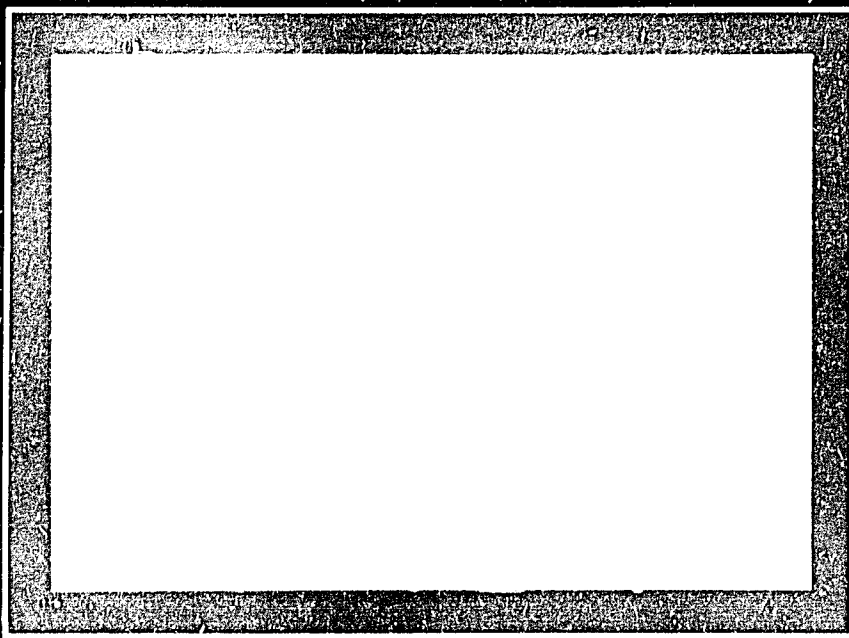
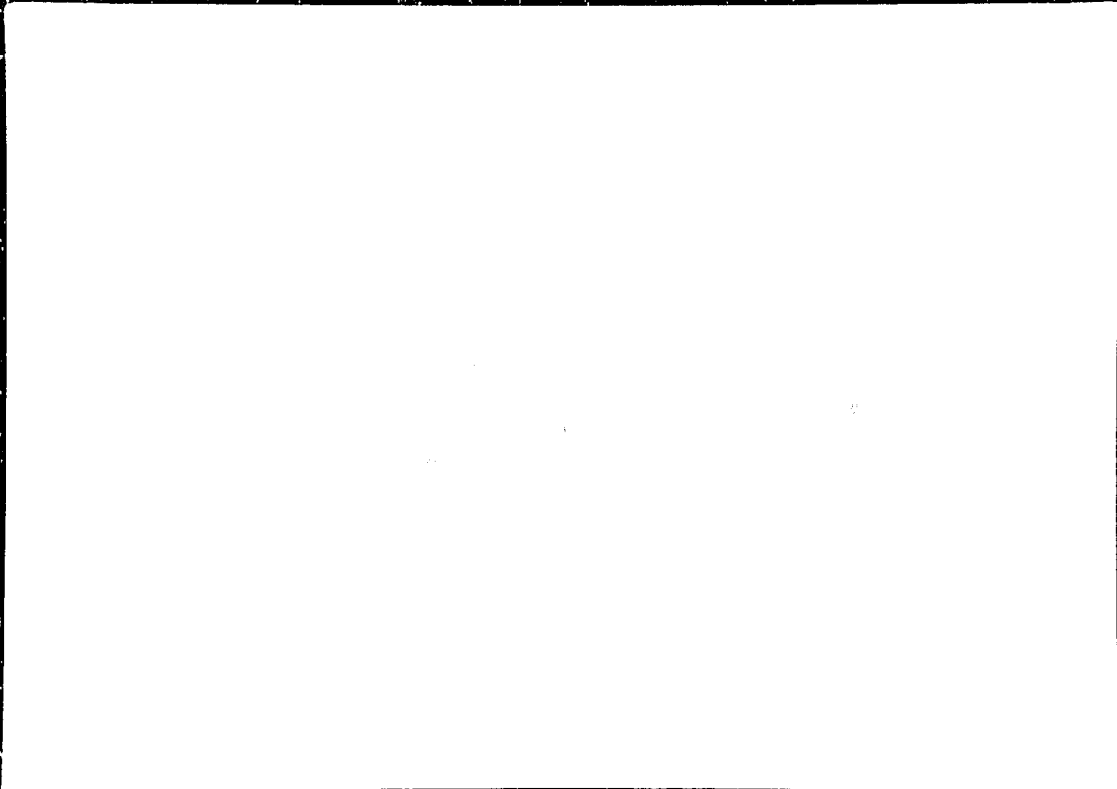


PA-ABW-643



FAMILY
PLANNING
MANAGEMENT
DEVELOPMENT

*A project of Management Sciences for Health
in collaboration with
The Centre for Development and Population Activities*



Family Planning Management Development (FPMD) is a five-year project designed to provide practical solutions to the management problems faced by senior- and mid-level family planning program managers in both the public and the private sector. FPMD is a world-wide project, assisting family planning managers in Africa, Asia, the Caribbean, Latin America, Eastern Europe, and the Near East. It is implemented by Management Sciences for Health in collaboration with The Centre for Development and Population Activities (CEDPA).

PN-ABW-643

12/1/95

**FPMD STRATEGY AND TECHNICAL
ASSISTANCE IN KENYA**

MANAGEMENT INFORMATION SYSTEMS

MAY 1995

Dick Roberts, Principal Program Associate, MSH/MIS

FAMILY PLANNING MANAGEMENT DEVELOPMENT

Project No.: 936-3055

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EXECUTIVE SUMMARY

Service Statistics. The consultant reviewed the utilization of HealthWare, the MSH software recently installed at FPAK to process their service statistics. He found the data files current, but noted a need for some work on reports (one, he re-programmed) and for the incorporation of past service statistics in the new data files to permit easy production of comparisons of current and past performance. Appropriate recommendations were made, discussed and included in this report.

Following up work on the previous visit, he showed the PO/MIS additional techniques for work with databases from a spreadsheet (and was pleased to note that the related tools taught in December are being used by the MIS staff). He also introduced to the Research/Evaluation and MIS staff a method mix indicator FPMD had developed with CAs in Bangladesh (it is now tentatively included in the Method Mix Report produced by HealthWare for FPAK); developed - on request - the bare bones of a spreadsheet based query to produce CYP tables from the service statistics database; discussed with the Research & Evaluation (and MIS) program officers the need for reports presenting overall FPAK results in addition to results by program.

C L M. The consultant worked with FPMD's MIS Advisor to accelerate the disappointing pace of work related to the adjustment of computerized stock records so that the pilot test of CLM could continue as planned. It was finally completed, but much tighter management oversight of the CLM pilot is needed for a satisfactory test of CLM, and to prove for the benefit of FPAK itself that the organization can successfully utilize a computerized stock management system. The consultant produced a sample of a management report of particular interest to FPAK (frequency of ordering by clinic, excessive in many cases) but not among those in CLM at present; his CLM-related recommendations to MSH include adding such a report to CLM in Kenya, even during the pilot. A set of sample pages of most standard reports was left with the SPO/Research & Evaluation for the FAM. For the pilot test, Joyce Goodman's CLM evaluation visit to Kenya has been postponed until later in the year (probably August) to allow time for normal use of CLM now that the adjustments have been completed.

C H A K. The consultant and FPMD MIS staff spent a morning discussing the status and future direction of CHAK MIS with the Executive Director and several key managers of CHAK. The minutes of the meeting are to be the basis of internal guidelines for the development of MIS at CHAK. In addition, on the basis of the meeting this visit and of previous meetings with CHAK, the consultant prepared and left with FPMD for transmittal to CHAK a brief document suggesting what CHAK might try to accomplish in the remainder of 1995 and put on its agenda for 1996.

Continuation Rate Monitoring. The consultant and the FPMD MIS Advisor visited a CHAK and an FPAK clinic in the company of MIS personnel of each of the concerned NGOs to review the record-keeping system, with particular attention to the FP register. The findings confirmed the idea that the registers can easily be used to produce an indicator reflecting clinic success in retaining new clients, in general or for specific methods such as pills or injectables, through their first resupply visits (a period when "quality of care" factors are likely to have their greatest impact on decisions to continue or quit). Such an indicator is proposed to help clinic, area and headquarters personnel anxious to improve performance; it would do so by identifying clinics with larger than normal losses during the clients' first months, as well as those that have found ways to have very low loss rates, and by defining norms. FPAK staff (including the Executive Director) expressed interest in testing the indicator. Both FPAK and CHAK have received documentation on the concept, which is also annexed to this report.

FPMD MIS Program. FPMD activity in Kenya is to be closed down in the next three to four months. Staff focus is very sensibly on completing what has been begun, or cutting off activities in any cases where the next step cannot be made in time to allow FPMD to provide the support it considers necessary to make that step productive.

One activity on the agenda which should be given high priority is a workshop to bring together the technical staff using HealthWare at four Kenyan organizations so that they can share experiences and, most importantly, get to know each other and what each is doing with HealthWare (and QuattroPro for Windows, which FPMD has been making available); a HealthWare user network, formal or informal, would be a major contributor to the sustainability of HealthWare and of productive MIS in these NGOs.

