS), was started in 1985¹; prior to that time, SDARHS functioned as part of the Adventist Development and Relief Agency (ADRA). The concept of Rural Health Service Unit was prompted by the need to extend health services to the rural areas where the population is underserved. Previously, the S.D.A. church (organization) had based most of its health activities on curative health centered at Kendu Mission Hospital in South Nyanza, Nyanchwa Health Centre in Kisii and the Adventist Health facility based at Milimani in Nairobi. Since 1985, SDARHS activities have more than doubled and spread to many areas outside South Nyanza and Kisii, where the majority of health units are centered. The health units all provide integrated health services (including MCH and FP). Community based activities such as FP services, health promotion, self-help groups and income-generating activities have been included in the services being provided from several health unit sites.

Role of SDARHS

SDARHS is responsible for managing an extensive network of about 40 rural health units. Based in Nairobi, the SDARHS headquarters has a staff of seven; Medical Director, Business Manager, Purchasing Coordinator, Family Planning Coordinator, two accountants, and a secretary. The SDARHS, through its network of clinics, provides both curative and preventive (MCH/FP) services to mainly low and middle income groups in the rural area of Kenya.

The units support their activities by fees generated from the sale of drugs and medical supplies. It is estimated² that these fees cover approximately 80% of the costs of the health units. The difference is made up from individual and institutional donations, harambee collections and occasionally from church contributions.

Rural communities are often very active in the establishment and operation of the rural health units. Establishing and financially supporting the health units gives them a sense of ownership and responsibility to ensure that the health units are well run.

Although the health units have a certain degree of independence, they are directly responsible to the SDARHS headquarters in Nairobi. In addition to its direct management role, the SDARHS plays an important part in establishing rural health units.

¹. The Kenya S.D.A. Rural Health Services, Needs Assessment; J. Dondo, FMPD Nairobi December 1991.

². This estimate is made by the Director of SDARHS.

Currently there are 33 rural health units (three of which were started during 1992) under the control of SDA Rural Health Services. There are also 10 private clinics³ which are loosely affiliated with SDARHS. In addition, the SDA Church has two clinics in Nairobi that are operated and managed separately from the SDARHS. SDA's Kamagambo clinic is run independently from SDARHS and is managed directly by the Kamagambo High School and Teachers College. Although the SDA Mission Hospital at Kendu is not directly a part of the SDARHU, it plays an important role as a referral hospital for the clinics. Kendu has a significant part in supplying SDARHS health units with trained ECNs through its School of Nursing. A very high percentage (80-90%) of all rural health unit staff have received their training at Kendu, and staffing of the health units is not considered a problem.

In addition to its management role, SDARHS establishes rural health units (dispensaries and clinics) in areas where the health needs are inadequately served. Based on the concept of community involvement, the units are typically initiated at a local level by community church members. The involvement of SDARHS is usually initiated at the request of local community and church leaders. Outlined in Appendix II is the "typical" process followed in the development/establishment of a Seventh Day Adventist Rural Health Unit (SDARHU).

Organizationally, SDARHS is divided into six areas or fields, i). Central Kenya Conference; ii). Western Kenya; iii). South Kenya Conference; iv). Rareren Field; v). Kenya Lake Field; and vi). Coast Kenya. Each field has a field director who is responsible for field church matters. Although semi-autonomous, the field directors are answerable to the Church board. The field directors play an important role in the creation of health units, schools and in the decision making at community level. It is clear from the needs assessment and this review of the management information systems, that the SDARHS system would benefit greatly if the headquarter staff⁴, the Field Directors, the health units and the health unit committees had formalized policy procedures and guidelines. This would include job descriptions, clarified roles and responsibilities and lines of communication. The current system is discretionary, and therefore difficult to oversee and manage. This makes it difficult to develop and implement new strategies to improve upon the management and sustainability of SDARHS.

³. The private clinics affiliated to SDARHS are required by the Ministry of Health to have a medical doctor supervise the quality of their services. In the current agreement, these services are provided by SDARHS for a small annual fee. Several of the private clinics are currently in arrears with the payment of the annual fee.

⁴. Job descriptions for the Director and FP coordinator are included in the new FP project proposal, (FPPS).

Introduction

This report outlines the work accomplished during a visit to the Seventh Day Adventist Rural Health Services (SDARHS) in May 1992. This work was conducted within the framework of the centrally funded Family Planning Management Development Project (FPMD).

This visit focused on a review of SDARHS's information and management systems. This report makes recommendations on how to improve some of the existing systems and develop new systems for personnel, supervision, performance planning, drug procurement and inventory control, and family planning service statistics. The approach used in both the review and recommendations concerns viewing the management information systems as an integral part of management systems and functions. Weaknesses in the management systems have been identified and recommendations have been made to address them through the development of new systems (such as personnel systems), review of the organizational structure, clarification of the roles and responsibilities, and the need to develop health unit procedures manuals with job descriptions and defined roles and responsibilities. As issues of management control, especially of finances, have been reviewed, recommendations have also been made to continue to explore other ways of improving the long term capacity (sustainability) to provide health and family planning services.

The effectiveness of the technical assistance provided in the area of MIS will depend to a large extent on how well the MIS (and its development process) can become an integral part of the organization. This integration will require the development of staff skills both at Headquarters and at health unit level. In addition, the MIS development work will go hand in hand with the strategic planning processes and the planned work on sustainability, cost recovery and financing. This work was conducted through a series of meetings with the Director of Rural Health Services, Dr. Peter Mokaya and other Headquarter staff members⁵. One field trip was also made to Kagwathi dispensary in Muranga district.

The purpose of this MIS review and development effort is to provide guidance to SDARHS in its current and future MIS development efforts. The review of the existing reporting systems shows that the health units are currently submitting the following monthly reports:

- Drug Inventory;
- Monthly Financial Report
- Family Planning Service Statistics

Clinic reporting provides some of the indicators necessary to monitor the SDA rural health units.

A brief commentary is given on each one of the systems reviewed during this trip:

⁵. See Appendix III for Persons Contacted.

- Family Planning
- Drug Inventory Control
- Financial Reporting
- Supervision
- Payroll
- Personnel

Family Planning:

The S.D.A. RHS has provided family planning services primarily as a sub-project of the Family Planning Private Sector Project (FPPS). These services were being provided through 25 SDA rural clinics. Recently the program incorporated an additional 10 clinics, making a total of 35 clinics. The implementation of the program occurred in two phases. Phase I of the program achieved a target of over 8,000 new clients within a period of two years; this was 71% of the projected target. Phase II achieved a target of over 2000 new clients, approximately 61% of the target. Since March 1992, SDA has proposed a new phase of the FPPS project.

In the new phase of the FPPS project, 21 old health units and 8 new health units will provide FP services as part of the FPPS project. The clinics with the poorest performance will be excluded from the new project.

Family Planning Services Provided through the FPPS Project.

New Phase of FPPS Project. Project Sites	SDA Rural Health Units Providing FP Services.	Associated or Private Health Units Providing FP Services
21 old project sites	20 SDA rural health units.	1 Kamagambo clinic
8 new project sites	2 SDA rural health units.	6 privately owned and managed clinics
Total = 29	Total = 22	Total = 7

In addition to the 29 FPPS project sites, 14 other health units will provide FP services outside the FPPS project framework. Ten of these health units are SDA rural health units and 4 are privately owned and managed.

