

Findings from the Sub-Saharan Africa Urban Family Planning Study

MOMBASA City Report

The Center for African Family Studies, Nairobi, Kenya
John Snow, Inc., SEATS Project, Washington DC
Center for Population and Family Health, Columbia University, New York City

In collaboration with:

Mombasa District Health Office
Mombasa Municipal Health Department

Funded by:

USAID Bureau for Africa

Produced by:

A.B.N. Maggwa, CAFS
I. Muvandi, CAFS
Martin Gorosh, JSI/SEATS and CPFH
Kate Miller, JSI/SEATS and CPFH
Melinda Ojermark, JSI/SEATS
Carolyn Vogel, JSI/SEATS
Mary Mujomba, CAFS
David O'Brien, JSI/SEATS
Lenni Kangas, USAID Bureau for Africa
Guy Stecklov, JSI/SEATS
Patrick Kelly, JSI/BASICS

March 1995

Contents

List of abbreviations	i
Acknowledgements	ii
Introduction	1
Summary of findings and conclusions	2
Background	6
Kenya	6
Urbanization	6
Family planning and fertility	7
Mombasa	8
Geography and population	8
Family planning services and fertility	8
Methodology	10
Reconnaissance activities	10
Recruitment and training of data collection assistants	11
Data collection	12
Situation Analysis data	12
Service statistics	13
Secondary data	13
Mapping data	13
Data management and processing	13
Dissemination workshop	14
Principal findings and conclusions	15
Future capacity requirements	15
SDPs by type	20
Geographical distribution of SDPs	20
Private sector	21
Pharmacies	22
Community-Based Distribution (CBD)	24
Overall status of SDPs	26
Physical infrastructure	26
Method mix	28
Publicity	30
IEC materials	31
Record keeping and supervision	31

Commodities and logistics	32
Staff characteristics	33
Nurse training in family planning services	33
Physician training in family planning services	34
Staff method preference	35
Client/service provider interactions	36
Client characteristics	36
Medical history and examination	36
Information about contraceptive methods	38
Follow-up	39
Client satisfaction	39
Cost sharing	40
Integration of STD/HIV management with FP service programs	41
The need for integration	41
Staff training in STD/HIV management	42
Staff knowledge of signs and symptoms of STDs	43
Facilities, equipment, and supplies for integration	44
Supervision and morale	44
Appendices	45
Appendix 1: Summary of findings from the Mombasa sub-sample of the 1993 Kenya DHS	46
Appendix 2: Inventory of service delivery points in Mombasa	49
Appendix 3: Mombasa dissemination workshop group presentations	52
Appendix 4: Maps of Mombasa	60
Appendix 5: Technical note on estimating CPR with FPPMES	70

List of abbreviations

AIDS	-	Acquired Immuno-Deficiency Syndrome
BCH	-	Bulawayo City Health
CAFS	-	Centre for African Family Studies
CBD	-	Community-based distribution
CPFH	-	Center for Population and Family Health
COC	-	Combined oral contraceptives
ERU	-	Evaluation and Research Unit
FP	-	Family planning
FPPMES	-	Family Planning Program Monitoring and Evaluation System
GGD	-	Guided group discussions
GOZ	-	Government of Zimbabwe
HHRAA	-	Health and Human Resources Research and Analysis for Africa
HIV	-	Human-immunodeficiency virus
IEC	-	Information, education and communication
IUD	-	Intra-uterine device
JHPIEGO	-	Johns Hopkins Program for International Education in Reproductive Health
KAP	-	Knowledge, attitudes, and practice
LAP	-	Lower abdominal pain
MCH	-	Maternal and child health
MOH	-	Ministry of Health
MWRA	-	Married women of reproductive age
NGO	-	Non-governmental organization
NFP	-	Natural family planning
PNO	-	Provincial Nursing Officer
POP	-	Progestogen only pill
SDP	-	Service delivery point
STD	-	Sexually transmitted disease
TFR	-	Total fertility rate
SEATS	-	Service Expansion and Technical Support
VSC	-	Voluntary surgical contraception
WRA	-	Women of reproductive age
ZNFPC	-	Zimbabwe National Family Planning Council

Acknowledgements

In addition to the organizations listed on the front cover of this report, numerous other organizations and individuals contributed to this study.

We are grateful to the family planning clients, service providers, and organizations in the public and private sectors who participated in the study. We are also grateful to the Government of Kenya for approving the conduct of the study. We thank the Population Council for its assistance in adapting the situation analysis approach to this study. We also wish to thank the USAID Bureau for Africa HHRAA Project for financial support and the USAID Mission to Kenya for concurrence to conduct the study.