ACTIVITIES, OBSERVATIONS AND RECOMMENDATIONS

FPAK

The consultant worked primarily with the Program Officer/MIS, but also met to discuss data utilization with the Senior Program Officer/Research & Evaluation and the Program Officer/Research in that section, spent time following up the CLM pilot test with the SPO/Logistics and other staff of the Logistics Unit in Eastleigh, reviewed his program and observations in mid-visit with the Executive Director. A planned debriefing with the Finance and Administration Manager (FAM) was canceled at the last minute, but key issues were covered with the Senior Program Officer/Research & Evaluation for relay to concerned colleagues.

Service Statistics Information System

Effective with 1995 data reporting, HealthWare, an MSH software package, has replaced the products previously used to process FPAK service statistics. The standard HealthWare data entry screens and reports were modified to meet FPAK. Using the initial 1995 field data, the FPMD MIS advisor trained FPAK staff in the use of the new software. Minor problems, have been resolved by the FPMD MIS advisor, who remains in touch with FPAK staff and available for back-up.

Very little use has been made of the capacity to easily produce the programmed reports from HealthWare, so there has been no feedback on them as yet. In mid-May, with a product in service since early in the year, this is a bit disappointing. Review of some of the Static Service reports identified one mis-labeled and in need of minor modifications to let it meet a reported need (the consultant made the changes needed); it reports new, continuing and revisit clients by clinic.. The review also found two reports (quarterly method mix by clinic, and by area) for which apparent miscommunication had led to designs that will not meet staff needs (but since this had not been discovered, since they had not been printed out). The consultant programmed and documented a replacement for one of the reports (Annex 1); the FPMD MIS Advisor has agreed to produce the other one.

The MIS staff have learned to use the Query capability of Quattro Pro 5 for Windows which FPMD recommended and provided in late 1994, and they have used it to print out for reference data from the Healthware databases; this is commendable, a smart move. However, it would also be wise to print out reports available through HealthWare so that anyone interested, or asking for data, can see what is most readily available, and so that additional needs can be identified.

FPAK's very capable Program Officer/MIS has learned how to use R&R Report Writer to create additional reports. He is even more familiar with report programming in dBase, and has used that skill to respond to some *ad hoc* demands in the few months he has been with FPAK. Now that HealthWare is operational, it would be preferable to give preference to R&R Report Writer when new reports are needed if there is any likelihood they will be wanted again in the future. The reason for this is that reports done in R&R Report Writer and included in the HealthWare report library automatically appear on the Standard Reports menu in HealthWare, where anyone can print them out; reports done through other channels are less accessible.

The one major Healthware-related task left incomplete was the addition of historical data to the new database. Effectively linking the files to transfer in the old data required some modification of the file structure in the case of static clinic and outreach data, and, in the case of CBD files, consolidation of data to correspond with the level of reporting on which the new files are based. During this visit, the consultant showed FPAK's PO/MIS how to consolidate these files using the Database Desktop tools of QuattroPro for Windows; initial experimentation was undertaken, but the consolidation remains to be completed.

This consolidation will make it possible to easily generate reports that include historical comparisons, such as the graphs FPAK includes in their quarterly reports. The QuattroPro file the consultant produced during his 12/94 visit (FPAK has a revised version) is an example of how updating and production of standard graphs from database files can now be made very easy, accessible to anyone using the computer with the data files. .

CLM - Logistics Management Information System

Activity related to CLM is reported under a separate heading. It is mentioned here, in the context of FPAK activities for two reasons. One is that it is an FPAK activity. The other is that, if FPAK decides to adopt CLM on a regular basis after the pilot test, management will have to make a special effort to ensure that CLM is not left in isolation in Eastleigh. The PO/MIS is in constant demand at headquarters. Eastleigh is out of his sight, but it must be allowed to be out of his mind. If CLM becomes the system, it is important that the PO/MIS stay in touch with the data entry personnel and the SPO/Logistics on a regular basis to make sure that problems are identified and solved as they arise, and that any needed modifications in reports are made as identified. This is in no way criticism of past or current performance, it is just a reminder.

Data Interpretation and Use

Ideally, a day could usefully be spent discussing with program officers collectively what one can observe about FPAK programs through the information system, or what they would like to be able to see through the MIS. Better yet, two days could be spent on it, the second based on MIS outputs for which demand was stimulated in the first.. demonstrating responsiveness. This will be more feasible a little later in the year when 1993 and 1994 data have been incorporated in the main data files, additional reports (including graphics) have been programmed with R&R and QuattroPro, and some overall (as opposed to program-specific) reports are available.

During this visit, the consultant worked with the PO/MIS on QuattroPro query applications, using the processes needed to adjust files for the consolidation of past and current database files. A new set of Technical Notes were produced incorporating these procedures; these have been left with FPAK and FPMD and are enclosed in Annex 2. At the request of the PO/MIS, he also programmed the basic elements of a small application to produce in QuattroPro from the main database a table of CYP figures by reporting unit. The PO/MIS should obtain the currently recommended CYP multipliers from USAID.

Method Mix is an important aspect of program quality at FPAK, and one of the principal complaints of the medical officers in the past was that the former computerized system did not provide the necessary data. HealthWare does hold the data needed and Method Mix reports have been programmed (with some modifications during this visit, as noted above). The reports were reviewed in draft form with the Senior Medical Officer, who found that the revised version meets his needs (percent. distribution, without the raw data).

In monthly reports, FPAK service statistics report the number of clients by method for three categories of client: new acceptors, continuing acceptors and revisits. The question was raised as to whether "revisit" clients were included in the calculation of method numbers each month or quarter; including them would result in somewhat muddled results. The HealthWare report producing percentage distribution of clients by method does not include revisit data.

It is noted that the FPAK definition of new and continuing acceptors and the use of data for these clients as described above, mean that, during each year, the calculations do not reflect any changes resulting from clients stopping the use of any method. At any given time, it is based on the clients of previous years who have visited a clinic at least once the current year, plus any new clients of the current year. This creates the interesting possibility of calculating client loss by method when Continuing Acceptor data become available for a second year.

Method Mix Indicator FPMD devised a method mix indicator for use by NGOs in Bangladesh as an easy-to-use way to monitor significant changes in the percentage of more reliable and/or long-term methods in the method mix; in effect, it reflects the "quality" of the method mix. The method mix indicator is a way of showing in a single figure the extent to which the family planning users in a group, e.g. those served by a given clinic, are using more versus less reliable, and short-term vs long-term methods. FPAK Evaluation and Research staff expressed interest in the indicator and were left with the information necessary to begin using it with FPAK clinics and Area programs. Following those discussions, the consultant took the liberty of programming it into the Method Mix report in HealthWare during its revision; it will now appear automatically in that report (see Annex 1), but can be easily deleted by the PO/MIS if it is not wanted. A descriptive note and a table of indicators reflecting sample Kenyan clinic data are in Annex 3.

FPAK Monitoring and Program Monitoring. The Executive Director and the SPO/Research and Evaluation were very interested in seeing statistical and graphic reports developed to reflect overall FPAK performance. This has not been common practice, but such reports would complement the reports currently prepared by program area. Looking at the organization as a whole, rather than as a collection of programs, can help create more cohesive efforts on the part of field staff and a more productive overall program. This was not a new idea to them and had, in fact, been discussed during an earlier visit of the consultant. It will be greatly facilitated by the use of the new HealthWare software and by changes that have been introduced in the data collected, and standardization of definitions across programs.

RECOMMENDATION: Complete the consolidation of the 1993 and 1994 static/outreach and CBD data files in the two HealthWare databases so that historical comparison reports can be programmed, and prepare at least one such report (e.g., same quarter this year vs last year) for staff (including Area Manager) review. If done in the relatively near future, it may be possible to obtain some report programming help from FPMD.

RECOMMENDATION: Print the Standard Reports in HealthWare and make them available to program and management staff so they can see what is readily available, and to stimulate feedback that will guide development of new "standard" reports. If this is done in the relatively near future, it may be possible to obtain some report programming help from FPMD.

RECOMMENDATION: The method mix indicator has been added to the information provided in the Method Mix Report generated by HealthWare. Use the indicator as the basis of continuing discussions with Area and Clinic managers on the importance of continually upgrading the method mix of their clients.

RECOMMENDATION: The Research and Evaluation Section should produce for review by the program staff and Area managers some samples of tables/graphs showing overall FPAK performance from a few perspectives, including the ways in which individual programs contribute to the overall result. These could be the documentation around which a workshop could be held to help program staff develop a better understanding of the way the parts fit together and to obtain inputs that would make it possible to improve the draft MIS outputs on the overall view.

CLM - Logistics Management Information System

Overview

Since mid-March order and shipping data have been input to CLM files on a more or less regular basis. Earlier shipments had been input previously, or have been since. Orders/shipments had been input through the end of April when the consultant arrived.

