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K E N Y A

An Assessment of
Voluntary Surgical Contraception
Information, Education and Counseling

3 to 18 November, 1986

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Executive Summary

An assessment of surgical contraception education counseling and client follow-up services was conducted in 34 service sites throughout Kenya where VSC services are being delivered. Sites visited by three two-person teams during the period November 3 to 18, 1986 included health facilities in government, non-government, mission and private sectors. This assessment is part of continuing efforts to develop more effective VSC education, counseling and follow-up programs within the context of the increasing surgical contraception services in Kenya. It can contribute to the national VSC guidelines for education and counseling being developed by the Reproductive Health Technical Committee (RHTC) of the National Council on Population and Development (NCPD).

Interviews held with both clients and service providers at the 34 facilities indicate that clients are making informed, voluntary decisions for surgical contraception. The demand for VSC is usually higher than the existing facilities and staff can accommodate. Clients' desire for permanent contraception is demonstrated by their perseverance to obtain services despite substantial obstacles. A major barrier is the lack of facilities and trained staff for VSC education, counseling and services, especially in the public sector. In addition, the lack of spousal agreement serves as a deterrent for many clients who desire permanent contraception.

Despite these obstacles, the findings were quite favorable regarding the extent and quality of clients' understanding of tubal ligation. They are well-informed that surgical contraception is permanent, are very sure that they want no more children, and have both knowledge of and access to methods of temporary family planning. Service providers exhibit no bias towards promoting permanent contraception, and are committed to the issue of client choice. However, misconceptions about VSC and temporary methods of contraception exist and efforts should be made to address those in future training programs for family planning education and counseling staff. Finally, the issue of vasectomy and the male's responsibility for family planning are not adequately addressed, nor have service providers addressed ways to deliver services in settings which are acceptable to men.

These findings reflect observations common to all sectors, although there were differences, most notably between the government and non-government sectors. These differences are due, in part, to the fact that government facilities are less likely to have adequate numbers of staff trained in VSC education and counseling and surgical techniques.

Specific recommendations have been made for each sector and are found in the relevant sections of this report. General recommendations to improve quality of voluntary surgical contraception education and counseling in Kenya are as follows:

1. All sites which perform VSC services should have staff trained in education and counseling and in performing minilaparotomy under local

anesthesia with light sedation.

2. The quality of family planning information and education needs to be improved for all contraceptive methods, including surgical contraception. Family health educators need to be more thoroughly trained, particularly on the risks, benefits and misconceptions related to each method. In addition, the development or adaptation of appropriate printed materials to assist in I&E efforts are strongly recommended.

3. All information programs should include more than just a perfunctory mention of vasectomy to help create awareness and acceptance of the male's role in family planning.

4. A form to document informed consent for surgical contraception should be developed for national use. This form should include the following elements of informed consent, which ensure the client's understanding that:

- temporary methods of contraception do exist and are available;
- the procedure is surgical and there are attendant risks;
- the operation should be considered permanent, and if successful, the client will be unable to have more children;
- the client may change his or her mind at any time prior to the surgery.

This form should also be signed and dated by the client, a witness (for illiterate clients), and by the staff person attesting to the client's informed choice.

5. To reduce the number of visits and waiting time for the operation, hospitals and clinics should decentralize client education and booking for final counseling and surgery. A staff person at each service site should be identified as responsible for supervising client education and ensuring informed choice. Actual client counseling and obtaining signed informed consent forms should be conducted by a limited number of staff who have received special training.

6. The Ministry of Health (MOH) should designate VSC Medical and Nursing Coordinators to ensure good quality service, counseling and voluntarism, similar to the supervision systems in place in the Family Planning Association of Kenya and the Protestant Churches Medical Association.

7. The MOH should develop or adapt a standard client record form for use in all surgical contraception service sites. This form should be simple to fill out yet capable of recording VSC services and client satisfaction.

8. A concerted effort should be made to remove obstacles to obtaining voluntary surgical contraception services by: 1) upgrading facilities and staff where there is a commitment to and interest in expanding VSC services; 2) placing emphasis on the voluntary informed consent of the client rather than on that of spouse or other family members while encouraging agreement of both partners.

PURPOSE, BACKGROUND AND METHODOLOGY

The purpose of this assessment is to survey the quality of surgical contraception education, counseling, and client follow-up services being provided at 34 service sites throughout Kenya. Those sites represent facilities in government, non-government, mission, and private sectors and include current and projected AVSC-supported service sites as well as facilities not receiving AVSC assistance. The objectives of this assessment are: (1) to determine how VSC education, counseling, and client follow-up services are being provided in Kenya; (2) to identify existing strengths and weaknesses of these services, including actual and potential problems; (3) to make recommendations for appropriate follow-up actions; and (4) to prepare a comprehensive report which will be made available to the Reproductive Health Technical Committee (RHTC) of the National Council on Population and Development of Kenya.

Tubal ligation services for medical indications have been provided in Kenya for quite some time. In the past few years, however, the demand for elective surgical contraception has increased significantly among clients who have attained their desired family size. This needs assessment is seen as a major effort to improve and/or develop effective VSC education, counseling, and client follow-up programs within the context of the increasing demand for, and expansion of, surgical contraception services in Kenya. The availability of high quality education and counseling services is necessary to safeguard each client's right to make an informed decision about voluntary surgical contraception. The VSC subcommittee of the National Council on Population and Development has identified the need to establish national guidelines for surgical contraception service provision which will include medical, training, and education/counseling components. This assessment provided the opportunity to survey current VSC education, counseling, and client follow-up services and the resulting report can be used in the development of the education and counseling components of the proposed national VSC guidelines.