In particular, we would like to thank the following individuals for their extensive assistance: Dr. Chidagaya, District Medical Officer, Mombasa District Health Office; Dr. Lugogo, Medical Officer of Health, Mombasa Municipal Health Department; Ms. H.R. Nyaga, MCH/FP Supervisor, Mombasa Municipal Health Department; and Ms. J.M.A. Oburu, Mombasa District Health Office. We also thank AVSC's Africa Regional Office in Nairobi for assistance with sterilization statistics in Mombasa.

A.B.N. Maggwa, Centre for African Family Studies
I. Muvandi, Center for African Family Studies
Martin Gorosh, JSI/SEATS and CPFH, Columbia University
Kate Miller, JSI/SEATS and CPFH, Columbia University
Melinda Ojemark, JSI/SEATS
Carolyn Vogel, JSI/SEATS
Mary Mojumba, CAFS
David O'Brien, JSI/SEATS
Lenni Kangas, USAID, Bureau for Africa
Guy Stecklov, JSI/SEATS
Patrick Kelly, JSI/BASICS

Introduction

The SEATS project of John Snow, Inc., in collaboration with the Centre for African Family Studies, Columbia University's Center for Population and Family Health, and the Population Council, with funding from the USAID Bureau for Africa, recently completed a major study to determine how family planning service delivery programs in Sub-Saharan African cities can be made more efficient and effective. The working hypothesis is that many/most urban family planning programs are overwhelmed by the recent rapid growth of urban populations and are not equipped to satisfy potential demand for contraceptive services. In part, past decades of focussing development assistance on unserved and underserved rural areas has contributed to the inability of urban infrastructure to keep pace with rapid urbanization. Three cities are included in the study: Mombasa, Kenya; Blantyre, Malawi; and Bulawayo, Zimbabwe.

This report covers the work done in Mombasa, Kenya, during the period January through November 1994, using new situation analysis data, service statistics, the Mombasa sub-sample of the 1993 Kenya DHS, geographical data, and an assessment of the capacity required for future family planning services.

Summary of findings and conclusions

Overall, family planning service delivery in Mombasa has the potential to expand and reconfigure itself in response to changing demand.

- Estimates of the service delivery capacity in Mombasa suggest it could support a CPR of approximately 39% of the current population. However, the "burden" of serving large numbers of clients in the future requires substantial expansion of services to maintain and to increase contraceptive prevalence rates. This burden is increased in the light of post-Cairo Conference mandates for greater integration of family planning and other reproductive health services.
- The private and NGO/PVO sectors are currently an important source of contraception in Mombasa, accounting for 56% of current users. However, they have clearly not been developed to their full potential. These sectors should be further stimulated:
 - Of 136 registered private clinics in Mombasa, only 48 (35%) provide family planning services.
 - Pharmacies already provide some FP services, and the proprietors realize the importance of contraceptive sales to their business.
 - Although CBD service delivery has been shown to be effective in making FP services more accessible elsewhere in Kenya, it has not been well developed in Mombasa.
- Many women are already paying for services, and the majority of women who are not paying report that they would be willing to do so should the need arise. This indicates possibilities for cost sharing and sustainability.

- The current method mix in Mombasa is heavy in resupply methods, which dramatically increases the future demand for services. Women in Mombasa currently exhibit a substantial preference for spacing methods, however, so those women who are eligible to use long-term and permanent methods should be responsibly encouraged to do so.

Although it is acceptable in some respects, the quality of services in Mombasa is in need of improvement.

- Some of the SDPs have adequate basic physical infrastructures that facilitate an acceptable quality of services. The major deficiencies are in sluice rooms, laboratory facilities, and piped running water.
- Most of the SDPs lack the necessary equipment and commodities to provide the full range of contraceptive methods. Less than 40% of the SDPs can provide the intrauterine contraceptive device (IUD) or surgical methods.
- Although FP services are provided at many SDPs, the availability of these services is not well advertised.
- Many SDPs lack IEC materials. Of those with IEC materials, a large proportion are in English, although many women in Mombasa cannot read and/or understand English easily.
- A large number of SDPs do not receive adequate supervision, and even where supervisory visits are made there are no standardized procedures to be followed.

- Overall, both nurses and physicians are in need of increased training on prescribing particular methods, and extensive training on the use of IEC materials.
- During the client/provider interactions, history taking and examination of clients was observed to be inadequate to enable decision-making by the service providers.
- Information about the various contraceptive methods is given selectively to clients. Information on the surgical methods, spermicide, Norplant® and natural FP is given to less than 50% of the new clients
- In the majority of the observed client/provider interactions, the service providers collected adequate information to facilitate follow up, and the clients were made aware of what was expected of them.
- The majority of clients are satisfied with the services they receive.