Family Planning Information Systems

The FP information system is comprised of the following forms (see Appendix):

- CBD Weekly Log Sheet
- CBD Referral Form
- FPPS CBD Oral Contraceptive Checklist
- Consent Form
- Monthly Acceptor Report⁶
- Hours Worked Report
- FPPS Monthly Report
- Contraceptive Request Form

See Appendix IV for copies of these forms.

Currently, all family planning data from the health units is processed manually at headquarters and one standard report completed and sent to FPPS headquarters in Nairobi (FPPS Monthly Report). To compile the FPPS Monthly Report, the FP coordinator at SDARHS headquarters transfers data from the Monthly Acceptor Reports. No other management reports are produced on a regular basis, and very little use is made of this information for project management purposes. Each component of the existing system is reviewed below:

CBD Weekly Log Sheet

The CBD log sheet is used by the FP motivator⁷ to record the activities carried out in the field. The form records the distributors name, date (Month, Week & Year of the report), date of services given, client name and address, type of client (NF=New Female, CF=Continuing Female, NM=New Male, CM=Continuing Male), quantity of contraceptives distributed, referrals by method, date of next contact, and comments. This data is later transferred by the motivator to the daily family planning activity register.

Recommendation: Data from the CBD weekly log sheet should from now on be kept separate from the Daily Family Planning Activity Register. A monthly summary sheet will be designed (see draft copy in Appendix IV) which will allow the FP facilitator to report to SDARHS Headquarters. The FP facilitator should keep a copy of the monthly summary sheet at his/her health unit.

The current form does not collect new acceptor and/or revisit data using the MOH definition.

⁶ The clinics use the MOH "Daily Family Planning Activity Register" to record all daily activities.

⁷ The CBD Facilitator or Motivator is attached to a health unit and will spend time in the field and at the clinic providing FP services.

Recommendation: To maintain compatibility with the national family planning information system, the MOH definitions should be used by all CBD facilitators/motivators and CBDs. (See Appendix V for the MOH definitions and forms). These definitions should be adopted by the family planning program and efforts made to ensure that the definitions are operationalized at the field level (CBD motivators/facilitators and health unit staff).

The CBD Weekly Log Sheet collects data on the number of pill cycles, condoms, and foaming tablets distributed to each client. However, the order in which these pill types appear on the log sheet does not correspond to the order in which they appear in the daily family planning activity register or on the MOH reporting forms.

Recommendation: A new log sheet should be designed to record pill types, condoms and foaming tablets in the same order as in the daily family planning activity register.

CBD Referral Form

The CBD referral form is completed by the FP motivator and given to the client to carry to the referral institution. This form records the name of the clinic to which the CBD motivator is attached, the FP motivator's (distributor) name, name of client, the hospital (or other institution) to which the client is referred, and the motivator signature and the date.

Recommendation: FPMD recommends that SDARHS adopts CHAK's referral form so that a portion of the referral form can be retained and filed at the health unit (see Appendix VI). Using the health unit records, the FP Motivator should count the number of confirmed referrals and transfer the information to the monthly reporting form.

Daily Family Planning Activity Register

The National Family Planning Information system and the Contraceptive Logistics Management Information system both use the DFPAR to record information on the quantity of contraceptives distributed to clients and the number of new acceptors and revisits. One of the important observations made during the field trip to the Kagwathi Dispensary and during discussions with the Family Planning coordinator is that both CBD Motivators and health unit staff use the old definition of new acceptor and revisits. Those definitions are not compatible with the NFPIS or the CLMIS.

Recommendation: Changing the definition of new and revisit acceptor. The existing two columns "New Acceptor" and "Revisit" in the daily family planning activity register (DFPAR) (Appendix VI) should be used to record only the clients who receive a family planning commodity during their visit (pill, condom, injectable,

implant, IUCD, foaming tablets, sterilization etc). Using the MOH definitions, the clients are either completely new to modern methods of family planning or they are a revisit client.

FPMD does not recommend that additional continuing user definitions be added to the register. We believe that this would add an unnecessary level of complexity to the recording of FP clients. We recommend that SDARHS, when evaluating the quality of services being provided, conduct focused assessments (e.g. local rapid assessments). Given the difficulty in operationalizing any definition of continuing user and the extensive number of possible reasons for using, not using, continuing or discontinuing to use a SDARHS facility, any evaluation of quality of services would have to go much further than recording the number of new and old clients to a health unit.

Monthly Acceptor Report

The monthly acceptor report (see Appendix VII) allows the health unit staff to records the following data:

- 1 SDA Dispensary:
- 2 Date (for the month of):
- 3 Project Start Date:
- 4 Amount of Grant:
- 5 Target Number of acceptors:
- 6 Cost per acceptor:
- 7 Number of new acceptors this month:
- 8 Revisits this month:
- 9 Dropouts this month:
- 10 Transfers out this month:
- 11 Number reported previously for fields 7-10:
- 12 Number from start of Project for fields 7-10:
- 13 Commodities distributed by type "Methods of Contraception" for Clinic, CBD and Total.

Currently, only the number of new acceptors, number of revisits, and commodity data is collected, compiled and incorporated in the monthly reports.

Recommendation; Modifying the Monthly Reporting Form: FPMD recommends that each health unit use the same format as the MOH national family planning information system form to report to SDARHS Headquarters. This will simplify the transfer of data from the daily family planning register to the reporting form. The SDARHS form should be completed and submitted to SDARHS Headquarters on a monthly basis.

FPPS Monthly Report

The FPPS Monthly Report format shown in Appendix VIII, records new acceptors, revisits and commodities distributed to clients.

Recommendation: FPMD recommends that one of the standard reports from the proposed computerized family planning services statistics system (see below), include a printed copy of the FPPS Monthly Report.

Recommendation for the Computerization of SDARHS FP Service Statistics System: FPMD recommends that a computerized Family Planning Service Statistics program be installed on one of the SDA computers. The FPPS coordinator and the data entry clerk (currently employed on a temporary basis by SDARHS) should be trained in this program. FP service data from the health units and FP motivator should be entered on a monthly basis and the program used to generate a standard set of management reports. These reports would be used by headquarter managers to monitor the FPPS project and to provide feedback to regional supervisors, health committees, Field Directors and health units. In addition, the program would generate reports for the FPPS Project, the National Council for Population and Development (NCPD) and the Ministry of Health (MOH). FPMD proposes that a version of HealthWare, a Family Planning Service Statistics Program⁸ currently being developed for CHAK and NCPD, be installed and used by SDARHS headquarters. This will ensure compatibility with the CHAK and NCPD systems. Any reporting to CHAK secretariat or NCPD can then be done on a disk.

Providing feedback and Using Output From the System

It is important for the project coordinator to ensure that the health units and FP motivators receive feedback so they can see that their reports are taken seriously. However, there is currently no systematic and analytical review of the family planning reports, nor feedback to the health units or FP Motivators.

⁸. HealthWare is a Family Planning Service Statistics program written in Clipper. This program maintains a high degree of compatibility with the MOH National Family Planning Information System by sharing a similar file structure and database field names.