The assessment was conducted by a six-member team comprised of:

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The group was subdivided into three teams, each of which visited 10-13 of the 34 service sites between 3 - 18 November 1986. A list of the 34 sites is appended as are the itineraries for the three teams. (Individual site reports are on file at AVSC.)

The teams held detailed discussions with hospital/clinic administrators and staff involved in providing surgical contraception services at each site. Team members observed group education sessions and client counseling sessions, and interviewed clients who had received surgical contraception

services at the site as well as those currently booked for services. An assessment tool was prepared for use by the teams and is appended to this report.

Following the field visits, the group met in Nairobi on 19-21 November 1986 to prepare this report on the quality of surgical contraception education, counseling, and client follow-up services being provided in Kenya. Recommendations for appropriate actions are included in the report. The report will be used by AVSC, the Ministry of Health, and appropriate non-government, mission, and private organizations and will be shared with USAID. In addition, the report will be made available to the RHTC for use in developing the education and counseling components of the national VSC guidelines to be presented to the National Council on Population and Development.

MINISTRY OF HEALTH INSTITUTIONS

Seventeen MOH hospitals were visited during this assessment, five of which receive AVSC support. Many of these are now providing tubal ligation (T.L.) services on a limited basis, either during the postpartum or interval periods. The demand for services is greater than the capacity of MOH facilities to provide services requested, as evidenced by long waiting lists and postponement of scheduled elective surgery.

The following aspects of the MOH hospitals' VSC programs were found to enhance a client's ability to make an informed decision about permanent contraception:

- (1) There is a very good outreach network in place; family health educators, in general, have a good understanding of all methods of family planning, including T.L.
- (2) Family planning services, including T.L. services, are provided as an integral part of the MCH program. This greatly enhances the acceptability of family planning.
- (3) A range of temporary methods is generally available at provincial, district and sub-district hospitals. Supply problems, though infrequent, do exist.
- (4) There are no restrictive age/parity requirements for obtaining a T.L.
- (5) The cost of the procedure is not prohibitive; in general, clients pay a registration fee of 10-20 shillings (\$US 1.50) for T.L. Payment of this symbolic fee is an indication of client choice.
- (6) Virtually all staff demonstrates a high level of commitment to and interest in providing T.L. services as an integral part of the MCH/FP program.
- (7) All clients interviewed were satisfied with the services received and with their decision to have surgical contraception.

The following program areas need to be reinforced to ensure the client's informed decision:

- (1) Although the quality of information provided in the field and in the MCH/FP programs is good, counseling is not systematically provided to all clients who express an interest in surgical contraception. Counseling is defined as the process which:
 - . provides accurate information on all family planning methods including risks and benefits of each;
 - . examines the feelings and motives of the client and neutrally

- assists in his or her decision-making;
 - . ensures that the client has an opportunity to express fears and doubts and ask questions;
 - . ensures that the client understands that the procedure is intended to be permanent but has a slight risk of failure, that it is a surgical procedure with attendant risks, that it results in having no more children, and that the client is free to change his or her mind at any time prior to surgery;
 - . prepares the client for what is to be expected during the surgical procedure and afterwards.
- (2) There are a few, if any, quality audio-visual aids available for use by field and hospital-based staff who provide information, education, and counseling for temporary and permanent methods of family planning.
 - (3) The informed consent process and documentation needs improvement. An informed consent form is important to service providers to document that clients are informed prior to undergoing surgery. The surgery consent form generally used is limited to authorization of surgery, is not always properly completed, and is not descriptive of the procedure to be performed. Documentation of informed consent was sometimes lacking, often in cases of postpartum tubal ligation.
 - (4) There is no standard format for collecting socio-demographic and medical data, for example, age, parity, reasons for choosing surgical contraception, medical history and physical exam, surgical notes and follow-up.
 - (5) Improvement of access to surgical contraception is critical to ensure a client's free choice of family planning alternatives. Problems with access are related to factors such as:
 - . Curative surgery takes precedence over elective surgery;
 - . Immediate postpartum tubal ligations are often difficult to schedule;
 - . Spousal participation cannot always be obtained;
 - . Requested surgery is frequently postponed or rescheduled;
 - . Facilities are limited and insufficient numbers of staff are trained in minilaparotomy under local anesthesia.

Recommendations

1. Key personnel in the MCH/FP and maternity units should be identified for training in information, education and counseling for surgical contraception. After training, this staff should be responsible for

ensuring that all clients receive complete information in preparation for decision-making. They should also be responsible for training additional staff to provide accurate information on all methods.

2. The MOH should develop the capacity to monitor and supervise quality VSC medical services as well as education and counseling on a national basis to ensure that voluntarism is maintained in all sites offering these services. This will require designating coordinators and staff.
3. Appropriate educational materials should be developed or obtained on all family planning methods, to assist in the information, education, and counseling services.
4. A form to document informed consent for surgical contraception should be developed. This form should include the following elements of informed consent which ensure the client's understanding that:
 - . temporary methods of contraception exist and are available;
 - . the procedure is surgical and there are attendant risks;
 - . the operation should be considered permanent and if successful, the client will be unable to have more children;
 - . the client may change his or her mind anytime prior to surgery.

This form should also be signed and dated by the client, a witness (for illiterate clients), and by the staff person attesting to the client's informed choice.

5. A standard client record form should be developed which would be simple to fill out, yet complete enough to monitor the quality of surgical contraceptive services and client satisfaction.
6. Hospitals with staff which have exhibited commitment to providing surgical contraceptive services should be given priority assistance to upgrade the facilities (such as additional operating, recovery and counseling areas), and to train physician-nurse teams in the refined minilaparotomy technique with local anesthesia and light sedation on an out-patient basis. Special consideration should be given to district and sub-district hospitals who serve clients that often have no other access to temporary or permanent family planning.