Non-family planning services are available at many SDPs, but the level of integration of these services with family planning varies.

- Consultation for STDs is provided at 75% of SDPs, and 49% of SDPs specifically provide IEC on AIDS.
- However, during the client/service provider interactions, AIDS was discussed with only 6% of the new clients and none of the revisit clients. Other issues (ORT, malaria, and immunization) were also discussed very infrequently.

- SDP staff displayed generally poor knowledge of symptoms and modes of transmission of STDs and HIV/AIDS. Most of the staff members expected to provide STD/HIV management have not attended any specific training in STD/HIV management. Improved staff training is necessary for full integration of FP and STD services.

Background

Kenya

Urbanization

Eastern Africa, like the rest of Sub-Saharan Africa, is urbanizing at a rapid pace. Although other regions on the continent are urbanizing faster than Eastern Africa, this process will nonetheless have significant demographic impact in the area (Figure 1). By 2025, fully 41% of the Eastern African population is expected to reside in urban areas, up from 19% in 1990.

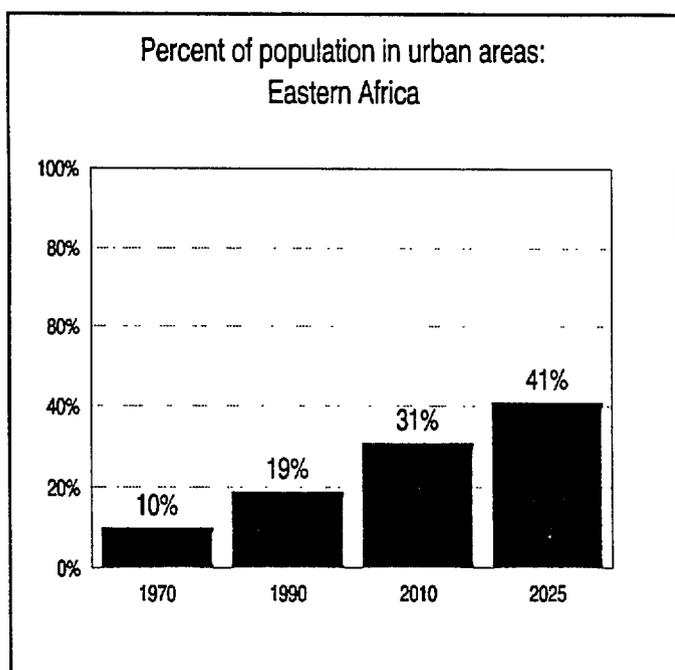


Figure 1

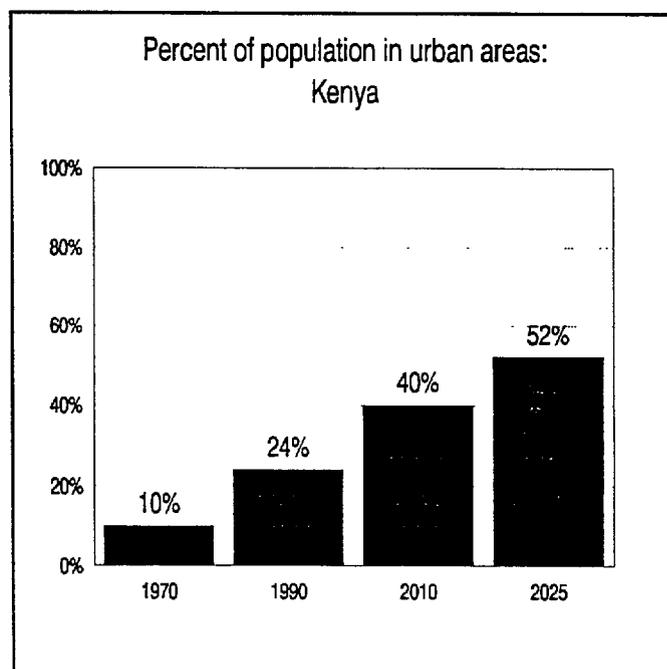


Figure 2

Source: World Urbanization Prospects: The 1992 Revision, United Nations Department of Economic and Social Information and Policy Analysis, ST/ESA/SER.A/136, New York, 1993.

Figure 2 shows that Kenya is urbanizing slightly faster than the region as a whole. In 1990 the proportion of its population in urban areas was 24%, and by 2025 it is projected to be 52%.