Drug Inventory

Since February 1992, the drug inventory and financial have been systematically reviewed and analyzed by the accountant, director and the purchasing coordinator at SDARHS headquarters. One major objective of this review and analysis has been to try to bring some control to the escalating costs of drugs and medical supplies while income from fees has been falling. Although this review system has only been in place since February, it has been successful in identifying significant anomalies between expected health unit revenues (based on drugs given to clients) and actual reported dispensary income. To date, four health units asked to explain large discrepancies have agreed to adjust their stated income upward by approximately Kshs. 60,000. Although this system is simple, it is well on its way to becoming an effective monitoring and control mechanism. In addition the system is able to identify gross overstocking of drugs and medical supplies. In several cases, drugs and other medical supplies have been recalled from one health unit and redistributed to another so that they can be used before expiration dates. It is felt that this system will introduce better inventory control and reduce drug costs at health unit level. The feedback given to the health units has so far dealt with trying to get the health units to explain anomalies and discrepancies between recorded drug and medical supply usage and reported income. FPMD recommends that the drug reporting system be used provide feedback to all health units on a regular basis and not solely as a control and enforcement monitoring system. The data can be used to study prescribing pattern; this could be used to provide health unit staff constructive feedback, suggestions and recommendations on the above.

The drug and medical supplies inventory system is made up of three components:

- physical inventory carried out by headquarter staff (the latest was carried out in December and January 1992);
- drug and medical supply purchase information either from the medical store in Nyanchwa, directly from the purchases made by the purchasing coordinator at headquarters or from invoices directly from the health units in the case of direct purchases;
- a monthly stock report from the health units.

The monthly report form collects the following data:

Amount in stock Stock at end of month (day of reporting), this information is usually arrived at by subtracting daily sales from physical inventory stock;

Expiration date This information can be used to determine the risk of and potential amount of wastage of expired drugs. The amount in stock

and the current months consumption figure, can be used to estimate the amount that will remain in stock beyond the expiration date;

Amount Sold This field is used to record the sales for the month. The health units are supposed to keep a record of the distribution of all drugs and medicines, this is compiled and transferred to the reporting form;

Quick, Slow and Dormant Drugs An estimate by the health facilitate as to the rate of sale (movement) of the drugs and medical supplies. These three columns are not being used by the health units on a regular basis;

Unit Price, and Total The unit price from the set price list can be multiplied by the amount sold monthly to obtain the expected sales. However, these last two columns are not used by the health facilities.

Using output from the system

A physical inventory was conducted at 32 of SDARHS rural health units during December and January 1992. This inventory was carried out by the purchasing coordinator, the FP coordinator and the accountant. In the process, large quantities of expired drugs were collected from the health units and later disposed of. This wastage emphasized the need to improve the control of the drug and medical supplies inventory.

This inventory also allows the headquarters to have a benchmark when reviewing stock information from the clinics. Currently, the SDA accountant reviews all stock reports from the clinics each month and compares reported income with projected income based on the supply information, i.e. amount in stock at the end of the previous month plus purchases during the month, minus the amount in stock at the end of the month is equal to expected sales quantities. This is completed for all drugs and medical supplies for all the clinics. The projected sales is based on the itemized price list, times the estimated number of units sold. The accountant is then able to compare reported income from sales with expected sales. These calculations are done using SuperCalc spreadsheet software.

Recommendation: FPMD proposes to help SDA set up a more effective spreadsheet program so that much of the repetitive work of entering data is minimized. Some of the data that is currently being collected on a regular basis such as slow-moving, quick-moving and dormant (drugs) should be removed from the monthly reporting form. Currently, the data on the quantity of drugs sold during the month ("Amount Sold Monthly") is not entered into the spreadsheet and therefore not used to compare projected and estimated incomes. FPMD recommends that this be done in order to identify which particular drugs (if any) are contributing to the discrepancy between projected and reported income from sale of drugs. The possibility of installing Lotus 123 or QuatroPro and training both the accountant and the

data entry clerk in this new software will be explored. An improved spreadsheet application will be developed in collaboration with the SDA accountant during the August-September 1992 visit. A copy of the "Interim Drug Inventory Form for Kebeneti clinic (4-30-92) is shown in Appendix VII, together with the new proposed recording and reporting form. FPMD recommends that the clinics use the new record sheet to record all transactions at clinic level. However, it is not practical for all the clinics to send the record sheet to SDA headquarters (the sheer volume would make data entry very cumbersome). FPMD proposes to review the design of a simplified reporting form in August 1992.

Financial Reporting

In principal, health unit committees are supposed to manage the financial resources of the health units. This is more a control function to ensure that clinic funds are used appropriately. Except for the procurement of drugs, medical supplies and contraceptives, the health units are expected to pay for all other expenses (utilities, minor repair, office supplies etc) out of the patient fees. Each clinic is required to report on monthly income and expenditure to the SDA Headquarters.

Monthly Financial Dispensary Report contains the following information from the health unit:

- Daily Cash Flow Statement: This shows the daily receipts in the clinic;
- Cash Reconciliation: Summary of total expenditure and (total) income;
- Pay Slips: Prepared at HQ and sent to the health units. Payments made on the basis of payslips from fees collected. The payslips are signed by the employees and returned to headquarters;
- Receipts: to back up cash reconciliation;
- Medical and Educational claims: listed by recipient and amount.

Financial Systems: SDARHS is currently using DacEasy to enter transactions in the general ledger. This provides the accounting office with the ability to print a General Ledger Journal Report and a Account Activity Detail Report and a Trial Balance.

Recommendation: The version of Daceasy that is currently being used by the secretariat is several years old. It seems as if many of its possible functions and capabilities are not being utilized. The accountants have not received any

formal training on the software package and are therefore reluctant to try to use any of the other functions of the software. FPMD proposes that Peter Kibunga (FPMD) will review the software package (Daceasy) in June 1992 together with the accountants to determine how appropriate the software is for SDARHS current needs.

Note: Mr. Amos Kimunji, (Carr, Stanyer and Gitau) will conduct a financial analysis of SDARHS, and take a closer look at the financial reporting issues.

Payroll System

The staff of the 32 SDARHS health units are paid on a fixed salary scale set by the SDA Union Board. Employees are paid their net salaries out of the fees that are collected by the health unit; these salaries are based upon and authorized by the individual employee payslips. All payroll transactions are processed at SDARHS headquarters in Nairobi, so that all taxes (PAYE), social security, national health, tithe and other deductions are made by the headquarters accounts department. A few days before the end of each month, individual payslips are sent to the health units to be signed and returned to the headquarters accounts department. Salary advances are approved by those in charge of the health unit, who will send a letter to the headquarters. Nearly all employees make monthly contribution to a cooperative loan society which is run independently from SDARHS by the SDA Union with four elected members (Chairman, Vice-Chairman, Treasurer, Vice-Treasurer). The SDARHS keeps track of approximately 200 rural health unit staff and about a 100 casual employees. A master list of all permanent staff is maintained at headquarters. A leave roster for all employees is prepared by the SDARHS Director and senior headquarter staff together with the Regional (clinic) Supervisors.

Recommendations: SDA is currently using supercalc to keep track of the payroll. FPMD recommends that this spreadsheet be reviewed by Peter Kibunga in September 1992. If an upgraded version of DacEasy is installed, the possibility of integrating this function in the accounting software should be reviewed.

Supervision: As observed in the recently completed need assessment, supervision of the health units is extremely weak. One recent attempt to improve supervision by SDARHS, was the deployment of four rural based Regional Clinical Supervisors to oversee the operations of the health units at the field level. The supervisors are attached to one of the health centers. i). Central and Coast; ii). Western including Pokot; iii). Nyanza and South Nyanza; and iv). Kisii, Nyan-dra and Masaii. Three of the clinic supervisors are officers and one is a ECN. The clinical supervisors are expected to spend about 50% of their time on supervisory activities.