FAMILY PLANNING ASSOCIATION OF KENYA

We visited the five FPAK clinics currently providing voluntary surgical contraception services. Virtually all tubal ligations are performed as interval procedures, on an out-patient basis, and a few cases of vasectomy have been performed. Each service site provides surgery two or three times per week, and thus far has been able to meet the demand without long delays. In addition, FPAK serves as a major training institution for physician-nurse teams in the preferred minilaparotomy technique using local anesthesia, and for nurses providing information and counseling. They also train field educators and lay educators in all methods of family planning.

The following aspects of the FPAK VSC programs were found to enhance a client's ability to make an informed decision about permanent contraception:

- (1) Staff has been well trained in all aspects of education, counseling, and services.
- (2) All FPAK clinics provide the full range of temporary family planning methods.
- (3) The clinics have strong grass-roots support from community leaders, e.g., chiefs, church leaders, and womens' groups.
- (4) FPAK lay and field educators are well-trained and supervised.
- (5) The client education and counseling process is thorough for all clients. This is generally a three-tiered process involving the field educators, the clinic-based counselor, and the physician-nurse operating team.
- (6) There are no restrictive age-parity requirements for obtaining surgical contraception.
- (7) Medical counseling services are monitored on an on-going basis by the FPAK Programme Manager - Medical.
- (8) The forms documenting informed consent include all necessary points and provisions for appropriate signatures, and in general are properly completed.
- (9) FPAK utilizes a standard VSC client record form to collect socio-demographic and medical data to monitor the quality of surgical contraceptive service and client satisfaction.
- (10) There is good client follow-up at one and six weeks post-operatively, and there is a high rate of return.
- (11) Clients pay 200 shillings (US \$12.50) for surgical contraception services, indicating that clients are freely choosing the method

and are willing to pay for it. However, clients are not denied service due to inability to pay.

- (12) FPAK vehicles are utilized to provide some transportation assistance.
- (13) All clients interviewed were satisfied with services and with their decisions for surgical contraception.

The following program areas need to be strengthened to improve various aspects of VSC service provision:

- (1) There are few, if any, quality audio-visual aids available for use by field and clinic-based staff who provide information, education and counseling for temporary and permanent methods of family planning.
- (2) Clients generally are required to make three visits: initial request, medical examination and booking, and finally the surgical procedure. This could pose an obstacle for those who must travel considerable distances.
- (3) Shortage of staff and limited space in busy facilities increase the risk of less than optimal conditions for counseling and care; for example, lack of privacy for counseling, inadequate recovery time and monitoring and incomplete documentation (Kakamega and Thika).

Recommendations

- 1. Appropriate educational materials should be developed or obtained on all family planning methods, to assist in the provision of information, education, and counseling services.
- 2. FPAK should attempt to reduce the number of visits by clients from three to two in order to facilitate access to services.
- 3. FPAK should attempt to alleviate staff shortages and facility limitations to improve the quality of service (Kakamega and Thika).

PROTESTANT CHURCHES MEDICAL ASSOCIATION

Nine of the twelve PCMA sites which receive support from AVSC were visited. Most tubal ligations are performed by minilaparotomy with local anesthesia. Female services are provided in both postpartum and interval periods and in most cases the demand for services is met without long delay. Vasectomies are performed on occasion.

The following aspects of the PCMA VSC programs were found to enhance a client's ability to make an informed decision about permanent contraception:

- (1) Family planning services, including tubal ligation, are provided as an integral part of the MCH program, which greatly enhances the acceptability of family planning.
- (2) At most sites there is staff trained in VSC education and counseling and, in general, the quality of the services is high.
- (3) Temporary methods of family planning are available at all PCMA sites.
- (4) PCMA hospitals generally have static or mobil outreach facilities with trained health education staff who often refer clients to the hospitals.
- (5) The hospitals have strong grass roots support from the communities they serve, and they are sensitive to community needs.
- (6) There are no restrictive age-parity requirements for obtaining surgical contraception.
- (7) A medical supervisor and a nursing supervisor are assigned to monitor medical and counseling aspects of surgical contraception services on an on-going basis.
- (8) The forms documenting informed consent contain all necessary points and provisions for appropriate signatures, and in general are properly completed.
- (9) PCMA uses a standard VSC client record form to collect socio-demographic and medical data to monitor the quality of VSC services and client satisfaction.
- (10) Clients pay from 50 to 150 shillings (US \$3 to \$9) (depending on hospital policies) for VSC services, indicating that clients are freely choosing the method and are willing to pay for the service. However, no clients are denied service for lack of ability to pay.
- (11) Staff involved in the program demonstrated a high level of

commitment to and interest in providing VSC services as an integral part of the MCH program.

- (12) All clients interviewed were satisfied with the services received and with their decisions for surgical contraception.

The following areas need to be strengthened to improve various aspects of service provision:

- (1) There are few, if any, quality audio-visual aids available for use by field and hospital-based staff who provide information, education, and counseling for temporary and permanent methods of family planning.
- (2) Decentralization of the informed consent and counseling process to the static or mobile sites increases the risk that some clients may not be adequately counseled.
- (3) In some sites, outreach community workers may not have benefitted from sufficient training to enable them to discuss risks and benefits of all methods of family planning.
- (4) General anesthesia is used routinely in a few sites, thus adding to risk, lengthening hospital stay, and increasing client fears of being "put to sleep."

RECOMMENDATIONS

1. Appropriate educational materials should be developed or obtained on all family planning methods to assist in the provision of information, education, and counseling services.
2. To ensure that all clients have been fully counseled and that informed consent has been properly documented, one person at each hospital should be identified to supervise the entire process.
3. All outreach workers should be trained in all family planning methods and information should be periodically updated.
4. At least one operating surgeon at each hospital should be trained in minilaparotomy using local anesthesia and light sedation.