While this kept the CLM inventory by product up to date, it did not do the same for the inventory by lot number. Each time a client order was input, CLM identified the lot numbers from which picking should occur. When shipment of the order was confirmed to CLM, it assumed that the lots specified had been picked and adjusted its stock records accordingly. However, since some stock was picked before CLM was operational, and the records were input after shipment, without lot numbers available, CLM's records by lot number are no longer correct (they were for the most part, when input on the basis of the end-of-year physical inventory). Thus, it became essential to do a physical inventory by lot number of the products managed through CLM and to update the lot number stock records in the computer.

Once that is done, picking should only be by CLM-generated picking list. This means that orders from clients can be filled only after the order has been input to CLM and the pick list generated. **This means that there must always be someone available who is capable of entering a client order and generating a pick list. That becomes as important as the availability of the keys to the storeroom.** During the first week of the consultant's presence, the agent who does the data entry was absent due to a death in his family. No one else did the order data entry that should have been done in his absence. (It was not crucial in the way it will be once the records are updated as just described, but the fact that no one stepped in or was assigned to take his place highlights the challenge ahead.)

Progress in getting the physical inventory done and the computer file updated has been very slow. After multiple communications and visits by the FPMD MIS Advisor and, during this visit, the Advisor and the Consultant, the job was finally completed. As of the end of the present mission, the adjustments of the inventory by lot number have been virtually completed and staff have been briefed on the procedures that must be followed in the future if FPAK does, in fact, wish to operate a computerized stock control system. The procedures will require most staff members to change some habits, always difficult. The SPO/Logistics will have to monitor operations carefully to help staff replace old habits with new, but the work of all of them can be facilitated if they succeed.

Joyce Goodman will review the results of the pilot test during a forthcoming visit, when she can also discuss any FPAK interest in formally adopting CLM.

Use of reports

The consultant produced several standard CLM reports. These he reviewed very briefly with the Executive Director and the Senior Program Officer/Research and Evaluation. An appointment with the head of the Finance and Administration Manager (FAM) was canceled at the last minute and the Senior Logistics Officer was unavailable much of the time. A set of the first two pages of several of the reports was left with the SPO/Evaluation to pass to the FAM. It is strongly recommended that FPAK management (Logistics, FAM, Medical) review the report samples and begin to use appropriate reports on a regular basis during the pilot test; if they are not used, FPAK cannot know if they are useful, or if CLM is worth the effort required to make it work.

Unfortunately, some of the key reports - those relating shipments to the same period a year earlier, and any that depend on inventory by lot number (i.e., any concerning expiring stock) - could not be reviewed because the current database in CLM does not contain the necessary data. The adjustments of the stock database were completed too late for the consultant to produce and review reports on expiring stocks, but that is now possible,

If FPAK decides to continue using CLM after the pilot test, the consultant is suggesting that a temporary report be designed comparing current stocks to needs on the basis of consumption rates year-to-date, or first semester 1995, to take the place of the report that in 1996 will make such comparisons on the basis of 1995 experience (but cannot do similarly now for want of 1994 data).

In a few cases, the consultant created modified versions of the standard reports to reduce the paper required to print them or, in one case, to make the report more easily readable. Models and diskette copies of the modified report libraries have been left for Joyce Goodman's upcoming visit.

Aware from previous visits that FPAK is concerned with such issues as frequency of ordering (stock management in the field) and the delays between orders and shipments, the consultant created one dummy report not offered by CLM and tried inconclusively to produce another. The first of these shows how many orders each client submitted during the past quarter and the number of items per order (see Annex 4). The one that was not successfully completed was to show the number of days between the date of an order and the shipment of the corresponding goods (it might even also show the date the pick-list was

generated, as that is incorporated in the number CLM assigns to the order). This work was done through the Database Desktop of QuattroPro. The Executive Director has asked that at least the first of these (which he saw) be set up so that it can be produced at any time through CLM.

Evaluation of the pilot test

This task on the scope of work could not be implemented because the evaluation had been postponed pending the completion of the database adjustments and full use of the CLM system as designed.

CHAK

MIS Program Direction

The consultant, the FPMD Advisor and his assistant (currently training CHAK MIS staff) participated in a morning-long meeting with the Executive Director and eight of his senior colleagues. The agenda included review of the status of the CHAK MIS Program (on the basis of a memo prepared by the FPMD MIS Advisor), future directions of CHAK MIS, and the recruitment of an MIS Manager (currently underway). It was clear that many of the managers want more, or more prompt information than they have been getting for at least several months, and that at least some have a pretty good idea of what they want. It is also evident that the data clerk and the officer on secondment from the Ministry of Health who are the MIS Unit, constitute a very limited capacity. The recent theft of one of the unit's two computers has also crippled them. The discussion was lengthy and quite frank; it did not seem to be a discussion they had been through together in the recent past. From the minutes, one manager is to produce guidelines for future program development. To complement their effort, on the basis of his understanding of their views and resources, the consultant has produced and left with them a brief document describing what they might try to complete in 1995, or have in process by the end of the year, and anticipate in 1996. See Annex 5.

MIS Program Officer workplan

Recruitment of the new officer is underway. The deadline for applications was 15 May, but which time nearly 30 applications had been received. The FPMD Advisor participated in the development of the job description (and they consulted the job description used by FPAK when recruiting for a very similar post in late 1994). The discussions of the MIS Program are to result in a set of guidelines, and these should help the new officer develop a workplan once on the job, but it seemed inappropriate to undertake that task in the absence of the person who will have to carry out the plan, or at this stage of CHAK consideration of MIS overall.

Continuation Rate Monitoring

The hypothesis

Among clients using oral and injectable methods, a significant percentage of those who drop family planning do so during the first few months after becoming acceptors. A large, even substantial percentage of the pill/injectable clients who do drop family planning during the first few months after starting with it do so for reasons linked to one or more of the factors collectively labeled "quality of care". Service providers and the agencies that support them can do something about these factors. Sites with particularly high or low premature discontinuation rates - the former needing to improve, the latter knowing how to do well - can be identified relatively easily from the family planning register, as can norms against which to monitor change in rates. This would be useful and practical on an annual basis, and could be done more often where there is interest and motivation.

Activity carried out

The consultant and the FPMD MIS Advisor visited an FPAK clinic (Thika) and a CHAK clinic (Kijabe Medical Center) with a representative from FPAK and CHAK in their respective cases. During these visits we reviewed the family planning registers, and discussed the definition of new clients, the assignment of numbers to them, and, in general, the ways the records are kept.

The findings confirmed prior impressions that the client numbers and registers can be used to produce an indicator reflecting clinic success in retaining new clients, in general or for specific methods such as pills or injectables, through their first resupply visits. We were reminded that in most locations there are several registers in use, both static and outreach. It also became clear that special attention will be needed to interpret the proposed indicator for pill clients where CBD programs are active. One option would be to find a way to determine whether clients who are not returning to the clinic for resupply have become CBD clients. Another would be to adopt a standard and targets for clinics serving CBD-intensive areas, as opposed to those adopted for clinics in other areas.

Prospects

The approach appears to be quite feasible. It was discussed with the Executive Director, who was very interested in it because of the potential he sees in it as a tool for Area and clinic managers. He asked that copies of the documentation be left for the SPO/Medical, Dr. Ashwal, as well as the SPO/Evaluation and Research. In practice, Dr. Ashwal reviewed it, felt the main issues were those that are addressed and considered it something that could be useful at FPAK. It was also reviewed in a meeting with the Research and Evaluation (and MIS) Program Officers, who agreed that it seemed quite feasible, and should be put to the test. The basic outline of what would be involved is attached as Annex 6.

FPMO MIS Program

Activities

FPMO/Kenya has an agenda of MIS activities for the coming months which are likely to keep the staff fully occupied during these last months of FPMO activity in Kenya. To a significant extent these are activities long on the program, but which have progressed more slowly than anticipated, mostly for reasons beyond the control of FPMO.

One activity of FPMO MIS staff has been the introduction of HealthWare (locally adapted) in four organizations (FPAK, CHAK, NCPD, SDA). It is more fully operational in some places than others, and the institutional staff ability to use its internal report writer, R&R Report Writer (a separate, commercial program) or the QuattroPro for Windows Database Desktop query tools is also highly varied. FPMO anticipates organizing a brief workshop to bring together technical staff working with HealthWare in the four organizations to try to begin the development of a HealthWare user network in Nairobi. This could be a major contributor to the *sustainability* of HealthWare and productive MIS in these NGOs; it should have high priority.

The other work anticipated has been promised and is useful, but in the absence of continuing assistance from outside the NGOs themselves, its impact will often be rather less than it might have been.

RECOMMENDATION: Give high priority to the proposed workshop to bring together technical staff working with HealthWare in the four organizations using the product. If FPMD can launch the development, informal or otherwise, of a HealthWare user network in Nairobi, it could be a major contributor to the *sustainability* of HealthWare and of productive MIS in these NGOs;

Issues

The principal issue is probably deciding what is high priority and how to ensure it gets done before the depletion of staff sets in. The FPMD Representative is aware of this and is planning accordingly.

Outlook

Donors and many CAs tend to focus on their own particular programs, and on their needs more than those of the implementing NGOs (or government). This is most emphatically the case with information systems. Reports to the effect that USAID does not intend to support technical assistance for overall management (including MIS) in its next project are disheartening, to say the least. Even supposing increased management focus on the part of the CAs working with the NGOs, realism requires recognizing that it will be program-centered, as have been all MIS offerings of the technical CAs in the past.