Family planning and fertility

National efforts toward reducing fertility are coordinated by the National Council for Population and Development, established by the Government of Kenya in 1982. The Kenya Development Plan for 1994-96, which adopts the Alma Ata goal of "Health for All by the Year 2000", includes sections on MCH/FP programs and expanded CBD.

The 1993 Kenya Demographic and Health Survey (KDHS) shows that there has been a steady increase in modern contraceptive use in Kenya, with an accompanying drop in the total fertility rate (TFR). The overall contraceptive prevalence rate (CPR) is 27.6% with a TFR of 5.4. The CPR for Coast Province, which includes Mombasa, is 16.6%, the lowest regional CPR in Kenya.

The increase in the CPR is a significant achievement, based largely on increased FP services. In the future, this continuing demand for services as well as the rapid urbanization in Kenya will place an extraordinary burden on urban family planning systems. This calls for a close examination of current service capacity and the development of innovative service delivery systems for the future.

Mombasa

Geography and population

Mombasa Municipality shares the same administrative boundaries as Mombasa district, covering an area of 210 square kilometers on the east coast of Kenya. It is made up of four divisions - Kisauni, Changamwe, Likoni and the Island (also called Mvita). There are a total of twelve administrative subdivisions within these divisions. Mombasa is also divided into four parliamentary constituencies that go by the same names as the divisions but do not necessarily have the same boundaries. Map 1 in Appendix 4 shows the outlines of the four administrative divisions as well as major and minor roads.

According to the 1979 census, Mombasa had a population of 341,148 people. This represented a 27.6% increase from the population in 1969, with an annual growth rate of 3.3%. Using data from this census, the population for Mombasa in 1993 was estimated at 589,379 people, out of whom 137,787 were women between the ages of 15 and 49. The provisional results from the 1989 census found the population to be 467,000, and the Kisauni division was found to have the largest population within the city, followed by the Island.

Family planning services and fertility

In 1989, Mombasa was recorded to have a total of 30 public health SDPs with an SDP/population ratio of 1:15,417. There had been no major changes in the number of SDPs available by the time of this study.

Although the local government is responsible for most SDPs in the urban centers, the private sector and NGO/PVO are an important source of contraception in Mombasa. The 1993 KDHS shows that these sectors account for 56% of current users in Mombasa. This contrasts with the sector mix for the whole country, in which the private

and NGO sectors account for only 32% of current users.

Population (est.)	589,379
WRA	137,787
TFR	3.3
CPR	23%
Unmet need for FP	23.4%
% of unmet need for spacing	74%
Users served by private and NGO/PVO sectors	56%

Source: 1993 Kenya DHS

Table 1

The 1993 KDHS also shows that the CPR for Mombasa is 23%, compared to 29% and 19% for other urban and rural areas respectively. The TFR is 3.3, similar to that of other urban areas but lower than the TFR of 5.9 reported for rural areas. A significant proportion (23%) of Mombasa women are defined as having unmet need for family planning; of these women, 74% have need for spacing rather than limiting. Further conclusions drawn from the KDHS about Mombasa reproductive behavior are included as Appendix 1.

Methodology

Following a series of planning meetings between the USAID Africa Bureau HHRAA project staff, the John Snow Inc. SEATS project staff, USAID Kenya Mission staff, Population Council Operations Research project staff and the Centre for African Family Studies staff, a methodology to be used for the study was developed and agreed upon. CAFS was then given the responsibility for developing the data collection instruments and the necessary field logistics. The Centre was also responsible for the data collection, analysis, preparation of city reports and coordination of the in-country dissemination workshops. The Center for Population and Family Health and SEATS staff were responsible for the FPPMES service statistics analysis, mapping reports, and editing of the city reports, as well as for the logistical arrangements for the final conference in Blantyre in March 1995.

In all, the study included the following activities:

Reconnaissance activities

After the USAID Mission in Kenya granted concurrence, discussions were held with agencies providing financial support to family planning services in Kenya with activities in Mombasa. The purpose of these discussions was to learn more about their various roles and to identify any special areas of interest for the study to address. The discussions were also used to obtain permission for the study and to solicit support and co-operation from the various agencies.

The agencies visited included the Ministry of Health headquarters, Kenya USAID Mission, Family Planning Association of Kenya (FPAK), Family Planning Private Sector (FPPS), Kenya Medical Association (KMA), Mombasa District Medical Officer of Health (DMOH), Coast Province Medical Officer of Health (PMOH), the Mombasa Municipal

Health Department (MMHD), the District Population Office (DPO), and Pathfinder International.