OTHER FACILITIES

The teams had planned to visit Kenyatta National Hospital and the Family Planning Association of Kenya clinics in Eldoret and Kisii. These two FPAK clinics had not begun VSC service provision as scheduled and, therefore, were not included in the assessment. Kenyatta National Hospital (KNH) did not grant clearance to the team to review VSC education and counseling. This is unfortunate since KNH serves as a national training institution for surgical contraception and is a major service provider.

The team visited four facilities not included in the MOH, FPAK, and PCMA sections of this report. These facilities are Pumwani Maternity Hospital in Nairobi (under the Ministry of Local Government), Kangaru Clinic and Maternity in Embu, and Mkomani and Changanwe Clinics in Mombasa. The three latter facilities are in the private sector. Individual site reports for these four facilities are on file at AVSC.

GENERAL FINDINGS

Based on interviews held with both clients and service providers at the thirty-four visited facilities, it is clear that clients are making informed, voluntary decisions for surgical contraception. In fact, at this stage of service provision, a client's commitment to obtaining surgical contraception is demonstrated by his or her efforts to overcome obstacles which hinder access to such services. Furthermore, the positive impact that FPAK training has had both in the areas of information, education and counseling, and in surgical techniques is clear. In sites where staff has had FPAK training, high quality services are provided and clients seem knowledgeable about all methods of family planning, including surgical contraception.

In general:

- . Clients are well informed, know that surgical contraception is permanent, and are sure they want no more children when they select this method. However, not all clients have an understanding of what the procedure entails, and the anatomical and physiological changes which occur. Common misconceptions encountered included attributing later illness or unrelated disability to the procedure, equating tubal ligation with hysterectomy or vasectomy with castrations, believing that surgical contraception results in decrease of sexual desire or cessation of menses, or believing that tubal ligation is only available to postpartum clients.
- . Clients are well aware of temporary methods but some misconceptions about these also exist. This issue should be addressed to prevent client from selecting surgical contraception in order to avoid another method.
- . No service site visited exhibited a bias toward promoting surgical contraception. The concept of client choice was evident in all sectors.
- . Even though there were no strict age parity requirements, many providers were very cautious about serving young clients (i.e. less than age 30) or clients with fewer than four children.
- . Client fears associated with tubal ligation are fear of method failure, and fear of general anesthesia. Women, in general, are not deterred by the fact that it is a surgical procedure. They desire a small incision with a speedy recovery. Minilaparotomy under local anesthesia is clearly preferred by clients.
- . Perfunctory mention of vasectomy is made during informational sessions, however the option for men is not adequately addressed.
- . Most clients interviewed had known other women who had received tubal ligations and were satisfied with the method.

This indicates that satisfied clients play a significant role in enhancing community understanding and utilization of VSC services.

- . Most surgical contraception procedures are done with the full participation of the spouse. However, there are cases where the voluntary nature of the decision to undergo a tubal ligation is hampered by the husband in one of two ways: (1) by denial of consent, or (2) by authorization of a tubal ligation to be performed against the wishes of his wife. The former is more prevalent than the latter, however both are important.
- . All MCH/FP clinics visited operated on an integrated basis; temporary methods and supplies were available in all sites. The integration of MCH and FP services adds to the acceptability of family planning; however, the number of staff is generally inadequate for the volume of clients requesting MCH/FP services. This leads to lengthy clinic visits for clients. Waiting periods for TL bookings are sometimes exacerbated by inadequate theater supplies.

This is less of a problem in PCMA and FPAK sites where there is an overall medical coordinator who looks after medical standards and a nursing coordinator responsible for counseling and voluntarism; however MOH has no such management support at this time.



34 Sites in Numerical Order and By Team:

Team #1 (NK/DN)

1. Kangundo
2. Machakos
3. Kitui
4. Coast General
5. Mkomani and Changamwe Harambee Clinics
6. Maua
7. Chogoria
8. Kangaru Materntiy and Clinic
9. Karatina
10. Tumu Tumu
11. Nyeri Provincial General Hospital
12. FPAK Nyeri
13. Muran'ga

Team #2 (LB/GW):

14. FPAK - Thika
15. Pumwani Maternity
16. Tigoni
17. Kijabe
18. Kendu Bay
19. Kisii District Hospital
20. Homa Bay
21. Tenwek
22. Gatundu
23. FPAK - Nairobi

Team #3 (BSG.SN)

- | | |
|-------------------------------|--|
| 24. FPAK - Nakuru | 31. Kaimosi |
| 25. Eldoret District Hospital | 32. Kapsabet |
| 26. Kapsowar | 33. Naivasha |
| 27. Lugulu | 34. Rift Valley Provincial Hospital (Nakuru) |
| 28. Bungoma | |
| 29. Port Victoria | |
| 30. FPAK - Kakamega | |



Voluntary Surgical Contraception Education, Counseling, and Follow-up Assessment

3 November - 18 November 1986:

Sites reviewed: (34 total)

Ministry of Health Hospitals (12)

(not currently supported by AVSC)

Homa Bay
Bungoma
Kitui
Muran'ga
Kangundo
Eldoret
Kapsabet
Naivasha
Tigoni
Gatundu
Karatina
Port Victoria

MOH (AVSC Programs) 5

Nyeri
Machakos
Kisii
Nakuru
Coast General

PCMA (9)

Kijabe
Lugulu
Kendu Bay
Kaimosi
Maua
Chogoria
Tumu Tumu
Kapsowar
Tenwek

FPAK (5)

Thika
Nyeri
Nairobi
Nakuru
Kakamega

Nairobi City Commission (1)

Pumwani Maternity Hospital

Private (2)

Kangaru Clinic and Maternity
Mkomani and Changamwe Clinics



Guidelines for Assessment of

VSC Education, Counseling, and Client Follow-up Services

Kenya: 3 - 21 November 1986

Activities at each of the 37 sites:

- 1) Review with clinic/hospital staff current family planning/VSC services and practices, i.e. client education and counseling, training, service provision, referral, client follow-up.
- 2) Review VSC informed consent documentation
- 3) Observe a group I&E session and/or individual/couple counseling sessions
- 4) Review/assess the status of trained personnel, and training needs, i.e. physicians/operating surgeons, OR nurses, counselors, field workers
- 5) Interview 5 clients (and spouses if possible) who have had elective VSC services in the past 6 months -- 2 years (ideally, randomly selected clients)
- 6) Interview 5 clients (and spouses if possible) who have been counseled and are booked for VSC.
- 7) Assess the "climate" at the hospital/clinic, i.e. subjective assessment of the interest and commitment of staff to providing quality, elective VSC services to informed clients (especially important in MOH hospitals)
- 8) Evaluate the AVSC client record forms being piloted at FPAK and PCMA sites



Guidelines for Assessment Activities:

Activity 1: Review with clinic/hospital staff current family planning/surgical contraception services and practices, i.e. client education and counseling, training, service provision, referral, client follow-up.

A) Are temporary family planning services available at the hospital/clinic?
If yes, what methods are available and what are the approximate numbers of clients per method?

If not, is there an effective referral system for clients requesting temporary methods?

- Where are they referred?
- Is there any follow-up of clients referred for temporary methods?

B) Surgical contraception services available at the hospital/clinic:

- number of procedures performed for medical indications, e.g. with C-sections, ruptured uterus
- number of elective procedures, technique and anesthesia used, timing of procedures
 - postpartum
 - interval
 - minilaparotomy
 - laparoscopy
 - vasectomy
 - anesthesia used, i.e. general vs. local

C) Availability and accessibility of VSC and temporary family planning methods:

- cost - do clients pay for VSC? Other family planning methods?
If yes, what is the cost?
- is operating time/space/staff adequate to meet the demand for VSC?
- availability of temporary method supplies
- availability of expendable supplies
- staff (physician, nurse, field worker, counselor) bias for any method, including VSC? (subjective assessment)
- waiting period for VSC
- is spousal consent required for VSC/other methods

D) Are there client eligibility requirements?

Are there age, parity, spousal consent, or other non-medical eligibility requirements for VSC? (e.g. age of last born child, sex of last born child). For temporary family planning methods? If yes, what are they?

Are there medical eligibility criteria for VSC?

- what are the medical indications for VSC? e.g. is VSC automatically recommended after a specified number of C-sections?
- are there medical contraindications on the basis of which clients are denied VSC? if so what are they?



Who sets the eligibility criteria (the government or the program)?

Are they enforced?

Does the program keep records on denial of services (rejection rates) based on clients not meeting these requirements?

- rejection for psychosocial reasons
- rejection for medical reasons

At what point can the decision be made to reject a client's request for VSC?

Who has the authority to make this decision?

What happens to those clients who are rejected? Are they referred for temporary methods/ follow-up?

Is this information routinely recorded?

E) Information and Education Activities

Are family planning I&E activities conducted at the hospital/clinic and/or in the community?

- when, where, and how are I&E sessions run?
- do clinic staff and outreach workers provide information about all family planning options? Are risks as well as benefits described?
- is information presented in a neutral way?
- how are the I&E workers reimbursed?
- are there special, method specific I&E activities? if so, for which methods?
- are there special activities targeted at specific population groups (e.g., age and parity groups, socio-economic groups)?
- are printed materials (posters, handouts) on all family planning methods available? in the local languages? are they displayed? distributed? are there adequate supplies?
- are these materials suitable for the intended audience?

Who provides VSC information and education?

- field workers
- "motivators"
- nurses
- physicians
- counselors
- volunteers
- what are the selection criteria for these individuals?
- what training have they received?
- do they speak the tribal language as well as Swahili/English?



F) Client Assessment and Counseling

Does the service provider have criteria or guidelines for assessing the voluntary nature of the client's request for VSC, and whether or not the client is at high risk of regretting the decision after surgery?

If so, what are they?:

e.g.

- parity
- age of client/of spouse
- sex of children/age of youngest
- past contraceptive practice and experience
- knowledge of family planning alternatives
- partner status, i.e. strength of union/marital stability; divorced? separated?
- length of time between decision not to have more children and request for VSC
- main sources of information about VSC: who and when
- reasons for requesting VSC
- who referred client to clinic
- can the client imagine wanting more children? if so, under what circumstances
- how would client feel if her life situation changed, e.g. child dies, change of partner

When is a client assessed/counseled?

By whom?

- do they receive special training for assessing/counseling clients? what does the training consist of?
- do they get refresher training? how often?
- how are they supervised and evaluated?
(by whom? how often?)
- what are their responsibilities?
- does the counselor speak the dominant tribal language of the area?

- is counseling conducted in private? if not, who is present besides the client and counselor?
- is the client given the chance to ask questions, and to address his or her feelings, doubts, and reasons?
- what is the content of counseling? does it involve both information on VSC and temporary methods plus psychological preparation for ending fertility?
- when is counseling performed?
 - for postpartum procedures
 - for interval procedures



G) Client Follow-Up

- Are VSC clients followed-up post-operatively? If yes, how many post-op vists?
- when and where?
- by whom?
- what kind of data is collected?
- is client satisfaction recorded?
- are client regret and reasons for regret recorded?

H) Payments/Compensation (not really applicable to the Kenya situation now but might prove useful to have documented that clients pay in most instances for services, and neither client nor government provider are compensated.)