Recommendation: One weakness with this current system is the lack of clear functions, roles and responsibilities, and the need to formalize reporting to headquarters. To ensure the effectiveness of the clinical supervisors, job description with clear roles and responsibilities need to be developed. The regional supervisors could play a very important role in the operation and utilization of the information systems by ensuring timely and accurate flow of information from the health units. In addition, they should become the HA between the information systems and supervision by receiving feedback and analysis from headquarters. This feedback to the regional supervisors should be used to select supervisory visit schedules, generate specific follow-up questions to the health units and allow the supervisors to make recommendations to the health units on matters ranging from accountability, income generation, quality of services, staff training etc. FPMD proposes that a Performance Review and Planning system be established at SDARHU Headquarters. This system would eventually be adapted for use at the clinic level.

Personnel Systems

Individual employee files are maintained by the SDARHS business manager at headquarters. The system is currently not kept up-to-date; for example, many employees do not have terms of employment letters.

Recommendation There is a strong need to develop policy procedures with job description for the health units. The personnel information system (individual personnel files) which are maintained mainly by the business manager, is not up-to-date. For example, several employees do not have letters of appointment. With nearly 200 employees, it is also very difficult and time-consuming to maintain the manual system or to retrieve any information from the system. FPMD recommends that SDARHU review all personnel files on hand to determine where such files are missing and/or incomplete. These files should be updated as quickly as possible. Terms of employment letters should be issued to all staff. In August 1992, the MIS consultant will review the possibility of developing a simple database system (with selected indicators) to complement the manual personnel system.

Personnel Systems, Roles and Responsibilities: The role of the health unit committees are not regulated by policy procedures or guidelines. Although many of the activities and functions of the health unit committees are practices developed since the creation of SDARHS, there is a wide range in the effectiveness and usefulness of several of the health unit committees. Several of the committees perform their role of overseeing the general management and monitoring the quality of the services of the health units. However, other

health unit committees have failed to fulfill this role and have instead become a financial burden on the resources of the health units (using health unit funds to organize committee meetings and to pay the committee members a sitting allowance, etc.).

Additional Issues

Training: Several SDARHU staff have received training through the CHAK training program, however, there is a need to match the training needs of health unit staff with training opportunities in a more systematic and sustainable manner.

Computer Equipment: The SDARHS currently has two PC's of which one is not functioning. There is one wide carriage dot matrix printer. Given the current use of the computer for financial and drug management purposes and the need to computerize the FP service statistics, there is a need to have two functioning computers. Recommendation: Peter Kibunga will visit the SDARHS headquarters to determine the problem with the computer and if possible, repair it.

- The Office of Director of SDARHS will conduct a need assessment of the proposed health unit and look at the dimensions such as, the communities commitment to the health unit, size of the target population at the proposed site, accessibility to the proposed health unit, availability of other (Government, private etc) health services in the area;
- The SDARHS will ask the originators of the proposal (usually community leaders) to create a committee of 13 members with a Chairman, Secretary, Treasurer, and ten other members. The committees will be made up of local community leaders, church leaders and respected members of the community.
- The community will be challenged by the SDARHS to contribute to the construction and establishment of the health centre. Harambees are often held to collect initial contributions in money, materials, and labor for the construction of the health facility.
- The community is also often asked to find appropriate staff (Enrolled Community Nurse (ECN) , patient attendant, watchman etc) for the facility. As the facility establish itself and client load grows a MCH/FP nurse is often added.

Notes From SDA Needs Assessment

- Dispensary and Health Centre administrators (In charges) be trained in basic Book-Keeping to enable them effectively keep track of incomes and expenditures at the units.
- Need a way provide funds so that clients do not have to pay. (Issue of users fees, their impact on use of services, impact on sustainability needs to be explored further.
- There is a need to forge closer links between KSDARHS and CHAK. The units are already members of CHAK and benefit through joint training activities, advice and exchange of experiences.
- The feed-back mechanism is weak as there are no effective links between the headquarters and the units.
- The committees would be responsible for recommending the number and calibre of staff at the dispensary, supervision of activities and generating funds to run the particular unit and how such funds could be best used at the particular unit. The committees will also be used to recruit CBDs.???

The weakness with this structure is that there is no effective official means of linking the units with the headquarters. The reporting is haphazard and irregular.

- The CBDs are not directly attached to SDA???
- Effective supervision is hardly in existence in South Nyanza and Kisii where there is a regional supervisor.

Each of the dispensaries visited had up to-date inventories of family planning registers showing new acceptors, cumulative totals by months, revisits dropouts, monthly targets, proportion of target achieved and transfers.

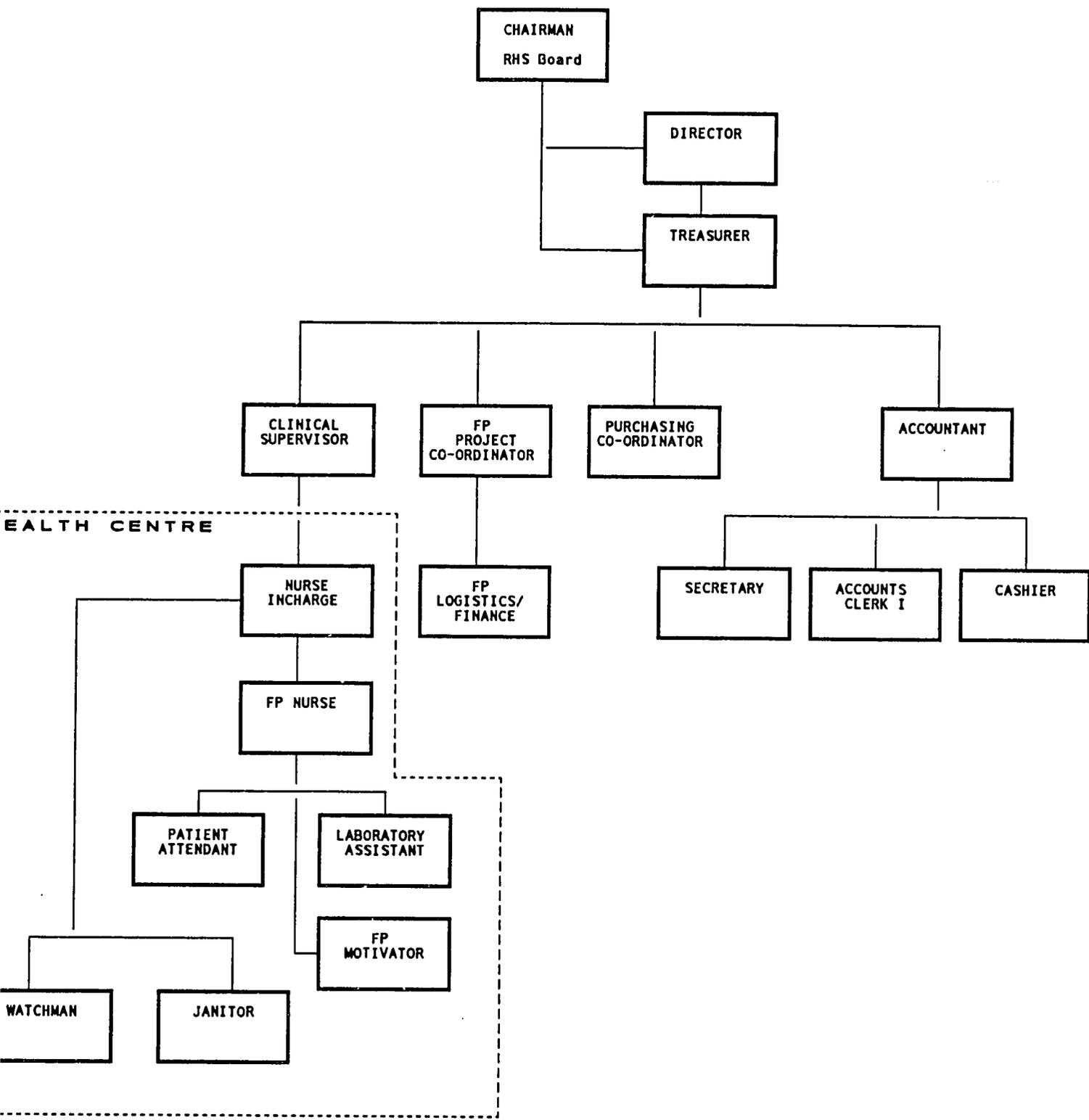
- However, there seems to be a very weak link between the units and the headquarters, one because Nairobi is far from many units and two because there are not enough staff at the headquarters to receive and respond to communications. There is no effective filing system for information storage and utilization.