Preparation of an inventory of the service delivery points in Mombasa was done with assistance from the DMOH, MMHD and KMA. The SDPs were classified into those that were providing FP services and those that were not at the time. This resulted in a complete listing of the Ministry of Health-supported SDPs, those supported by the Mombasa Municipal Council and those supported by non-governmental organizations (NGOs) or private voluntary organizations (PVOs). A complete listing of the profit-making private SDPs was not possible as there was no proper registration system at the time to keep track of the rapidly changing nature of this industry. The public and NGO inventories as well as a partial private inventory is included as Appendix 2.

Recruitment and training of data collection assistants

During the reconnaissance visits, the DMOH, MMHD, FPAK and the DPO agreed to collaborate with CAFS in the proposed study. The district public health nurse, municipal health department public health nurse, district population officer and nurse in charge of service delivery at the FPAK's Mombasa clinic were seconded to the project.

These contact people identified potential data collection assistants. Following interviews conducted jointly by CAFS staff and the collaborating agencies in Mombasa, a total of twenty-two nurses and ten statistical clerks were recruited. A ten-day residential training of these assistants involved theoretical and practical training on the study objectives, methodology and instruments. The assistants also participated in translating the questionnaires into Kishwahili, which is the most commonly used language in the district.

At the end of the training, both the data collection assistants and the customized data collection instruments were pretested in two of the clinics in the municipality. The final selection of assistants was based on performance in the pretest and review of the instruments.

Data collection

Situation Analysis data

Using a modified Situation Analysis methodology (based on the approach developed by the Population Council), data were collected on the status of SDPs, management systems, human resources, client/service provider interactions, non-clinic-based and other FP service delivery systems, and integration of FP services with other reproductive health services, especially STDs and HIV. Information was also collected on the feasibility of cost sharing in the FP programs and on pharmacy family planning activities. (This was an expansion of the areas usually covered by the Population Council Situation Analysis methodology, which does not include STD/HIV management, cost sharing, or pharmacy modules.)

The client/provider interactions were observed by trained nurses. The data were collected with as much objectivity as possible (a standard checklist was used), but the consultations were probably affected by the presence of observers. Over the course of the data collection, however, it became clear that behavior modification on the part of providers decreased with each client. Nonetheless, these results should be viewed with this potential bias in mind.

Service statistics

Using the available records at SDPs, service statistics covering a continuous period of up to 12 months in the past 24 months were collected. These data cover the number of new clients, number of revisits, and contraceptives dispensed by type. These data were then processed using the FPPMES (Family Planning Program Monitoring and Evaluation System) methodology to generate estimates of contraceptive prevalence, method mix, and service delivery capacities.

Secondary data

This involved an analysis of the Mombasa subsample of the most recent DHS for Kenya (1993). The analysis investigates general characteristics of WRA, fertility, proximate determinants of fertility, contraceptive knowledge and use, unmet needs, and method sources. A summary of this analysis is included as Appendix 1.

Mapping data

Geographical data on SDP location and district population data were collected in Mombasa by CAFS staff. CPFH staff then translated these data into computerized maps, showing the geographical distribution of SDPs by type along with demographic data. The maps generated in this analysis are included as Appendix 4.

Data management and processing

The Situation Analysis data were entered and analyzed at CAFS using EPI-INFO. The service statistics and DHS data were analyzed at CPFH using FPPMES (Lotus) and SPSS/PC+. Geographical data were collected by CAFS staff, and were entered and analyzed at CPFH using AutoCAD and MapInfo software packages.

Dissemination workshop

After data entry, a preliminary analysis was undertaken and the findings presented at a one day dissemination workshop in Mombasa. The objectives of the workshop were to interpret preliminary findings and to generate practical recommendations for program improvement.

The workshop was attended by a cross section of individuals involved or interested in FP services in Mombasa, who would appreciate the findings and enhance the output of the workshop. The majority of the 37 participants were invited by the DMOH and the MMHD from within Mombasa, and included representatives of the various types of SDPs and of the provincial, district and municipal administration, as well as community opinion leaders. In addition to the Mombasa residents, representatives from Family Health International , Kenya USAID Mission, FPAK, the National AIDS Control Program, Ministry of Health headquarters, SEATS, and CAFS attended the workshop.

The workshop consisted of plenary and group work sessions. At the start of the workshop, presentations of the study objectives, methodology and preliminary findings were made. The participants were then divided into four working groups to interpret study findings and generate practical recommendations. Each group was assigned an area of the study to review in detail: status of SDPs and management systems, status of human resources, client/provider interactions, and integration of STD services. The group discussions were facilitated by CAFS staff, who were familiar with the study and the data.