- are clients required to pay:
 - for VSC services? if yes, how much?
 - for other family planning services? if yes, how much?
- are payments paid to:
 - clients
 - recruiters/field workers
 - service providers
 - institutionsfor VSC acceptors? for other family planning acceptors?
- if so, what kind of payments (money or in kind)?
- what do payments cover? (e.g., transportation, lost wages, etc.)
- on what basis are payments made to service providers, e.g. per case, per session, for all clients counseled?

Activity 2: Review VSC informed consent documentation

- how does the program document a client's informed choice?
- who obtains the client's written consent?
- when is it obtained?
- what does the written form contain? does it include:
 - a statement of the permanence of VSC?
 - the fact that it involves an operation?
 - the fact that there are temporary family planning alternatives?
 - the fact that there are risks?
 - the fact that it ends the ability to have children
 - a statement that affirms the client is making a free, unpressured choice and that the client can change his or her mind at any time without penalty?
 - the signature or mark of the client? date of signature/mark?
 - the signature of a witness for illiterate clients? date of signature?
 - is a witness signature required for literate clients or just illiterate?
 - the signature of the physician? date of signature?

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- is the form available in the local language(s)?
- are there special provisions and procedures for illiterate clients? If so, what are they? e.g. witness signature for illiterate clients, counselors that speak the tribal language
- review random sample of client record forms: for compliance and completeness of informed consent forms.

Activity 3: Observe a group I&E session and/or individual/couple counseling sessions

- Accuracy and completeness of information given out, e.g. are risks as well as benefits discussed?
- Rapport with group or individual/couple
- Time allowed for questions
- Able to identify "red flags" for regret
- Use of educational materials, e.g. flipcharts, pamphlets
- Attitude of counselor (e.g. neutral?)
- Assess physical space/privacy provided for counseling

Activity 4: Review/assess the status of trained personnel and training needs

Physicians

How many trained? ~
where trained
when trained
procedures trained in
anesthesia regimen trained in

Have they been oriented or trained in counseling?
Is additional training needed to meet the demand for services?

Theatre Assistants

How many trained?
where
when
in what techniques/anesthesia

Have they been oriented or trained in counseling?
Is additional training needed to meet the demand for services?

Health/Family Planning Educators (hospital/clinic based)

How many trained?
where
when
in temporary family planning methods?
in VSC?

Additional training needs?



Counselors

How many trained?

where

when

in temporary family planning counseling?

in VSC counseling?

Additional training needs?

Field Educators

How many trained?

where

when

in temporary family planning?

in VSC?

Additional training needs?

Activity 5: Interview 5 clients (and spouses if possible) who have had elective VSC in the past 6 months - 2 years.

- Are they satisfied with their choice of VSC?
 - if yes, why?
 - if no, why?
- If no, could their regret have been prevented by better I&E or counseling? (might be subjective assessment on part of interviewer)

Questions to ask the client:

- Where did you first learn about VSC?
- Describe initial and all other contacts with clinic/hospital
 - I&E
 - counseling
 - surgery
 - follow-up
- What were you told about temporary methods of contraception and about VSC?
- Were you able to make an informed, voluntary decision to undergo VSC based on the I&E/counseling which you received from hospital/clinic and field staff?
- Why did you choose VSC?
- Have you referred any friends or relatives for VSC services?

Activity 6: Interview 5 clients (and spouses if possible) who have been counseled and are booked for VSC

Questions to ask the client:

- Where did you first learn about VSC?
- Describe initial and all other contacts with clinic/hospital
 - I&E
 - counseling
 - physical exam



- When did you decide not to have any more children?
- When did you decide to have VSC?
- Why did you decide to have VSC?
- Tell me what you know about temporary methods of family planning and about VSC
- What has the counselor/health educator told you and discussed with you?
- Were you encouraged to ask questions? Were they answered to your satisfaction?
- Were you able to make an informed, voluntary decision to undergo VSC based on the I&E/counseling which you received from hospital/clinic and field staff?
- Do you have any questions or doubts about the forthcoming procedure?

Activity 7: "Subjective Climate Assessment" (especially important in MOH sites)

- What are the hospital staff and administration's feelings about VSC as a contraceptive option?
- Do they appear to be interested/committed to establishing dedicated space and training personnel for the provision of quality VSC service to informed clients
- what is the attitude of hospital staff/supervisors towards informed choice/voluntarism?

(Difficult to come up with guidelines/questions for -- teams should be able to get a feel for the "climate" at the end of a day's discussion with various staff members).

Activity 8: Evaluate the AVSC client record forms being piloted at FPAK and PCMA sites (guidelines for evaluation by Betty Gonzales)

- Has there been any difficulty understanding the instructions? For example, is it clear what the boxes in the right margin are for?
- Are the various sections of the form being filled in by different staff? For example, the interviewer, an OR attendant, and a follow up examiner?
- Are there any questions which are not relevant to Kenya?
- Are there procedures requested by the form which are not usually performed? For example, lab work or monitoring of vital signs?
- Has there been any attempt to analyze the data collected thus far under questions 66, 67 and 81 regarding the causes, treatment and outcome of complications?
- If so, was any action taken, or change of technique recommended to prevent similar complications?
- If not, is there any plan to do this kind of assessment?



Guidelines for Assessment of
VSC Education, Counseling, and Client Follow-up Services
Kenya: 3 - 21 November 1986
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If the Kenyan medical directors feel that the client record form and supervising system is too long, we might attempt to justify each question or segment to be saved. Some considerations would be:

- What difference will each question make?
- How often does each problem with a question come up?
- Has anyone used Appendices C&D?
- How much time is involved in filling the various forms?