This is a weak area in the organization since the Kenya SDA Rural Health Services Director does not operate a budget. E.g. estimates of what the operations might cost in a given period and the possible sources of income. At the unit level, the in-charges need to keep accounts of cash received from fees and amounts spent on soap, paraffin, detergent etc. and Dispensary and Health Center administrators be trained in Elementary Book-Keeping to enable them keep track of income and expenditures.

Annex I

Organizational Structure of SDA Rural Health Services

Seventh Day Adventist
(Rural Health Services)



Annex II

Outline of Process Followed in Development/Establishment of an SDARHU

- The Office of Director of SDARHS will conduct a need assessment of the proposed health unit and look at the dimensions such as, the communities commitment to the health unit, size of the target population at the proposed site, accessibility to the proposed health unit, availability of other (Government, private etc) health services in the area;
- The SDARHS will ask the originators of the proposal (usually community leaders) to create a committee of 13 members with a Chairman, Secretary, Treasurer, and ten other members. The committees will be made up of local community leaders, church leaders and respected members of the community.
- The community will be challenged by the SDARHS to contribute to the construction and establishment of the health centre. Harambees are often held to collect initial contributions in money, materials, and labor for the construction of the health facility.
- The community is also often asked to find appropriate staff (Enrolled Community Nurse (ECN) , patient attendant, watchman etc) for the facility. As the facility establish itself and client load grows a MCH/FP nurse is often added.

Annex III
Persons Contacted

Persons Contacted

Dr. Peter Mokaya	Director
Mr. David Mbaluka Kisyua	Assistant Business Manager
Mr. S. Kahinidi	Accountant
Mr. J. Gitabi	FP Programme Officer
Ms. Joan Ricketts	Purchasing Coordinator

Annex IV

CBD Weekly Log Sheet
FPPS CBD Referral Form
FPPS CBD Oral Contraceptive Checklist
**MOH/FP Form of Consent for Injectable
Contraceptives**
Monthly Acceptor Report
FPPS Timesheet
FPPS Client Form

FPPS COMMUNITY BASED DISTRIBUTION PROGRAMME REFERRAL FORM

Dispensary:.....

Distributors Name:.....

Name of Client:.....

This is a CBD client. She has been referred to Central
Hospital for:.....

.....

.....

.....

Please do the needful

Distributors signature:.. ..

Date:.....

Family Planning Private Sector Programme

4th Floor, Longonot Place, Kijabe Street, P.O. Box 46042, Nairobi, Kenya. Phone 24646 & 27614, Telex 25342 1316RUMP

FPPS COMMUNITY-BASED DISTRIBUTION PROGRAMME

Oral Contraceptive (Pill) Checklist

INSTRUCTIONS TO DISTRIBUTOR: This Checklist must be completed for any NEW FEMALE Client who wishes to use the Pill (Oral Contraceptives). If the answer to ALL the questions below is "No", you may give her pills. If the answer to ANY question is "Yes", you MUST refer her to a doctor for an examination before she can use pills. Save the completed Checklist as your permanent record of this interview.

You DO NOT have to complete this Checklist for continuing pill users, but you should always ask continuing users if they have had any problems before giving them additional supplies.

QUESTIONS FOR NEW FEMALE PILL CLIENTS:

	<u>YES</u>	<u>NO</u>
Are you over 40 years of age?	_____	_____
Are you over 35 years of age and a heavy smoker?	_____	_____
Do you ever have fits (seizures)?	_____	_____
Do you ever have severe pain in your calves or thighs?	_____	_____
Do you have swollen legs (oedema)?	_____	_____
Do you have visible veins in your legs?	_____	_____
Do you ever have severe chest pains?	_____	_____
Are you usually very short of breath after hard work?	_____	_____
Do you get severe headaches or visual disturbances?	_____	_____
Are you now breastfeeding a baby less than six months old?	_____	_____
Do you have bleeding between periods or after sex?	_____	_____
Have you now or do you ever miss your period?	_____	_____
Are your skin or eyes abnormally yellow?	_____	_____
Do you have a history of high blood pressure?	_____	_____
Do you have a lump or swelling in your breasts?	_____	_____

_____ If the answer to any of these questions is YES, you should see a doctor before using the pill. This does NOT mean anything is seriously wrong with you, but it may be better for you to use a different contraceptive method.

CLIENT'S NAME AND ADDRESS: _____

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FORM OF CONSENT FOR INJECTABLE CONTRACEPTIVES

Client's Name _____

Client's Number _____

I hereby certify that I have been explained the possible side effects of the injectable contraceptives in my own language/English/Swahili* to my satisfaction. I have also been asked questions on the check list and answered NO to all of them. The side effects explained are:-

1. Onset of irregular vaginal bleeding.
2. Onset of amemorrhoea;
3. Delay in return of fertility up to 2 years.

I agree to use the method.

Signature/Thumb Print _____

Name of Witness _____

Designation of Witness
(MO/ECN i/c)

Signature of Witness _____

SDP Clinic No. _____

* Delete as applicable

Monthly Acceptor Report
 Family Planning Private Sector Programme
 P.O. Box 46042
 Nairobi, Kenya

SDA DISPENSARY-----
 Project Status Report, no. .
 for the month of _____

Project Start Date: Amount of Grant:
 1 September 1985

Target Number of
 acceptors 480

Cost per
 acceptor:

Number of new
 acceptors this
 month: _____

Revisits
 this month _____

Dropouts this
 month _____

Transfers out
 (this month): _____

Number reported
 previously: _____

Number reported
 previously: _____

Number reported
 previously: _____

Transfers out
 previously: _____

Number of new
 acceptors from
 start of project _____

Revisits
 from project
 start: _____

Dropouts from
 project start: _____

Transfers out
 from project
 start: _____

Proportion of
 target achieved

Methods of Contraception

Cycles of Pills:

IUCD:

Injectables:

Other Methods:

Microgynon
 Clinic _____
 CBD _____
 Total _____

Lippes Loop
 Size B _____
 Size C _____
 Size D _____

Noristera: _____
 Depo-Provera _____

Condoms, no. of units
 Clinic _____
 CBD _____
 Total _____

Eugynon
 Clinic _____
 CBD _____
 Total _____

CopperT _____

Others:

Foam. Tabs., no. of units
 Clinic _____
 CBD _____
 Total _____

Microlut
 Clinic _____
 CBD _____
 Total _____

IUCD's checked _____

IUCD's removed _____

Sterilization _____

Natural Method _____

Other

Other

FAMILY PLANNING PRIVATE SECTOR PROGRAMME - HOURS WORKED

MONTH.....