The dissemination workshop yielded useful comments and recommendations that are discussed together with the results. A report of the Mombasa dissemination workshop is included as Appendix 3.

Principal findings and conclusions

Future capacity requirements

The magnitude of the task facing family planning programs in Mombasa in the coming decades is formidable. Estimating this magnitude into the first quarter of the next century requires several assumptions and invokes numerous unknowns. This study's assumptions include continued high rates of urban growth, increasing urban demand for family planning services, and differing proportions of longer term and more effective methods. Among the important unknowns are social and economic changes in the coming decades, changes in reproductive behavior and contraceptive technology, whether new urban service delivery strategies will evolve, the impact of stronger links between family planning and other reproductive health services, and the role of the private sector.

FPPMES estimates of CPRs and capacities	
Type of estimate	Value
Crude CPR	25%
Adjusted CPR	33%
Peak CPR	39%

Table 2

Nevertheless, it is important to develop estimates of future workloads to illustrate the capacities required. The first assessment is of the maximum possible capacity of the existing Mombasa services, and the second is of the magnitude of services needed in coming decades.

For the first task, the FPPMES was used to estimate contraceptive prevalence for Mombasa and to attribute prevalence to different types of SDPs. Data were first collected

from a combination of central sources and individual SDPs, and "crude" estimates were made based on actual data collected. A next step involved estimation of data for non-reporting SDPs to produce "adjusted" estimates. In effect, these adjusted estimates are estimates of capacity assuming non-reporting SDPs could perform at the same level as those reporting. A further step considers the "peak" performance period of each type of SDP and estimates prevalence assuming that all SDPs could perform at those "peak" levels at the same time. Appendix 5 contains a more detailed discussion of how these estimates were derived.

This application of the FPPMES produces a crude CPR of 25% (compared with a CPR of 23% derived from the 1993 DHS) and an adjusted CPR of 33%. The estimate of peak CPR suggests that the current service delivery capacity is capable of supporting a CPR of 39%. Table 2 summarizes these estimates.

For the second task (estimating future service delivery needs), our model was developed as follows. First, the current CPR and method mix are used to construct a baseline of client contacts. Next, the population of WRA is projected through 2025 from the current population estimate, using United Nations urban growth rates.

Two additional parameters are introduced at this point. The first considers maintaining or doubling the current CPR of 25%, and the second introduces various levels of use of longer term methods.¹ The results are then expressed as the number of client contacts² required in a future year under various combinations of these assumptions.

¹ These levels are set at 0%, 20%, 40%, and 60% users of IUD's, sterilizations, and Norplant®. Note that these figures do *not* refer to the percent of all WRA using long-term methods. Instead, they refer to the percentage of the overall CPR attributable to long-term methods. For example, if the CPR is 20%, and half of those users are practicing long-term methods, then for our purposes the "level of use of long-term methods" is 50%.

² Standard numbers of client contacts are estimated as follows. These values may vary for individual programs, so the projections should be evaluated in light of these defaults.

Figure 3 shows the estimated number of client contacts to maintain the 25% CPR, assuming 0%, 20%, 40%, or 60% of that CPR is comprised of long-term methods. In the most extreme scenario, in which no women use long term methods, Mombasa would face 650,000 client contacts in the year 2025, up from about 100,000 in 1990. Currently about 25% of all contraceptive users in Mombasa use long term methods; continuing with this mix would result in about 500,000 client contacts by 2025. Figure 4 shows a similar estimate of future client contacts given a doubled CPR of 50%. It predicts over a million contacts under some circumstances, and about a million contacts if 25% of all users continue to practice long-term methods.

Clearly, the service delivery "burden" of maintaining clients on resupply methods is dramatically lessened by increasing the proportion that choose longer term methods. Nevertheless, this "burden" requires substantial expansion of services if contraceptive prevalence rates are to be doubled by 2025. This burden is further increased in the light of post-Cairo Conference mandates for greater integration of family planning and other reproductive health services.

oral contraceptives	4 visits per year
injectables	4 visits per year
sterilization	2 visits/current year acceptor (with 10% of total sterilization users assumed to have accepted in the current year)
IUD	2 visits/current year acceptor (with 33% of total IUD users assumed to have accepted in the current year)
Norplant®	2 visits/current year acceptor (with 33% of total Norplant® users assumed to have accepted in the current year)

Condoms are not included in this analysis. Assuming a condom user requires 12 contacts per year, including condoms in this projection resulted in astronomical figures. This was judged to be fairly misleading, since condom resupply visits normally take very little staff time as compared to other methods.