NK/rf
9/30/86

TYPES OF PROCEDURES PERFORMED CURRENTLY

AT EACH SITE

	MINILAP WITH LOCAL ANAESTHESIA	MINILAP WITH GENERAL ANAESTHESIA	LAPAROSCOPY	LAPAROTOMY FOR TUBAL LIGATION	VASECTOMY
<u>FPAK</u>					
THIKA	YES	NO	NO	NO	YES
NYERI	YES	YES	YES	NO	YES
NAIROBI	YES	NO	NO	NO	YES
NAKURU	YES	NO	NO	NO	YES
KAKAMEGA	YES	NO	NO	NO	YES
<u>PCMA</u>					
KIJABE	YES	YES	NO	NO	YES
LUGULU	YES	NO	NO	NO	YES
KENDU BAY	YES	YES	NO	NO	UNKNOWN
KAIMOSI	YES	NO	NO	NO	YES
MAUA	YES	NO	NO	NO	NO
CHOGORIA	YES	YES	YES	NO	YES
TUMU TUMU	YES	YES	NO	NO	YES
KAPSOWAR	NO	YES	NO	NO	NO
TENWEK	YES	YES	NO	NO	YES
<u>OTHERS</u>					
PUMWANI	YES	NO	NO	NO	NO
KANGARU	YES	NO	NO	NO	NO
MKOMANI AND CHANGAMWE	NO	NO	NO	NO	NO

TO COMMENCE VSC END OF NOVEMBER 1986

TYPES OF PROCEDURES PERFORMED CURRENTLY

AT EACH SITE

	MINILAP WITH LOCAL ANAESTHESIA	MINILAP WITH GENERAL ANAESTHESIA	LAPAROSCOPY	LAPAROTOMY FOR TUBAL LIGATION	VASECTOMY
<u>M.O.H.</u>					
HOMA BAY	NO	NO	NO	YES	NO
BUNGOMA	NO	YES	NO	NO	NO
KITUI	NO	YES	NO	NO	NO
MURAN'GA	YES	YES	NO	NO	NO
KANGUNDO	YES	NO	NO	NO	NO
KAPSABET	NO	YES	NO	NO	NO
NAIVASHA	YES	NO	NO	YES	NO
TIGONI	NO	NO	NO	NO	NO (REFERRALS ONLY)
GATUNDU	YES	YES	NO	NO	NO
KARATINA	YES	YES	NO	NO	NO
PORT VICTORIA	0	0	0	0	0
ELDORET	NO	YES	YES	NO	NO
<u>M.O.H. WITH AVSC)</u>					
NYERI	YES	YES	YES	NO	NO
MACHAKOS	YES	YES	NO	NO	NO
KISII	YES	YES	YES	NO	YES
NAKURU	NO	YES	NO	NO	NO
COAST GENERAL	YES	YES	NO	NO	NO

TIMING OF FEMALE VSC PROCEDURES

	INTERVAL	IMMEDIATE POST-PARTUM (FIRST-WEEK)	LATE POST PARTUM (AFTER FIRST WEEK)	WITH CESAREAN SECTION
<u>FPAK</u>				
THIKA	YES	NO	NO	NO
NYERI	YES	A FEW	UNKNOWN	NO
NAIROBI	YES	NO	NO	NO
NAKURU	YES	NO	YES	NO
KAKAMEGA	YES	NO	YES	NO
<u>PCMA</u>				
KIJABE	YES	YES	NO	YES
LUGULU	YES	NO	NO	YES
KENDU BAY	YES	YES	NO	YES
KAIMOSI	YES	YES	NO	YES
MAUA	YES	YES	UNKNOWN	YES
CHOGORIA	YES	YES	UNKNOWN	YES
TUMU TUMU	YES	YES	UNKNOWN	YES
KAPSOWAR	FEW	YES	NO	YES
TENWEK	YES	YES	NO	YES
<u>M.O.H (WITH AVSC)</u>				
NYERI	YES	YES	UNKNOWN	YES
MACHAKOS	YES	YES	UNKNOWN	YES
KISII	YES	NO	NO	YES
NAKURU	YES	YES	NO	YES
COAST GENERAL	YES	YES	UNKNOWN	YES

TIMING OF FEMALE VSC PROCEDURES

	INTERVAL	IMMEDIATE POST-PARTUM (FIRST-WEEK)	LATE POST PARTUM (AFTER FIRST WEEK)	WITH CESAREAN SECTION
<u>OTHERS</u>				
PUMWANI	YES	YES	YES	YES
KANGARU	YES	YES	UNKNOWN	YES
MKOMANI AND CHANGAMWE	YES	YES	UNKNOWN	NO
<u>M.O.H</u>				
HOMA BAY	NO	YES	YES	YES
BUNGOMA	YES	NO	NO	YES
KITUI	YES	YES		YES
MURANG'A	YES	YES	UNKNOWN	YES
KANGUNDO	YES	NO	UNKNOWN	YES
KAPSABET	YES	NO	NO	YES
NAIVASHA	FEW	FEW	MOST	YES
TIGONI	NO	NO	NO	NO
GATUNDU	YES	YES	YES	NO
KARATINA	YES	YES	UNKNOWN	YES
PORT VICTORIA	NA	NA	NA	NA
ELDORET	FEW	FEW		YES



CASE LOAD:

M.O.H.	Monthly Average of Family Planning	Monthly Average of MCH Clients	Monthly Average of Female VSC	Number of Vasectomies per year	Waiting List Time for VSC	Request for VSC per week
M.O.H.						
Homa-Bay	109	Unknown	3	None	2 - 3 weeks	UNK
Bungoma	240		3-4	0	Long	
Kitui	Unknown	Unknown	3	0	Long	UNK
Murang'a	Unknown	Unknown	10	0	Long	UNK
Kang'undo	200	Unknown	20-25	0	None	UNK
Kapsabet	100-150		7			
Naivasha	240		8-12			
Tigoni	120	2240	NA	NA	NA	UNK
Gatundu	1200	9000	12	None	2 months	UNK
Karatina	Unknown	1800 ante-natal Clinics	15	0	2 months	UNK
Port-Victoria	15-20		0	0	NA	UNK
Eldoret	50				Long	10
M.O.H. with AVSC						
Nyeri	Unknown	Unknown	40	None	None	UNK
Machakos	Unknown	Unknown	20	0	6 months	UNK
Kisii	Unknown	Unknown	60	None	6 months	UNK
Nakuru	Unknown	7000	12-6	0	3-6 months long	
Coast-General	Unknown	Unknown	10	0	None	UNK