NAME.....

Fill in the blank square with the day of the month and the amount of hours per day spent on family planning.

Holidays this month.....

Year to date.....

Sick Leave this month.....

Year to date.....

Vacation days this month.....

Year to date.....

Signature.....

Rate of pay:..... per month

Hours/weeks/month worked:.....

Due from FPPS.....

Supervisors Signature:.....

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Annex V

MOH Definitions MOH Quarterly Report

INSTRUCTIONS FOR FILLING NFPIS QUARTERLY REPORT

1. Fill in the identifying information for your Reporting Unit. The "Name of (Your) Reporting Unit" is simply the name of your facility, or mobile clinic, or non-health-facility district program.
2. Fill in the quantities of commodities dispensed and services provided by your Reporting Unit for the specified quarter. (An organisation's non-health-facility data for a single district is considered a Reporting Unit. See below.) Consider a single unit of condom to be one condom and a single unit of foaming tablet to be a single tablet (not a packet of multiple tablets). Consider the following official definitions of "New Clients" and "Revisits" and "Referrals" carefully as you prepare the report.

DEFINITION OF A FAMILY PLANNING REPORTING UNIT: A FP Reporting Unit is defined as any static facility, or any mobile facility, or any organisation's non-health-facility-based district program that provides family planning commodities and/or services. Non-health-facility district programs include Community-Based Distribution (CBD), private sector, social marketing, and non-MOH governmental distribution programs. A reporting unit for a non-health-facility district program is considered to be the sponsoring organisation's family planning program data for a single district. For example, if CHAK has a CBD program that is active in nine districts, that will be comprise nine reporting units.

NEW CLIENT: A client is defined as a "new client" if he or she has never used a modern method of contraception. Modern methods are defined as pills, condoms, IUCDs, injections, sterilisation, barrier methods, and spermicides. A clients is not "new" if he or she previously used modern methods regardless of source or duration of use.

REVISIT: A "revisit" is defined as a client that is not a "new client" and who comes to the clinic (fixed or mobile) or Community-Based Distributor for supplies, follow-up, motivation or information. The number of "revisits" plus the number of "new clients" gives the total number of contacts made with clients.

REFERRAL: A "referral" is defined as a client who is confirmed to accept a method the reporting unit does not provide. For example, a CBD agent who sends and confirms that a client went to the clinic for a contraceptive he or she could not provide should report one "referral". "Referrals" are reported in the reporting period when use actually started and not when the client agreed to seek other services.

Note that only CBD programs should report on referrals that are other than for sterilisation or for natural family planning.

3. Fill in your personal details and sign the form. Make any comments you wish to make in the lower right hand corner of the other side of this page. You may wish to comment on how you think the form or the information system can be improved.
4. Mail the completed form to your organisation's headquarters. An officer there will process it and mail it on to the NFPIS Manager at the Ministry of Health.

KENYA MINISTRY OF HEALTH
NATIONAL FAMILY PLANNING INFORMATION SYSTEM

QUARTERLY REPORT

IDENTIFYING INFORMATION

REPORTING PERIOD: Beginning _____, 19__ and Ending _____, 19__
 REPORTING UNIT NAME: _____ CODE NUMBER: _____
 LOCATION AND DISTRICT: _____
 REPORTING UNIT TYPE: Static Facility Community-Based Distribution
 Mobile Clinic Other: Specify _____
 NAME OF SPONSOR OR SUPERVISING ORGANISATION: _____

CONTRACEPTIVES DISPENSED

PILLS	CYCLES DISPENSED
Microgynon	
Neogynon	
Eugynon	
Microlut	
Nordette	
Logynon	
Trinordial	
TOTAL PILL CYCLES	

INJECTABLES	NUMBER OF INJECTIONS
Depo-provera	
Noristerat	
TOTAL INJECTS.	

IMPLANTS	NUMBER OF IMPLANTS
Norplant	

IUCDs	NUMBER OF INSERTIONS
Copper T	
Nova T	
Multiload	
TOTAL IUDs	

OTHERS	UNITS DISPENSED
Condoms	
Foaming Tabs.	

OTHER SERVICES PROVIDED

CONSULTATIONS	NUMBER PROVIDED
New Clients	
Revisits	

STERILIZATIONS	NUMBER PERFORMED
Males	
Females	

REFERRALS	NUMBER PROVIDED
For sterilization	
For natural family planning	
FOR CBD ONLY: Referrals for any other reasons	

NAME OF PERSON MAKING REPORT: _____

SIGNATURE: _____

ADDRESS: _____

PHONE NUMBER: _____

COMMENTS: _____

NOTE: See reverse for instructions on how to fill this form.

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Annex VI
CHAK CBD Referral Form

CHAK CBD REFERRAL FORM

To:

Family Planning Provider.....

Health Facility:

Agents Name:.....

Name of Client:

Reasons for Referral:-

.....
.....
.....
.....
.....
.....
.....
.....

Please do the needful.

Agents Signature:

Date:

To the Agent:

Name of FP Provider:

Signature: Date:

Report:

.....
.....
.....

Annex VII

Drug Inventory Form Daily Medication Record Sheet

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KENYA S.D.A. RURAL HEALTH SERVICE

INTERIM DRUG INVENTORY FORM

DISPENSARY

KEBENEJI

DATE COMPLETED

20-4-92

INCHARGE

R. O. TH. 700

DRUG	PACKAGE UNIT	AMOUNT IN STOCK	EXPIRATION DATE	AMOUNT SOLD MONTHLY	QUICK MOVING	SLOW MOVING	DISCOUNT	UNIT PRICE	TOTAL
ALIXMET (METHILDOPA)	1000	774	Aug 92	12		✓			
AMODIAQUIN	1000	0							
AMPICILLIN (LACILLIN) 250mg	1000	0		244	✓				
AMPICILLIN (LACILLIN) 500mg	500	345	Oct 94	95	✓				
ASPRIN	1000	501	Aug 91	0		✓			
ASPRIN WITH CODEINE (DIENECO)	1000	-							
ASPRIN, JUNIOR	1000	1024	Sept 91			✓			
ASPRIN, PARACETAMOL, CAFFEINE	1000	-							
BELLADONNA, PHENOBARBITAL	1000	-							
BISACODYL	1000	-							
BUSCOL (ANALGESIC/ANTISPASMODIC)	1000	174							
CALCIUM LACTATE	1000	365	Oct 92	33	✓				
CASCARA	1000	-							
CILORAMPHENICOL	1000	1467	Jan 94	0		✓			
CHLOROQUINE/BRILLOQUIN	1000	2352	Sept 92	254	✓				
CHLORPHENIRAMINE/CLONIDINE/PIRACETAM	1000	1498	May 92	92	✓				
CHLORPROMAZINE/LORAZEPAM	1000	-							
CO-TRIMOXAZOLE (SEPTECEL, BACTRIM)	1000	810	OCT 94	153	✓				
DIAZEPAM 2mg	1000	1511	Dec 94	34	✓				
DIAZEPAM 5mg	1000	735	Dec 94	62	✓				
DIGENE	1000	-							
DICOXYN	1000	-							
ELOXIN (CLOZINE 6)	1000	1171	Aug 92	35		✓			
ENTEROMYCIN	500	1029	Feb 93	9		✓			
EPHEDRINE	1000	-							
ERCOMETRINE	1000	-							
FANSIDAR	1000	338	Feb 93	43	✓				
FERROUS SULFATE	1000	1311	May 93	102	✓				
FLU-COLD TABS (APC/CHLORPHENIRAMINE)	1000	1777	Sept 93	149	✓				
FOLIC ACID	1000	2410	Aug 93	20	✓				
FRANOL/IFETHYLLIN (GIFOL)	1000	1492	Oct 94	0		✓			
FURSEMIDE (LASIX)	1000	-							
GRISEOFULVIN 500mg	1000	-							
HELAKAMON (OXYTETRACYCLINE)	1000	-							
IBUPROFEN 200mg	1000	264	Oct 94	94	✓				
IRAXNETRACINE (RIMECTH)	1000	2113	Feb 93	29	✓				
IODIZED THROAT TABS	1000	2125	Feb 94	44	✓				
KOFED TABS	1000	-							
LAVIDOX	1000	-							
LEVAMISOL/KEPPAX/LEVASOL	1000	2516	Jan 94	21	✓				
LUNA TABS	1000	-							
MAGNESIUM TRISILICATE COMP	1000	272	Jan 93	82	✓				
MEBENDAZOLE (MAYDA) 100mg	1000	1074		54		✓			
MEPACRINE	1000	-							
MEPROBAMATE	1000	-							