Client contacts to maintain 25% CPR in Mombasa

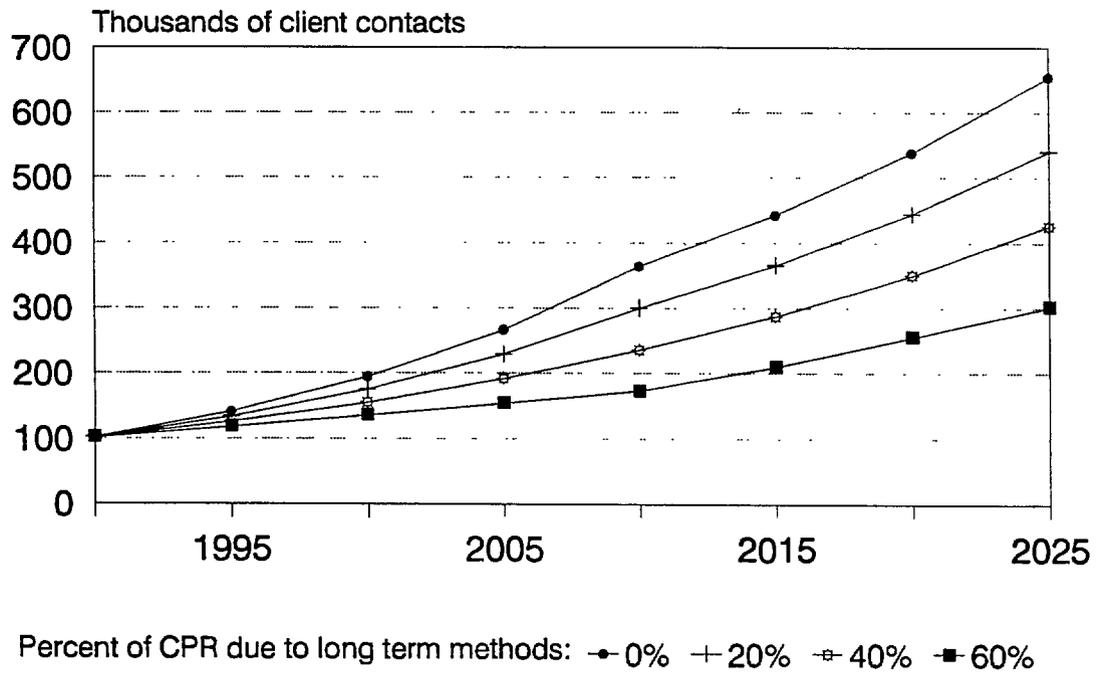


Figure 3

Client contacts to achieve 50% CPR in Mombasa

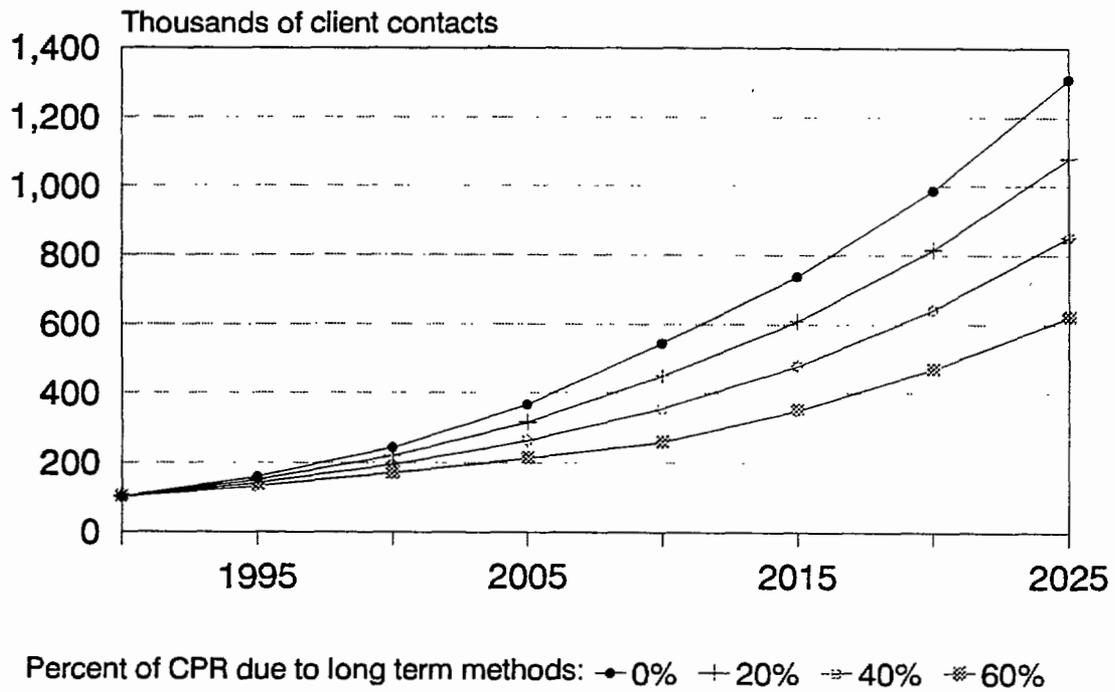


Figure 4

SDPs by type

The following sections assess the current status of Mombasa's family planning program, and are used to identify areas for attention in light of future service requirements. For this portion of the study, data were collected from a total of 83 SDPs, 105 staff members providing FP services, 109 FP clients, 168 non-FP clients, 56 community-based distributors (4 CBDs, 26 CSWs, and 26 DHs), 21 pharmacies and 21 pharmacists.

Geographical distribution of SDPs

As previously noted, map 1 in Appendix 4 shows Mombasa's four administrative divisions: the Island (or Mvita), Changamwe, Likoni and Kisauni. According to the 1989 census, Kisauni has the largest population, but it also has the largest area - over 51 square miles. Using population data projected from the 1989 census, the current populations of women of reproductive age (15-49) were calculated: Mvita - 39180, Kisauni - 43840, Likoni - 18861, and Changamwe - 31451. Map 2 shows that the density of WRA varies tremendously within divisions -- Mvita is about five times as dense with WRA than the other areas.

Map 3 shows the locations of all visited SDPs in Mombasa. This overall distribution is appropriate: most SDPs are on the Island, which has the densest population of WRA, and those in the other divisions are located along major routes which are easily accessible.

The clustering of SDPs on the Island is appropriate not only because the population of WRA is densest there, but also because women and couples in the other three divisions can travel there efficiently and cheaply. Although the situation analysis data indicate that a major consideration in choosing a service delivery point is distance from

clients' homes, other evidence suggests that frequent trips to the Island for shopping are combined with family planning visits. Transport by matatu from the outer three divisions to the Island is inexpensive and efficient.

Maps 4 through 8 display the distribution of SDPs by type. Map 4 gives the six government clinics: three are on the Island, two are on Likoni, and the third is near the airport in Changamwe. The municipal clinics appear quite appropriately distributed in all areas of the city, including those difficult to reach by main road (Map 5). The NGO clinics are heavy in the Likoni district, and in one particular area on the Island (Map 6). Private clinics are also located in this region on the Island (Map 7), but are also fairly well distributed elsewhere. Map 8 shows that all the pharmacies are located on the Island. Thus, the distribution of clinics in all sectors is reasonably appropriate, but there is room for pharmacies to move into the outer regions of the city.