At best -- and Murphy's Law will ensure results less than that -- there may in some cases be improved management of *parts* of the NGO *whole*. In the view of this consultant and of numerous NGO officials who have raised the issue with him during this visit, the whole organization, in most cases, is in need of strengthening, not just parts of it. Failure to recognize and act on this does not augur well for sustainability of the NGO as a whole, or for the program's that depend on it.

ANNEXES

**FPAK FAMILY PLANNING INFORMATION SYSTEM
CLINIC QUARTERLY METHOD MIX REPORT**

REPORTING UNIT NAME: Eastleigh CODE NUMBER: 21301

REPORTING PERIOD: Quarter 1 1995 MONTHS REPORTED: 3

TOTAL NUMBER OF NEW ACCEPTORS: 50 CONTINUING ACCEPTORS 998

	Diaph.	Condom	Pills	Inject	Norpl.	IUCD	TL	VS	INDICATOR
NA	0.0%	8.0%	26.0%	34.0%	20.0%	12.0%	0.0%	0.0%	64
CA	0.0%	3.0%	16.5%	69.6%	7.1%	3.7%	0.0%	0.0%	65
NA+CA	0.0%	3.2%	17.0%	67.9%	7.7%	4.1%	0.0%	0.0%	65

REPORTING UNIT NAME: Phoenix House CODE NUMBER: 21302

REPORTING PERIOD: Quarter 1 1995 MONTHS REPORTED: 3

TOTAL NUMBER OF NEW ACCEPTORS: 99 CONTINUING ACCEPTORS 2676

	Diaph.	Condom	Pills	Inject	Norpl.	IUCD	TL	VS	INDICATOR
NA	0.0%	16.2%	35.4%	13.1%	16.2%	18.2%	1.0%	0.0%	56
CA	0.1%	4.6%	21.9%	36.3%	8.5%	26.3%	2.2%	0.0%	70
NA+CA	0.1%	5.0%	22.3%	35.5%	8.8%	26.0%	2.2%	0.0%	70

REPORTING UNIT NAME: Pumwani CODE NUMBER: 21303

REPORTING PERIOD: Quarter 1 1995 MONTHS REPORTED: 3

TOTAL NUMBER OF NEW ACCEPTORS: 14 CONTINUING ACCEPTORS 497

	Diaph.	Condom	Pills	Inject	Norpl.	IUCD	TL	VS	INDICATOR
NA	0.0%	28.6%	50.0%	14.3%	0.0%	0.0%	7.1%	0.0%	36
CA	0.0%	7.4%	36.2%	41.2%	0.4%	14.5%	0.2%	0.0%	55
NA+CA	0.0%	8.0%	36.6%	40.5%	0.4%	14.1%	0.4%	0.0%	55

REPORTING UNIT NAME: Ribeiro CODE NUMBER: 21304

REPORTING PERIOD: Quarter 1 1995 MONTHS REPORTED: 3

TOTAL NUMBER OF NEW ACCEPTORS: 156 CONTINUING ACCEPTORS 1787

	Diaph.	Condom	Pills	Inject	Norpl.	IUCD	TL	VS	INDICATOR
NA	0.0%	12.8%	51.9%	21.2%	3.2%	10.3%	0.6%	0.0%	45
CA	0.0%	4.5%	30.2%	51.5%	4.5%	8.9%	0.3%	0.1%	59
NA+CA	0.0%	5.2%	32.0%	49.1%	4.4%	9.0%	0.3%	0.1%	58

HEALTHWARE R&R METHOD MIX REPORT FIELDS

NOTE: FoamT and Cream/J are omitted from these calculations. They represent double counting in most cases, as they are used with condoms and diaphragms. This was discussed with the Sr. Medical Officer, who agrees with the procedure.

FOLLOWING FIELDS ARE USED FOR NEW ACCEPTOR [NA] clients, Method Mix

1. The **NA_Meth** field sums new clients for the methods of interest, summing for a record.
Field: `_FPDATA->NA_Meth()`
(`NEW_PILL+NEW_INJE+NEW_NORP+NEW_IUCD+NEW_DIAP+NEW_COND+NEW_TL+NEW_VS`)

2. The **QNA_Meth** field sums NA_Meth fields for the quarter.
Field: `_FPDATA->QNA_Meth()`
Sum(`FPDATA->NA_Meth,FPDATA->QUARTER,Automatic Pre-processed`)

3. The **NAMM_...** fields define New Acceptor MMix Client Numbers for 1 method, 1 quarter.
Field: `_FPDATA->NAMM_Pill(), Inj, Con, Dia, Nor, IUD, TL, VS`
Sum(`FPDATA->NEW_PILL,FPDATA->QUARTER,Automatic Running`)

4. The **MMmethod** fields define % share of clients using principal methods.
Field: `_FPDATA->MMPill(), Inj, Con, Dia, Nor, IUD, TL, VS`
`NAMM_PILL/QNA_Meth`

5. Field: `_FPDATA->MMNA_Indic()` This is the INDICATOR field.
 $((.03*(MM_CON+MM_DIA))+(.3*MMPI))+(.7*MM_Inj)+(1*(MM_Nor+MM_IUCD))+(.14*(MM_TL+MM_VS)))^*100$

FOLLOWING FIELDS ARE USED FOR CONTINUING ACCEPTOR [CA] clients, Method Mix

6. **'CA_Meth'**
(`CA_PILL+CA_INJE+CA_NORP+CA_IUCD+CA_DIAP+CA_COND+CA_TL+CA_VS`)

7. Field: `_FPDATA->QCA_Meth()`
Sum(`FPDATA->CA_Meth,FPDATA->QUARTER,Automatic Pre-processed`)

8. Field: `_FPDATA->CMM_Inj()` [...one for each included method, as with NA]
Sum(`FPDATA->CA_INJE,FPDATA->QUARTER,Automatic Running`)

9. `_FPDATA->MMCDia()` [...one for each included method, as with NA]
`CMM_Dia/QCA_Meth`

10. Field: `_FPDATA->MMCA_Indic()` This is the INDICATOR field.
 $((.03*(MMCDia+MMCCon))+(.3*MMCPill))+(.7*MMCInj)+(1*(MMCNor+MMCIUCD))+(.14*(MMCTL+MMCVS)))^*100$

FOLLOWING FIELDS ARE USED FOR TOTAL [NA+CA] clients, Method Mix

11. Field: `_FPDATA->QT_Meth()`
`QNA_Meth+QCA_Meth`

12. Field: `_FPDATA->TMM_IUD()` [...one for each included method, as with NA]
`CAMM_IUD+NAMM_IUD`

13. Field: `_FPDATA->MMTIUD()` [...one for each included method, as with NA]
`TMM_IUD/QT_Meth`

Field: `_FPDATA->MMTotInd()` This is the INDICATOR field.
 $((.03*(MMTDia+MMTCon))+(.3*MMTPill))+(.7*MMTInj)+(1*(MMTNor+MMTIUD))+(.14*(MMTVS+MMTTL)))^*100$

ANNEX 2 : QUATTRO PRO TECHNICAL NOTE

A. Setting up a QUERY in a SPREADSHEET.

1. Include the path in the name of the file.

A query in a spreadsheet must start with the name of the file in its top left hand corner. It is wise to include the path with the file name, as in Figure 1.

Figure 1

	A	B
1	c:\fpakqp\cbd\fpdata	YEAR
2	check	1900

The name of the file alone in the upper lefthand corner of the query (without the path) is enough if the working directory of the Database Desktop is set to the sub-directory containing the file or files to be queried. [The working path is set from the File choice in the menu in Database Desktop.] Including the path eliminates the need to be concerned with the working directory setting and makes it possible to do queries linking files in different sub-directories.

2. Use a separate cell for the file name and each field.

Setup is facilitated and flexibility created if the name of the file (with or without path) is in the first cell, and each field name (or each one to be used) in a separate cell to the right. (see Figure 1) It is possible to put the file name and fields all in one cell, separated by a vertical bar (|), but this makes it harder to add or change specifications in individual fields. In addition, the single cell arrangement makes it very much more difficult to set up macros that make changes in field criterion in response to remote commands.

3. Ask the database to put a list of its fields in the spreadsheet.

Getting the correct names of the desired fields from the database file can be a chore. One easy way to do it is to identify one field name, put it in the query with the file name, check the entire file (the word "check" in the cell below the file name), put a criterion known to fit NO records under the field name, and run the query. In Figure 1, YEAR is a real field, but there are no records with 1900 in that field. That query resulted in the downloading of all field names. One can then move the field names (each in a separate cell) to the cells immediately to the right of the field name, where they will become part of the query being set up. See Figure 2.

NOTE that the field with the criterion (YEAR in this case) will show up at the end of the row of field names resulting from the query just run. If this is inconvenient, move it elsewhere; the order of the fields does not effect the query. In Figure 2, YEAR has been moved to the beginning of the row of field names.