DRUG	PACKAGE UNIT	AMOUNT IN STOCK	EXPIRATION DATE	AMOUNT SOLD MONTHLY	QUICK MOVING	SLOW MOVING	DORMANT	UNIT PRICE	TOTAL
AMPICILLIN SYRUP	60ml								
AMPICILLIN SYRUP	100ml	2	Aug 53	2	✓				
ANTACID, ALUGEL	4Ll	10 Liters							
ANTACID, TRYACTIN	5Ll								
ANTIASTHMATIC SYRUP	100ml	10	Aug 53		✓				
CHLORAMPHENICOL/ELACETIN SYRUP	4Ll								
CHLORAMPHENICOL/ELACETIN SYRUP	3Ll								
CHLORAQUINE SYRUP/ROKXQUIN	75ml								
CHLORAQUIN SYRUP/ROKXQUIN	5Ll	10 Liters	July 93	750mls	✓				
CHLORPHENIRAMINE/CHLORATE/PIRT- TON	125ml								
CHLORPHENIRAMINE/CHLORATE/PIRT- TON	5Ll	15.750 Liters	Sept 94	552mls	✓				
CO-TRIMOXOZOLE/PAPUSOLE/ALP/ SEPT/LE	60ml								
CO-TRIMOXOZOLE (ALPRIM,SEPTIM)	100ml								
CO-TRIMOXOZOLE (ALPRIM,SEPTIM)	1Ll								
CO-TRIMOXOZOLE (ALPRIM,SEPTIM)	4Ll	10 Liters	Feb 53	0					
COD LIVER OIL	5Ll								
COUGH SYRUP, COPITDREX	100ml								
COUGH SYRUP, COPITDREX	5Ll								
COUGH SYRUP, ELTUSA FORTE(PAPUSOL)	75ml								
COUGH SYRUP, ELTUSA FORTE(PAPUSOL)	5Ll								
COUGH SYRUP, KOFED (CODELZINE)	125ml								
COUGH SYRUP, KOFED/CODELZINE	5Ll	6 Liters	Nov 53	300mls	✓				
COUGH SYRUP, LUNAHIST	125ml								
COUGH LUNAHIST	100ml								
COUGH SYRUP, PECTADOL	5Ll								
COUGH SYRUP, TRICHIST EXPECTORATE	100ml								
CREAM OF MAGNESIA	4Ll								
D.R.F. PACKETS	pkc	26	Sept 94	4	✓				
ENTEROMYCIN SYRUP	4Ll	7.050 Liters	126 93	0	✓				
FRANOL SYRUP (GIF)	120ml	77 500mls							
FRANOL/ASOL	60ml								
HIBITANE	5Ll								
IRON SYRUP	5Ll								
LEVAMISOLE/LEVASOLE SYRUP	500ml	300mls	140 93	100 mls	✓				
LIQUID PARAFFIN	5Ll								
MEBENDAZOLE SYRUP	500ml								
NEOGASTROL SUSP.	5Ll								
PARACETAMOL SYRUP	60cc								
PARACETAMOL SYRUP	5Ll	7.5 Liters	NOV 94	2.5 Liters	✓				
PARAGORIC ACID I	1Ll								
PENICILLIN SYRUP	60ml								
PENICILLIN SYRUP	100ml	22	12 93	12	✓				
PENICILLIN SYRUP	2.5Ll								
PIPERAZINE SYRUP	60ml								
PIPERAZINE SYRUP	5Ll								
PROMETHAZINE SYRUP	5Ll	4.5 Liters	Jan 93	500mls	✓				
VITAMIN B COMPLEX/EUVITLEX SYRUP	5Ll								
MULTIVITAMIN/ELYDAC SYRUP	75ml	15.200 Liters							
MULTIVITAMIN/ELYDAC SYRUP	5Ll	15.200 Liters	Oct 94	313 Liters	✓				

1/1

DRUG	PACKAGE UNIT	AMOUNT IN STOCK	EXPIRATION DATE	AMOUNT SOLD MONTHLY	QUICK MOVING	SLOW MOVING	DORMANT	UNIT PRICE	TOTAL
INJECTIONS AND INFUSIONS									
ADRENALIN	lamp	22	not indicated	1		✓			
AMINOPIHYLLIN 250mg	lamp	13	May 94	0		✓			
AMPICILLIN 250mg	ea								
AMPICILLIN 500mg	ea								
CALCIUM GLUCONATE 10%	vial	2	not indicated	1		✓			
CHLORAMPHENICOL 1gm	vial								
CHLOROQUINE 5%	ea	22	Dec 91	11	✓				
CHLOROQUINE 10%	ea								
CHLORPHENTRAMINE 10mg, 2cc	vial	2		0		✓			
CHLORPROMAZINE 25mg/LARGACTIL	lamp	4							
CHLORPROMAZINE 50mg/LARGACTIL	vial	4	Aug 92	4	✓				
DARROMS	500ml								
DAWADAR 2.4/LONGACTIL IN BENGACILL	ea	27	May 96	7					
DAWADAR 6:3:3 (See TRIPLOPEN)	ea	20	May 93	0	✓				
DEXTROSE IN WATER N/C	500cc	4							
DEXTROSE IN WATER	500cc	2							
DIAZ AM 10mg, 2ml	vial	65	Dec 93	3	✓				
EPIEDRINE	ml								
ERGOMETRINE 5mg	vial								
FRUSEMIDE (LASIX)	vial								
GENTAMYCIN, 80mg, 2ml	vial	40	Feb 93	4	✓				
HAKIMANS	500ml	1		0					
HYDROCORTISONE INJECTION, 25mg	ea								
HYDROCORTISONE SUCCINATE 100mg	ea	7	Jun 93	0		✓			
INTERON 2cc									
IRON 2cc	vial								
IRON 5cc	vial	30	not indicated				✓		
KANAMYCIN									
LIDOCAINE	50ml	1							
NICOTINIC ACID	ea								
NOVALGIN/PACIMOL	5ml								
PASUNA STRONG/FORTE	ml								
PENICILLIN BENZATHINE (DAWADAR) 2.4	vial								
PENICILLIN CRYSTALLINE	ea	43		1	✓				
PENICILLIN, PPF 4.8 MEGA	vial	38		5	✓				
PENICILLIN PPF OILY	ea								
PHENOBARBITONE SODIUM 100mg	vial	8		0			✓		
PROGESTERONE	ml								
PRORITHAZINE 50mg	vial								
QUININE DIHYDROCHLORIDE 600mg	vial	110	Sept 92	11	✓				
SREPTAMYCIN 1gm	vial								
TESTOSTERONE	ml								
TOGAMYCIN	ea								
TRIPLOPEN (see DAWADAR 6:3:3)	ea								
VITAMIN B COMPLEX	ea 10cc	17	July 94	3					
VITAMIN B1	ea								
VITAMIN B2	ea								
VITAMIN B12	ea								
VITAMIN B6	ea								
VITAMIN K	ea	13	not indicated				✓		
WATER FOR INJECTION	100ml	8							
WATER FOR INJECTION	500cc	3	Oct 93		✓				