	Monthly Average of Family Planning	Monthly Average of MCH	Monthly Average of Female VSC	Number of Vasectomies per year	Waiting List Time for VSC	Request for VSC per week
Others						
Pumwani	Unknown	Unknown	40-60	None	3 weeks P/Partum 6 months interval	Unknown
Kang'aru	Unknown	Unknown	8-10	0	None	Unknown
Mkomani and Changamwe	Unknown	Unknown	30-35	7 in last 2 years	None	Unknown
FPAK						
Thika	970	N/A	40	Unknown	2 weeks	20
Nyeri	1,100	N/A	40	18	None	Unknown
Nairobi	4,400	N/A	Just started	2		Unknown
Nakuru	500		30	4	No	
Kakamega	400		15-20			
PCMA						
Kijabe	40	Unknown	25	6	None	20
Lugulu	85		1-2			
Kendu Bay	100	Unknown	50	Unknown	None	13
Kaimosi	250		30-40			
Maua	Unknown	Unknown	10	0	None	0
Chogoria	Unknown	Unknown	25	2	None	Unknown
Tumu Tumu	Unknown	Unknown	40	1 since 1984	None	Unknown
Kapsowar	Unknown		12	0		
Tenwek	1,500	Unknown	20	2	None	5



NUMBERS OF TRAINED STAFF AVAILABLE

FPAK	Physicians trained in Moiilap	physicians trained VSC under L.A.	Nurses trained in VSC counseling	Physicians trained in Vasectomy	Physicians trained in Laparoscopy
Thika	1	1	3	1	0
Nyeri	2	2	3	2	0
Nairobi	1	1	1	1	0
Nakuru	2	2	2	2	0
Kakamega	2	2	2	1	0
PCMA					
Kijabe	2	2	1	2	0
Lugulu	1	1	1	1	0
Kendu Bay	2	2	1	UNK	UNK
Kaimosi	1	1	2	1	0
Maua	2	2	2	UNK	UNK
Chogoria	4	4	2	1 ⁺	1
Tumu Tumu	2	2	3	1	UNK
Kapsowar	1	0	1	0	0
Tenwek M.O.H	3	3	1	UNK	UNK
Homa Bay	0	0	0	0	0
Bungoma	1	1	0	0	1
Kitui	2	2	0	0	UNK
Murang'a	1	1	0	0	0
Kangundo	2	2	0	0	0
Kapsabet	1	1	0	0	0
Naivasha	1	1	0	0	0
Tigoni	0	0	0	0	0



Page 2 Numbers of Trained Staff Available

PCMA	Physicians trained in Minilap	Physicians Trained in VSC under L.A.	Nurses trained trained in VSC counseling	Physicians trained in vasectomy	Physicians trained in laparoscopy
Gatundu	2	2	0	0	0
Karatina	1	1	0	0	0
Port- Victoria	1	1	0	0	0
Eldoret	1	1		1	1
MOH (with AVSC)					
Nyeri	2 ⁺	2 ⁺	UNK	UNK	1 ⁺
Machakos	5	5	2 on-site	1	2
Kisii	2	2	1	1	1
Nakuru	5	5	0	0	0
Coast General	4	4	2	UNK	3
Others					
Pumwani	5	5	1 (on leave)	UNK	UNK
Kangaru	1	1	0	UNK	0
Mkomani and Changamwe	1	1	0	1	0

CLIENT INTERVIEW

SESSIONS OBSERVED

	PRE OPERATIVE	POST- OPERATIVE	VASECTOMY	INDIVIDUAL COUNSELING	GROUP INFORMATION
<u>M.O.H.</u>					
HOMA BAY	1	0	0		
BUNGOMA	0	0	0		
KITUI	0	4	0		
MURANG'A	6	3	0		
KANGUNDO	0	0	0		
KAPSABET	0	0	0	X	
NAIVASHA	4	2	9		
TIGONI	5	4	0	X	
GATUNDU	6	5	0		
KARATINA	0	0	0		X
PORT VICTORIA	0	0	0		
ELDORET	0	0	0		
<u>M.O.H. (WITH AVSC)</u>					
MACHAKOS	0	0	0		
KISII	20*	2	0	X	X
NAKURU	0	0	0		X
COAST GENERAL	0	0	0		
<u>OTHERS</u>					
PUMWANI	0	1	0		
KANGARU	3	3	0		

CLIENT INTERVIEWSESSIONS OBSERVED

	PRE OPERATIVE	POST OPERATIVE	VASECTOMY	INDIVIDUAL COUNSELING	GROUP INFORMATION
<u>FPAK</u>					
THIKA	4	5	0	X	X
NYERI	4	6	0		
NAIROBI	0	5	1		
NAKURU	2	5	0		
KAKAMEGA	3	4	1	X	
<u>PCMA</u>					
KIJABE	2	4	0		X
LUGULU	1	4	0		X
KENDU BAY	0	20			
KAIMOSI	1	12	0		
MAUA	0	10 ⁺			
CHOGORIA	3	5	0	X	X
TUMU TUMU	0	6	0		
KAPSOWAR	1	5	0		
TENWEK	6	5	1		
<u>OTHERS</u>					
PUMWANI	0	1	0		
KANGARU	3	3	0		
MKOMANI AND CHANGAMWE					