Figure 2

	A	B	C	D	E	F
1	c:\fpakqp\cbd\fpdata	YEAR	MONTH	QUARTER	FW CODI	SUP COD
2	check	1900				
3						
4	c:\fpakqp\static\areas	CODE				
5	check	99				

To obtain the field names for more than one file, repeat the process. In running a new query, make sure the location of the query is correctly identified (if prior queries have been run, this probably needs changing) and that the destination is what is really wanted (not already occupied by something you want to keep). In Figure 2 the new query will be in a new location (A4..B5 instead of A1..B2), but the results of the first query have been moved to B1 and the cells

to its right, so the destination used in the first query is now empty, ready to be used by the next query. Note that the second query is on a database in a sub-directory different from that addressed in the first one.

4. A handy macro to set up the query format

The top row of each query on a database file must have a vertical bar (|) to the left and right of the name of the file and of each field. The second row of each query must have an apostrophe on the left and a vertical bar on the right. NOTE that the left hand vertical bar is not seen on the screen, but it is there and can be seen in the Edit window in QPro; the same is true of the apostrophe in the cells or the second row. See Figure 3.

Figure 3

	A	B	C	D	E
1	C:\FPAKQPI\STATIC\FPDATA	FACCODE	ORGCODE	ORGNAME	DISTCODE
2	'				

To put the apostrophe and bar in the second row cells, just put them in the first one (' | makes it easy to see), then copy the results into all the other cells of the row. Putting bars on either side of field names is not quite so easy, but can be made so with the macro in Figure 4..

Figure 4

	A	B	C	D	E	F	G
4	REPEATS	14	CNTR	15			Q
5							(Edit) (Home)
6	QRY		The formula in "QRY":				(Del) (End)
7	(FOR CNTR,1,14,1,Q)		+*(FOR CNTR,1,"&@STRING(C4,0)&"1,Q)				↳(Right)

REPEATS is the number of times the macro loop is to run. CNTR is the counter used by the "FOR" command in QRY to tell when the macro has run the number of times desired. QRY is the macro you launch to run the operative macro (Q) the necessary number of times. And |Q, as just noted, is the operative macro, the one that actually puts Qpro in the edit mode, moves the cursor to the far left of the cell contents, deletes the apostrophe there and inserts a vertical bar, then moves the cursor to the far right, inserts another vertical bar, terminates the edit mode (~=Enter), and finally moves to the next cell, ready to begin again.

If you use Database Desktop very often and are likely to want to use this from time to time, put it in a separate worksheet to be used as a MACRO LIBRARY. (Naming it Macrolib helps make it easy to find.) In the worksheet that is to be used as a macro library, click on Property, Active Notebook and then on Macro Library, where you click on YES to make the file a macro library. [NOTE: The help screen says one does this by clicking on the Title Bar, but that does not seem to work; the Property/Active Notebook approach does work.] Once you have created a Macro Library, when you call a macro (ALT F2), the arrow to the right of the Macro Library window in the Run Macro box opened by ALT F2 lets you choose any open Macro Library spreadsheet as the source of a macro to run. See Using Macro Libraries under Macro Libraries in HELP for more on the subject.

To use this macro: Type it as shown here. The cells to the right of REPEATS and CNTR can be left blank for the moment. Note that what is typed in the cell named QRY (beneath the QRY label) is the formula shown to the right of the QRY cell in Figure 4; what should appear in the QRY cell is what appears in it in Figure 4. [Under HELP, Search for (FOR.. to get more information about the FOR command in macros.) Use Block, Name, Label, Right to give the names REPEATS and CNTR to the cells immediately to the right of those labels, and then use the same command, but with Label, Down to give the names QUERY and Q to the cells just below those labels. [Use other names if you prefer, but make sure the references to CNTR and Q in the macros specify the appropriate cell names.] Each time you plan to use the macro, put in the cell named REPEATS (B4 in the example here) the number of cells in which you want a vertical bar placed at the left and right edges. [Column letters help

minimize counting: E is the 5th letter/column, J the 10th, R the 18th and Z the 26th as points of reference.]

Having indicated the number of cells to modify, go to the spreadsheet with the query needing the vertical bars. Put the cursor on the first cell in which the bars are wanted (starting from the left). Hold down ALT and press F2. *If the list of macros shown in the Run Macro box does not include QRY and \Q, click on the arrow to the right of the Macro Library window, then click on the name of the file holding the macro wanted (your macro library spreadsheet). The list of available macros will change to reflect those in the macro library spreadsheet. If you don't find the macro library spreadsheet this way, it probably is not open; open it, then start again.* Click on QRY and the macro will then run repeatedly until it has modified the number of cells specified in REPEATS. [In the lower right hand corner of the screen, MACRO and WAIT signify a macro is running.] NOTE that if you click on \Q instead of QRY, the macro will run one time and stop.

B. Modifying a *.dbf file structure via Database Desktop and spreadsheet.

1. Making a *.dbf file from spreadsheet data.

It is possible, and very easy, to create a dBase (or Paradox) file from spreadsheet data without ever leaving the spreadsheet. This is a useful tool when existing files need changing, even temporarily, e.g., to put historic data in a new, differently structured file, or when a special linking file is needed.

Place the columns of data to become a database file, including a top row containing field names, in an empty notebook (spreadsheet) with the first field name in cell A1. Click on the Save As command under File in the main menu. In the lower left part of the box that opens is a File Types window. Use the arrow to its right to review the list of options; click on the appropriate one (*.dbf will meet most needs). Now give the file a name in the File Name window in the usual manner and make sure the right sub-directory has been selected. Click on OK. You will have a chance to be sure the fields to be created in the database have the right format (numeric, character, date..., and number of decimal places); use the mouse to move from one field to the next in the list. Take care not to make the fields too narrow for the field names. When finished, click on Write and the database file is created.

2. Inserting data from one *.dbf in another *.dbf.

There are times when there is a need to incorporate data from one database file in another. The case arises when a new system is installed, or a master file is redesigned to meet new needs and one wants to include historic data in the master file. This can be done through the database desktop. The files can be quite different from each other, but each pair of source and destination fields must be of the same type (character, numeric, date..) and the two files must be in the same sub-directory.

Click on the Database Desktop icon, or choose it from the Data option on the menu. Click on the table (file) icon, or choose File, Open, Table from the menu to see a list of files in the working directory; be sure both the source and destination files for your operation are there. If they are not, under File on the Database Desktop menu, choose Working Directory and change it to the one holding the files you want to use. That done, click on the Query icon or choose New Query from the menu under File. Click on the destination file in the list offered. The query screen is presented, showing the table (file) selected. Click on the "+" icon above the query to again see the list of available tables (files), and click on the source file.

At the far left of the destination file query, type INSERT, or click and pick it from the list. Then, for each field for which data is to be inserted, **put a unique example in each pair of corresponding field cells in the two tables.** The data in the source table field with example Ex1 will be put in the destination file field with Ex1; the data in the source table field with example Ex2 will be put in the destination file field with Ex2, and so on. One must take care to **ensure that the examples match up the proper fields.** Note also that the source and

destination fields must have the same character, both numeric, both character, both date, and so on. In an earlier technical note we suggested using the Edit, Copy commands to insert multiple examples. Having experimented a bit more, we now recommend using the mouse and the "example" icon; it really goes quite rapidly. Checks should be NOT be put in any cells of either table; if there are any checks, an error message will point this out. Run the query. It will produce a table called !INSERTED.DB listing the items inserted. You will have to open the destination file to see it with the additions.

3. Changing a *.dbf file from from *character* to *numeric*, or vice versa.

To link files on a field, or to insert into one file data from another, the paired fields must both have the same type of data: numeric, character, date or other special type. There are times when one wants to change the nature of the data in a field (or fields) of a file, or to create a linking file that can be used to link two files in which the fields have and will retain different characters. This is relatively easy in the spreadsheet.

Decide which field is to be changed and use a query to download it to the spreadsheet. To the right of the field name at the top of the downloaded data put a name for the field that is to contain the converted data.

- If the original is a numeric (value) field, immediately to the right of the first record type in the function @string(CELL, 0) where CELL is the address of the contents of the field in the first record and the "0" signifies that there are to be no figures to the right of the decimal point (change this to the appropriate number if figures are wanted to the right of the decimal).
- If the original is a character (string) field, immediately to the right of the first record type in the function @value(CELL) where CELL is the address of the contents of the field in the first record.

Figure 5

	A	B	C	D	E	F	G
9	<i>numeric to character</i>				<i>character to numeric</i>		
10	CODE	CODE-A	formula for CODE-A		Nmbr	Nmbr_A	formula for Nmbr_A
11	235467	235467	@STRING(A11,0)		987091	987091	@VALUE(E11)
12	878207				808660		
13	633108				309118		
14	236144				752827		
15	524196				649339		
16	811140				332025		
17	437929				470778		

Copy the formula down its column next to all of the occupied columns to its left. This will result in a value or numeric column and a corresponding character or string column. Use the Block, Values command to **convert** the functions and formulae to values. Create a database file from this two column table (see above, Making a *.dbf file from spreadsheet data); it might called CODECONV.dbf

CODECONV.dbf can be used as a linking file for report generation, or the field it shares with the original table (e.g., the CODE field in the *numeric to character* example in Figure 5) can be used to link it to that table in a query to create a new table with all fields except CODE from the original and with CODE_A from the one just created from the spreadsheet. The resulting file would look the same as the old one, but its CODE or CODE_A field would be a character field instead of a numeric field. To retain the old field name, when creating the new file, put a check (tic) in the CODE_A field of CODECONV.dbf, and type AS CODE in it to make the name of the resulting field in the new table CODE.