DRUG	PACKAGE UNIT	AMOUNT IN STOCK	EXPIRATION DATE	AMOUNT SOLD MONTHLY	QUICK MOVING	SLOW MOVING	UNKNOWN	UNIT PRICE	TOTAL
<u>TOPICAL MEDS</u>									
ANTIHISTAMINE CREAM, MEPPYRAMINE	25gm								
ANTIHISTAMINE CREAM, MEPPYRAMINE	400gm	8							
ANTIHISTAMINE CREAM, MEPPYRAMINE	1kg								
ANTIHISTAMINE/MEPPYRAMINE/HISTAMINE	500gm	2	12-94						
ANUSOL OINT	25gm								
BENZYL BENZOATE/SCABIZOLE	51c								
BETNOVATE OINT (LAEOVATE)	15gm	0		2 items	✓				
CALAMINE LOTION	51c								
CANESTEN PESSARIES	ea								
CHLORAMPHENICOL EAR DROP (OROMINT)	10ml								
CHLORAMPHENICOL EYE OINTMENT	ea								
CROVIFORM OINT (LACCORTEN)	15gm								
EMULSION OIL	ea								
EPHEDRINE NOSE DROP	ea	9	Jan 94	0		✓			
GENITAN VIOLET	51c								
GEOKORION EYE/EAR DROPS	5ml	13	Oct-92	2	✓				
GEOKORION SKIN OINT	10gm								
GYNOSTAT VAG. PESSARIES	61 tab	140	NW 93	0		✓			
HYCOMYCIN EYE DROPS	20ml								
HYDROCORTISONE EAR/EYE DROPS	5ml								
HYDROCORTISONE OINT/CREAM 1%/HYCOR	500gm								
HYDROCORTISONE SKIN OINT 1%	20gm	17	Feb 94	3					
HYDROCORTISONE SKIN OINT	1								
IODOPORN POWDER	500gm								
K-Y JELLY	25ml								
LAEOSOL/NEOMYCIN EAR/NOSE DROPS	10ml								
LINAMENT, FALCI (JALHO)	51c								
LUGOL'S SOLUTION	11c								
NAUMA (RUBEN)	20gm	5	"	6					
NITROFURAZONE SOL. DRESSING	25gm								
NOSE DROPS, NOSVIN ADULT 1%	10ml								
OGINOL/NEOMYCIN OINT	15gm								
ORASEPTIC MOUTH WASH	120ml								
PENICILLIN OPHTHALMIC OINT	4gm								
PENICILLIN SKIN OINT	20gm								
PETROLEUM JELLY	1kg								
PREPARATION H	ea								
TETRACYCLINE EYE OINT	20ml								
TETRACYCLINE EYE OINT	20ml								
SILVER SUFADIAZINE (BURNEZINE)	250gm								
SILVER SUFADIAZINE (BURNAZINE)	1kg								
SOPRADEX EYE/EAR DROPS	8ml								
SULFACETAMIDE EYE OINT	5ml								
SULFACETAMIDE EYE DROPS	10ml								
SULFUR OINTMENT	20gm								
SULFUR OINTMENT	500gm	2		0		✓			
SULPIATHIAZOLE OINT	25gm								
SULPIATHIAZOLE OINT	500gm								
SULPIATHIAZOLE POWDER	500gm								
SVS VAGINAL TABLETS	101 abs								
TERACORTIL	ea								
TETRACYCLINE EYE OINT 3.5gm	ea			6	✓				
TETRACYCLINE SKIN OINT	20gm	0							
TETRACYCLINE SKIN OINT	15gm								
TINAZOLE VAG TABLETS	14 Tab								
WILTFIELDS OINT	25gm								
WILTFIELDS OINT	20gm	18	Mar 94	1	✓				

DRUG	PACKAGE UNIT	AMOUNT IN STOCK	EXPIRATION DATE	AMOUNT SOLD MONTHLY	QUICK MOVING	SLOW MOVING	DORMANT	UNIT PRICE	TOTAL
WHITFIELDS OINT	500gm	1							
WHITFIELDS OINT	1kg								
Z GEL	50gm								
ZINC OINT	1kg	1							
MISCELLANEOUS SUPPLIES									
APPLICATOR STICKS	1000								
BANDAGE 1in	ea								
BANDAGE 2in	ea								
BANDAGE 3in	ea								
BANDAGE 4in	ea								
CANNETER	ea								
COMBURI TEST/COMB -3 TEST	box								
COTTON WOOL 4oz gm	ea	2 1/2							
ENVELOPES, MEDICINE	1000								
FEEDING TUBES - CHILDREN	10								
FEEDING TUBES - ADULTS	10								
FIELD STAIN A	25ml	2							
FIELD STAIN B	25ml	2							
GAUZE ROLL	100yds								
GLOVES, EXAM	ea	200 pairs							
GLOVES, RUBBER	pair	20 pairs							
I.V. GIVING SET	1000								
KNIFE BLADE #11	ea								
LUCI-N	15mg								
MICROSCOPE SLIDES	Box								
MEDICINE BOTTLES	ea								
MEDICINE BOTTLES - PLASTIC	ea								
NEEDLES, DISPOSABLE	ea								
NEEDLES, NON-DISPOSABLES	ea								
NORMAL SALINE	1L								
OIL IMERSION	ea								
PATIENT CARDS	250								
PLASTER, ADHESIVE/ZINC OXIDE PLAST	5mc								
PREGNANCY TEST	100								
RECEIPT BOOKS	ea								
SAVLON CONCENTRATE/INGINAL	5L	5 Ltrs							
SILVER NITRATE STICKS	ea								
SOLURACIN	ea								
SPIRITS	5L								
SURGICAL SPIRIT	5L	5 Ltrs							
SURGINAL	5L								
SUTURE, CATGUT WITH NEEDLES	ea								
SUTURE, NYLON WITH NEEDLES	ea								
SUTURE, NYLON WITHOUT NEEDLES	ea								
SYRINGE, INSULIN	ea								
SYRINGES, DISPOSABLE 2cc	ea								
SYRINGES, DISPOSABLE 5cc	ea								
SYRINGES, DISPOSABLE 10cc	ea								
SYRINGES, DISPOSABLE 20cc	ea								
SYRINGES, NONDISPOSABLE	ea								
THERMOMETER	ea								
TONGUE DEPRESSORS	100								
URISTIX, SUGAR, ALB	ea								
ZINC OXIDE PLASTER 5cm	ea								
ZINC OXIDE PLASTER 7cm	ea								