4. Adding fields to a *.dbf.

This is really just another form of creating a new file, or table. In one recent case the need arose because a new master file had been created to meet new needs, but it has year, quarter and month fields where the old file (which still holds historic data) has a date field. To link the files on date-based information, e.g., to create a report showing new clients the first quarter of this year and last, they must have date-related fields in common, or have a linking file.

The approach is the same as in the conversion of field characteristics case above. Use a query to download the dates from the old file to a spreadsheet. In the columns of the spreadsheet just to the right of the downloaded data, insert formulae or functions that identify the year, quarter and month represented by the date to their left, as in Figure 6, where the functions (for Year and Month) and the formula (for quarter) are shown above the field names. Type these into the first row (B11..D11 in Figure 6) and then copy them down to the last row of dates. Use the Block, Values command to convert the functions and formulae to values.

Figure 6

	A	B	C	D
9		@YEAR(A11)	@ROUND((+D11+0.6)/3.0)	@MONTH(A11)
10	DATE	Y-AR	QTR	MON
11	23/01/94	94	1	1
12	10/04/94	94	2	4
13	08/07/94	94	3	7
14	15/07/94	94	3	7
15	29/08/94	94	3	8
16	02/10/94	94	4	10
17	28/10/94	94	4	10

Create a database file from this four column table (see above, Making a *.dbf file from spreadsheet data); it might called DATECONV.dbf

DATECONV.dbf can be used as a linking file for report generation, or the field it shares with the original table (the DATE field in the example in Figure 6) can be used to link it to that table in a query that creates a new table with all fields except DATE from the original and with YEAR, QTR and MON from the one just created from the spreadsheet. The resulting file would look the same as the old one, except that in place of a DATE field it would have YEAR, QTR and MON fields. This could be linked to the new one to create reports, or its data could be inserted into the new one to create one multi-year file.

ANNEX 3: METHOD MIX INDICATOR

The method mix indicator is a way of showing in a single figure the extent to which the family planning users in a group, e.g. those served by a given clinic, are using more versus less reliable, and short-term vs long-term methods.

Long-term methods offer a high degree of reliability and convenience, thus facilitating continued protection and contributing to program sustainability. However, it is normal for the method mix of a clinic or program to include clients using short-term methods, too. These are more appropriate for those planning to have a child in the near future or just being introduced to contraception, but some short-term methods are more reliable than others. Those using the more reliable methods are better protected than those using less dependable, or more inconvenient methods.

The method mix indicator was devised as an easy-to-use way to monitor significant changes in the percentage of more reliable and/or long-term methods in the method mix in a given group of clients; in effect, it reflects the "quality" of the method mix. Points are given on the basis of the percent of active users employing each of the six principal modern methods (barriers, orals, injectables, implants, IUDs and surgical), with more points for orals than for barriers, more for injectables than for orals, and so on through the list. The necessary data are already collected as part of the service statistics of any program monitoring method mix.

Calculation: Calculate the method-specific percentage of all active users: the number using each method divided by the number using all methods. Multiply the resulting percentages by the following weighting:

- 0.03 or condoms and barriers,
- 0.3 or pills,
- 0.7 or injectables,
- 1.0 or IUD and Norplant, and
- 1.4 or surgical methods.

Sum the weighted scores and multiply by 100 to obtain a whole number. (See below, where the Method Mix Indicator is 59.)

	PILL	INJ	NORP	IUCD	Cond. & Oth.	STERIL	TOTAL
	21%	62%	2.2%	4.4%	8.4%	2%	100%
times	<u>0.3</u>	<u>0.7</u>	<u>1.0</u>	<u>1.0</u>	<u>0.03</u>	<u>1.4</u>	
=	6.3 +	43.4 +	2.2 +	4.4 +	0.25 +	2.8 =	5.9 x 100 = 59

The multiplication factors were developed to reflect differing reliability and facility of continued use characteristics, to be sufficiently sensitive to reflect changes likely to occur over 12 months, and to make scores over 100 unlikely. Note that data sometimes include a category "other". This usually covers relatively unreliable methods, and for this reason clients counted under "other" (or under foam, jelly, diaphragm) should be added together with condom clients for purposes of calculating the Method Mix Indicator.

METHOD MIX INDICATORS, a sampling of Kenyan Clinics

	Condom & Diaphragm	PILL	Injectable	Norplant	IUCD	TLVS	TOTAL	INDI
Clinic-903	3.3%	17.0%	50.0%	7.0%	19.6%	3.1%	100%	71
Clinic-693	3.2%	16.0%	65.8%	4.0%	4.0%	7.0%	100%	69
Clinic-356	4.0%	13.0%	69.0%	4.0%	6.0%	4.0%	100%	68
Clinic-466	9.0%	28.0%	30.0%	5.0%	25.0%	3.0%	100%	64
Clinic-342	7.0%	21.0%	55.0%	3.0%	11.0%	3.0%	100%	63
Clinic-546	2.1%	19.9%	71.0%	0.0%	6.0%	1.0%	100%	63
Clinic-665	3.9%	17.0%	76.0%	0.1%	3.0%	0.0%	100%	62
Clinic-465	10.0%	27.0%	40.0%	9.0%	11.0%	3.0%	100%	61
Clinic-231	8.4%	21.0%	62.0%	2.2%	4.4%	2.0%	100%	59
Clinic-375	12.0%	23.0%	47.0%	1.0%	17.0%	0.0%	100%	58
Clinic-243	6.0%	31.0%	50.0%	3.0%	9.0%	1.0%	100%	58
Clinic-239	7.0%	33.0%	50.0%	2.0%	7.0%	1.0%	100%	56
Clinic-723	12.0%	22.0%	60.0%	2.0%	4.0%	0.0%	100%	55
Clinic-557	11.0%	38.0%	38.0%	0.0%	13.0%	0.0%	100%	51

Maximum 71
Average 61
Minimum 51

THE METHOD MIX INDICATOR METHODOLOGY:

	C&OTHS	PILL	INJ	NORP	IUCD	STERIL	
WEIGHTS=>	0.03	0.3	0.7	1	1	1.4	
	x	x	x	x	x	x	
Clinic-903	0.033	0.17	0.5	0.07	0.196	0.031	
	=	=	=	=	=	=	
The sum of	0.00099	0.051	0.35	0.07	0.196	0.0434	X 100 = Ind. 71

BEST AVAILABLE DOCUMENT

ANNEX 4 : EXAMPLE OF ORDER FREQUENCY REPORT FOR ADAPTATION IN CLM

NOTE that the number of ORDER (DATES) is obtained by counting UNIQUE DATES in the Order Date c

How many orders did the Logistics Service receive from each Clinic during the first quarter of 1995?
How big/small were the orders? What is the Ideal or "normal" number of orders/quarter?

LOC_NAME	ORDER DATE	ITEMS	LOC_NAME	ORDER DATE	ITEMS
NYERI CLINIC	16/01/95	12	PUMWANI CLINIC	17/02/95	5
NYERI CLINIC	27/01/95	1	PUMWANI CLINIC	08/03/95	3
NYERI CLINIC	16/02/95	9	PUMWANI CLINIC	17/03/95	8
NYERI THEATRE	16/02/95	2	ORDER (DATES) DURING THE QUARTER : 3		
NYERI CLINIC	27/02/95	1			
NYERI THEATRE	23/03/95	13	RIBEIRO CLINIC	16/01/95	7
NYERI CLINIC	30/03/95	32	RIBEIRO CLINIC	15/02/95	2
ORDER (DATES) DURING THE QUARTER : 6			RIBEIRO THEATRE	15/02/95	12
THIKA CLINIC	09/01/95	1	RIBEIRO THEATRE	07/03/95	1
THIKA CLINIC	10/01/95	3	RIBEIRO CLINIC	13/03/95	12
THIKA THEATRE	10/01/95	3	RIBEIRO CLINIC	20/03/95	12
THIKA CLINIC	14/01/95	1	RIBEIRO THEATRE	20/03/95	10
THIKA CLINIC	16/01/95	5	ORDER (DATES) DURING THE QUARTER : 5		
THIKA THEATRE	10/02/95	7	NCPD	03/02/95	1
THIKA CLINIC	16/02/95	10	NCPD	13/02/95	6
THIKA THEATRE	02/03/95	4	ORDER (DATES) DURING THE QUARTER : 2		
THIKA THEATRE	24/03/95	2			
THIKA THEATRE	26/03/95	9	ELDORET CLINIC	25/01/95	4
THIKA CLINIC	27/03/95	26	ELDORET THEATRE	25/01/95	1
ORDER (DATES) DURING THE QUARTER : 10			ELDORET CLINIC	02/03/95	19
MOMBASA CLINIC	02/01/95	2	ELDORET CLINIC	03/03/95	1
MOMBASA CLINIC	16/01/95	9	ELDORET THEATRE	22/03/95	10
MOMBASA THEATRE	02/03/95	16	ORDER (DATES) DURING THE QUARTER : 4		
MOMBASA CLINIC	21/03/95	19			
MOMBASA THEATRE	21/03/95	10	KISII THEATRE	27/01/95	7
MOMBASA THEATRE	22/03/95	9	KISII CLINIC	20/02/95	9
ORDER (DATES) DURING THE QUARTER : 3			KISII THEATRE	20/02/95	9
EMBU CLINIC	03/01/95	1	KISII THEATRE	21/02/95	12
EMBU CLINIC	09/01/95	6	KISII CLINIC	01/03/95	4
EMBU CLINIC	16/01/95	12	KISII THEATRE	10/03/95	11
EMBU CLINIC	20/02/95	6	KISII CLINIC	24/03/95	26
EMBU CLINIC	23/02/95	1	ORDER (DATES) DURING THE QUARTER : 6		
EMBU CLINIC	03/03/95	12			
EMBU CLINIC	13/03/95	7	KISUMU CLINIC	16/01/95	10
EMBU CLINIC	27/03/95	14	KISUMU CLINIC	20/02/95	14
EMBU CLINIC	28/03/95	9	KISUMU CLINIC	13/03/95	14
EMBU CLINIC	*****	9	KISUMU CLINIC	24/03/95	7
ORDER (DATES) DURING THE QUARTER : 10			KISUMU CLINIC	27/03/95	8
MERU CLINIC	16/01/95	11	ORDER (DATES) DURING THE QUARTER : 5		
MERU CLINIC	10/03/95	13	OTHER	03/01/95	4
MERU CLINIC	16/03/95	2	OTHER	09/01/95	3
ORDER (DATES) DURING THE QUARTER : 3			OTHER	25/01/95	5
EASTLIEGH CLINIC	03/01/95	3	OTHER	16/02/95	14
EASTLIEGH CLINIC	12/01/95	1	OTHER	17/02/95	1
EASTLIEGH CLINIC	20/01/95	3	OTHER	28/02/95	1
EASTLIEGH CLINIC	27/01/95	1	OTHER	03/03/95	5
EASTLIEGH CLINIC	03/02/95	1	OTHER	10/03/95	1
EASTLIEGH CLINIC	07/02/95	2	OTHER	14/03/95	1
EASTLIEGH CLINIC	08/02/95	11	OTHER	23/03/95	1
EASTLIEGH CLINIC	13/02/95	1	OTHER	27/03/95	1
EASTLIEGH CLINIC	23/02/95	1	OTHER	31/03/95	3
EASTLIEGH CLINIC	06/03/95	2	ORDER (DATES) DURING THE QUARTER : 12		
EASTLIEGH CLINIC	16/03/95	1			
EASTLIEGH CLINIC	21/03/95	9	NAKURU THEATRE	25/01/95	3
EASTLIEGH CLINIC	29/03/95	1	NAKURU THEATRE	20/02/95	8
EASTLIEGH CLINIC	30/03/95	3	NAKURU THEATRE	01/03/95	3
ORDER (DATES) DURING THE QUARTER : 14			NAKURU CLINIC	06/03/95	3
PHOENIX THEATRE	17/01/95	6	NAKURU CLINIC	30/03/95	18
PHOENIX THEATRE	22/01/95	4	NAKURU THEATRE	30/03/95	19
PHOENIX HOUSE CLINIC	09/02/95	8	ORDER (DATES) DURING THE QUARTER : 5		
PHOENIX THEATRE	09/02/95	10			
PHOENIX HOUSE CLINIC	03/03/95	1	KAKAMEGA THEATRE	25/01/95	4
PHOENIX HOUSE CLINIC	07/03/95	6	KAKAMEGA THEATRE	20/02/95	12
PHOENIX THEATRE	14/03/95	2	KAKAMEGA THEATRE	01/03/95	24
PHOENIX THEATRE	16/03/95	7	KAKAMEGA CLINIC	07/03/95	2
ORDERS IN QUARTER 8			KAKAMEGA CLINIC	13/03/95	10
			ORDER (DATES) DURING THE QUARTER : 5		

CHAK MIS DEVELOPMENT, LOOKING BACK FROM THE END OF 1995

The evolution of CHAK's MIS capability and services over the seven months remaining in 1995 and during 1996 will depend in very large part on CHAK's success in strengthening its MIS staff and on where it decides to put priority. Staff capacity is currently a major limiting factor. Reflecting on discussions at CHAK this week and on the CHAK MIS STATUS notes prepared by the FPMD MIS Advisor, following is a brief outline of what CHAK might expect to have (a) accomplished, (b) underway and (c) planned for the first months of 1996.

Completed by the end of 1995:

- MIS Manager recruited with instructions to concentrate on MIS, and without responsibility for research beyond data processing support.
- The three-person MIS staff is spending all of its time on MIS, the senior staff members being called out to other work only very rarely.
- Responsibilities of the MIS unit clarified and now understood by all to be primarily,
 - + data processing, plus training and support of computer utilisation throughout CHAK,
 - + technical participation with concerned department/program staff in the evaluation and revision of forms, reports and other parts of the management information system,
 - + working with concerned departments/programs to introduce new software where appropriate, and to introduce new information system components or practices in field units.
- Data for 1993 and 1994 incorporated into the HealthWare databases and reports programmed to provide comparisons for a variety of indicators (new acceptors, overall method mix, CYP) between any period specified of the current year and the same period either of the earlier years.
- Since September, 1995, the MIS unit has successfully been producing standard reports for donors on the schedule required by the donors, and since October standard internal FP reports have appeared on a monthly basis, with consolidated reports each quarter; they are produced within a week to ten days of the arrival of the field reports at the MIS unit.
- The MIS unit has been successfully using the QuattroPro tools and skills acquired from FPMD to produce ad hoc reports, including graphics, for different programs.
- The MIS Unit participated in one program survey; it provided consultation on form design (to facilitate setting up data entry screens), provided data entry support (including training a program staff person in data entry), and processed the data, producing the final report tables as requested by the survey director. The program department concerned did most of the study design, development of survey instruments and data collection, as well as some of the data entry, then drafted the actual report, incorporating the tables and graphics from MIS.
- Standard internal reports were reviewed at the end of the year and, as a result, some will be changed, others added. The new report set will include graphs for use by headquarters' staff and to be sent as feedback to the field; the MIS unit will produce the graphs from data in the HealthWare database by using the FPMDprovided QuattroPro Database Desktop to download the relevant data each period into prepared locations linked to the standard graphs.

- On three occasions, the MIS staff was involved during one day of the 5 day training of staff from field units receiving new sub-grants under the USAID program. The MIS staff role was to review the existing information practices (registers, records, etc.) at the unit, to explain the special needs that arise because of the sub-grant, and to train them in the use of the forms that will be required. Program staff help in this process and as a result are increasingly able to present the material themselves. This should reduce the need for MIS staff to go to the field for such sessions.
- The computer program for Activity Reports was reinstalled in July, new guidelines were prepared by a committee of program officers, with MIS representation, and the system is to be reactivated with the activities in the 1996 workplan. It should greatly facilitate reporting to donors.
- The Finance Department and MIS reviewed three accounting software packages with payroll modules in late summer and selected one. The supplier and the accounting and MIS staff installed it and trained staff for a limited number of operations in October with a view to having it fully operational by the end of the year. It will be run in parallel with the manual system through June 1996.

The product is used by several organizations in Nairobi. The local supplier is long-established, has installed the software in most of the organizations using it, and has trained their staff and provided support during the first several months of use. CHAK accounting and MIS staff have discussed with two of the users the software itself, the introduction process and the help provided by the supplier; they have also checked more briefly with the other users. All give very positive reports. The users acknowledge that there were problems but conclude that the supplier helped resolve them, the product has worked well, and their own staff are now quite happy with it.

Anticipated during the first half of 1996.

- production of tables and graphics for the annual reports
- introduction of the new and revised FP reports, and continued, regular production
- continued support of the new accounting system
- introduction, with the supplier, of the payroll module of the accounting system, and provision of continuing support for it
- development of input screens, data files and reports for two CHAK sections whose activities are not yet incorporated in the system
- the revised activity report will be produced each quarter for use in quarterly PPMC meetings (as long as the report forms reach MIS at least 5 days before the meetings)
- Management have agreed with members on a new Facility Information Form to be introduced in 1996. MIS will prepare a data entry screen, data file and basic reports for use when the data begin to arrive in April-May..
- a computer program is being devised with QuattroPro to run quality control tests on field data, basing its evaluation on past trends and comparison of the service statistics and contraception consumption data reported; it will not identify all problems, but is expected to help improve the quality of our data and to help us assist those whose record-keeping and reporting need improvement. This will be tested on data samples during the first quarter of the year.
- participation in design and processing of data for operations research projects undertaken by program staff

MONITORING NEW ACCEPTOR RETENTION RATES

HYPOTHESIS: Among clients using oral and injectable methods, a significant percentage of those who drop family planning do so during the first few months after becoming acceptors. A large, even substantial percentage of the pill/injectable clients who do drop family planning during the first few months after starting with it do so for reasons linked to one or more of the factors collectively labeled "quality of care". Service providers and the agencies that support them can do something about these factors. Sites with particularly high or low premature discontinuation rates - the former needing to improve, the latter knowing how to do well - can be identified relatively easily from the family planning register, as can norms against which to monitor change in rates. This would be useful and practical on an annual basis, and could be done more often where there is interest and motivation.

OBSERVATION: In the Kenya Government family planning registers used by most clinics and in the nearly identical register used in FPAK clinics, clients are identified by registration number as well as by name. A client new to a facility is registered (and reported) as a NEW client and given a registration number. The numbers include a serial number, starting with 1 each year, and two digits to indicate the year; thus, the number given to the first client in 1995 is 1/95. Each time the client comes to the clinic, both the registration number and the name are recorded in the register, as are the date of the visit and other information about it.

IMPLICATIONS:

- the most recent number allocated to a new client equals the number of new clients registered to date during the current year (and the last number given out in a year equals the number of new clients registered during that year);
- the difference between the last number given to a new client one month and the last one given out the following month equals the number of new clients registered the second month;
- from the registration numbers of the clients served during any day, month, or quarter, one can determine when these clients were first registered with the clinic;
- the cohort or group of "new clients" in a particular time period, e.g., a month or a quarter, can be identified by the range of registration numbers they have, all those from the first number given out in the time period through the last one, and by combining this characteristic with the previous one, it is possible to determine what percentage of the new clients of one period visited the clinic during another period.

These last two implications of the system are what makes it possible to use the registers to find out what percentage of new clients give up family planning within a few months of starting.

EXAMPLE: In one clinic visited, the last number given to a new client in March 1995 was 56/95. This means there were 56 new clients during the first quarter of 1995 (the first in January was 1/95). During the second quarter, if they are to remain protected, the new injectable and pill clients of the first quarter (those with nos. 1/95 - 56/95) must return, the former for their second injections and the latter for resupply of pill cycles. *How many did return for re-injection or resupply?* The answer is found by counting the number of registration numbers from 1/95 through 56/95 in the Client Number column of the register pages for the second quarter of the year.

ISSUES: In practice, the process is not quite that simple.

- a. Some clients may return a little later than scheduled and should not be counted as having dropped out.
- b. Not all new clients in the reference period will use pills or injectables and those who do not return could be mostly condom users and IUD clients.
- c. Some clients may return more than once during the control period (e.g., to consult concerning a problem, or change methods) and are likely to be counted twice if one just counts numbers between 1 and 56.
- d. It would be useful to distinguish between methods when calculating retention rates, but simply counting cohort registration numbers does not allow this.
- e. People move away from the area, switch to other supply sources (e.g., CBD agents) and stop because they want to get pregnant, how does one take this into account?
- f. What is an acceptable level? What should we aim for?

ANSWERS: Among the issues above, consider the last questions first. *(f.) What is an acceptable level? What should we aim for?* What is "acceptable" and meaningful targets should be based on local realities. Those realities are reflected in the levels of retention actually experienced by local clinics. It is this experience that should be the source of targets, targets that can be met only by continuing improvement, not maintenance of an "acceptable" level (unless it is particularly high).

A key part of the answer, then, is that local experience must be defined for a reference group of clinics. The larger the group, the better, but one need not wait for national involvement. One could begin by identifying the retention percentages in moderate sized homogeneous groups of clinics (e.g., all those of FPAK, several or all of those of CHAK). The process is the one described in the rest of this note.

When it comes to setting goals, targets, there is no hard and fast rule other than, "be realistic". One possibility would be to decide that in a given year, any clinic with a new client retention rate below the average for the reference group should at least bring its rate up to that average, and any clinic with a rate already above the average should aim for the average rate of the 10-20% of clinics with the highest rates in the reference group.

(e.) People move away from the area, switch to other supply sources (e.g., CBD agents) and stop because they want to get pregnant. how does one take this into account? With an indicator based on failure to return for the second resupply or injection, there should be few clients who stop for a desired pregnancy; that would mean they changed their minds in the 3 months after becoming new acceptors. This and, more often, migration or change of supplier and other factors will keep the return level below 100% most places, most of the time. That is accepted. By using local averages as "norms" and targets, one takes into account local experience of migration, use of other supply sources and other "acceptable" reasons for retention rates of less than 100%.

In addition, however, it may be desirable to define norms and targets for special situation clinics. For example, in clinics surrounded by strong CBD programs, it may be quite normal for most pill clients who start at the clinic to switch to CBD supply; if there are many such clinics, their experience could be the source of norms and targets for that sub-group. Alternatively, a manager with a lower-than-average retention rate among new pill clients who suspects they are going to CBD agents should find out whether that, in fact, is the case.

It is essential that one keep in mind that what is proposed here is a management tool, an indicator that will help managers identify areas of program weakness, will help them know when their programs are doing well, and how well it is possible to do. A below-average retention rate does not tell a manager how to improve it, or even that it is unacceptable. It signals a need for information about why clients are not returning, about ways in which the manager's client environment may differ from that of most clinics in ways that explain below-average retention rates.

The indicator can answer such questions as:

- What is the average (in our association, a district, a province, the country) percentage of new clients (or new pill clients, or new injectable clients) who return for a second supply of pill cycles or injection?
- Are we losing more new clients than the average? How far are we from the average?
- How many clinics retain a larger percentage of their new clients than we do? How much larger?
- Have we increased since last year the percentage of new clients we retain?

How would one determine retention rates, taking into consideration the issues raised above?

1. To allow for (a) clients who return a little late, verify return visits over a four month period instead of the three months during which they should be coming to the clinic for re-injection or resupply, thus for first quarter new clients, revisits would be inventoried for the period April through July.

2. There is a relatively simple way to cope with (b), (c) and (d).

The key step is to prepare in advance a form on which the registration numbers for the reference cohort are listed with space to check (tic) when they appear in the control period (when they should be returning). By using such a reference list, one can avoid issue (c), double counting. [Note that, for management purposes, it might be wise to put a tic for each time the number appears, then return to the register to see why people make extra visits, an extra bit of information.] After registration numbers in the control period have been checked and tics have been put on the control form next to those numbers that were found in the control period, the absence of tics shows which clients did not return.

One can then return to the first quarter pages in the register and, **on the control list**, identify (with P or I) the pill and injectable users (if only those are to be monitored) among those who **did not return** during the control period. Part of the control list might look like Figure 1, below. Monthly/quarterly service statistics reports will show the number of new clients by method for the cohort being monitored. At this point, one knows from reference period reports how many new pill clients and new injectable clients there were, and one can see from the control form how many of clients of each of these methods did not return when expected; this responds to issues (b) and (d) above.

Figure 1

1/95 ✓	31/95 ✓
2/95 ✓	32/95 ✓
3/95 ✓	33/95 ✓
4/95 <i>Jy</i>	34/95 ✓
5/95 ✓	35/95 <i>P2</i>
6/95 ✓	36/95 ✓
7/95 <i>Jy</i>	37/95 ✓
8/95 <i>P2</i>	38/95 <i>P2</i>
9/95 ✓	39/95 ✓

EXAMPLE: The reports for January, February and March, 1995, show 8, 12 and 10 (a quarterly report would show 30) new pill clients during the quarter and 12, 18 and 20 (50 in a quarterly report) new injectable clients for the quarter; on the control list, 6 of the blanks (no tic, meaning no appearance during the control period) were pill clients and 5 were injectable clients. In this case, 6/30 or 20% of pill clients and 5/50 or 10% of injectable clients were apparently no longer getting family planning services from this clinic.

Note that in many, perhaps most cases, one clinic will have several registers (one per service delivery staff member, and often one or more for mobile units). The work should be planned to minimize the time required with the registers, and it must be recognized that clients who are registered as NEW in one register can appear for their revisits in another. If the reference period is the first quarter of the year, the new client numbers can be identified and the control form prepared without reference to the clinic (the first new client number is 1 and the last is equal to the number of new clients received in the period, which is reported in service statistics). For another reference period, one would have to ask the clinics for the first number given a new acceptor in the period (and request or calculate from reports of new acceptors, the last number given out).

WHAT NEXT: FPAK or CHAK could carry out this data collection in each of the clinics in which the association supports family planning activities. The control forms could (and should) be prepared at headquarters and the actual data recording from the registers should be done by program officers or regional staff during routine visits to give them a better idea of what is happening in their clinics; it is part of performance monitoring. The result would be two figures for each clinic involved, a retention rate for new pill clients and one for new injectable users.

To see quickly which clinics are doing well, which less well, and how wide the range of rates is, sort the list of clinics and their new pill client retention rates in descending order, from the highest rate to the lowest, then do the same thing with the new injectable client retention rate list. Now calculate the average for the group, and the average for the top 20%. If some clinics are much more strongly supported by CBD activities than others, are the former predominantly on the lower half of the list (less than average retention rates) for new pill clients? If so, try dividing the total group into those with extensive CBD support and those without, sorting them in the same way again, and calculating averages for both groups. If there is a wide range between the highest and lowest rates, what do they do at the clinics near the top of the list that might account for their performance? Can others learn to do the same? Give the results to clinic managers, along with the questions on the top of page 3 and the suggestion that improvement is possible.