The final map (9) shows clinic locations on the Island. Most are located along the major transportation routes - Moi Avenue, Kenyatta Avenue and Digo Road - where the General Post Office, markets, the main bus terminus, and major supermarkets can also be found. Most private and NGO clinics as well as pharmacies are clustered around the intersection of Moi Avenue and Digo Road.

Private sector

The private sector has the largest number of SDPs providing health services in Mombasa. According to a listing of private practitioners registered with KMA, there were 136 private clinics in the city. (The list has not been updated since 1991, and during the study several additional private clinics were encountered, so the current total is probably higher.)

With support from the KMA, family planning services are provided by 48 (35%) of the clinics on the listing. The infrastructure, equipment, and staff of the private clinics that do not provide family planning services are generally similar to those that do. The major cited reason for not providing family planning services is a lack of incentive, even though this study finds that clients are largely willing to pay for family planning services (see 'Cost sharing').

These results show that private clinics not currently providing contraception represent a major opportunity for expanding FP services in Mombasa. Their facilities are at least as good as other private providers, and clients are generally willing to pay for services. Dissemination workshop participants recommended updating the directory of private providers to target SDPs for training and material assistance.

Pharmacies

There are 33 registered pharmacies in Mombasa, 21 (64%) of which were visited in this study. Most of these pharmacies dispense condoms, foaming tablets and other nonprescription methods to clients, as well as pills, injectables and other prescription methods to those individuals referred by doctors.

None of the pharmacists interviewed have attended any courses in the delivery of family planning services. The only exposure they had to FP was during basic pharmaceutical training, which dealt mainly with the chemical nature of contraceptives. A large proportion of the pharmacists also report that many clients go to them for advice on various aspects of contraception, most commonly on avoiding pregnancy and side effects of the pill (Figure 5).

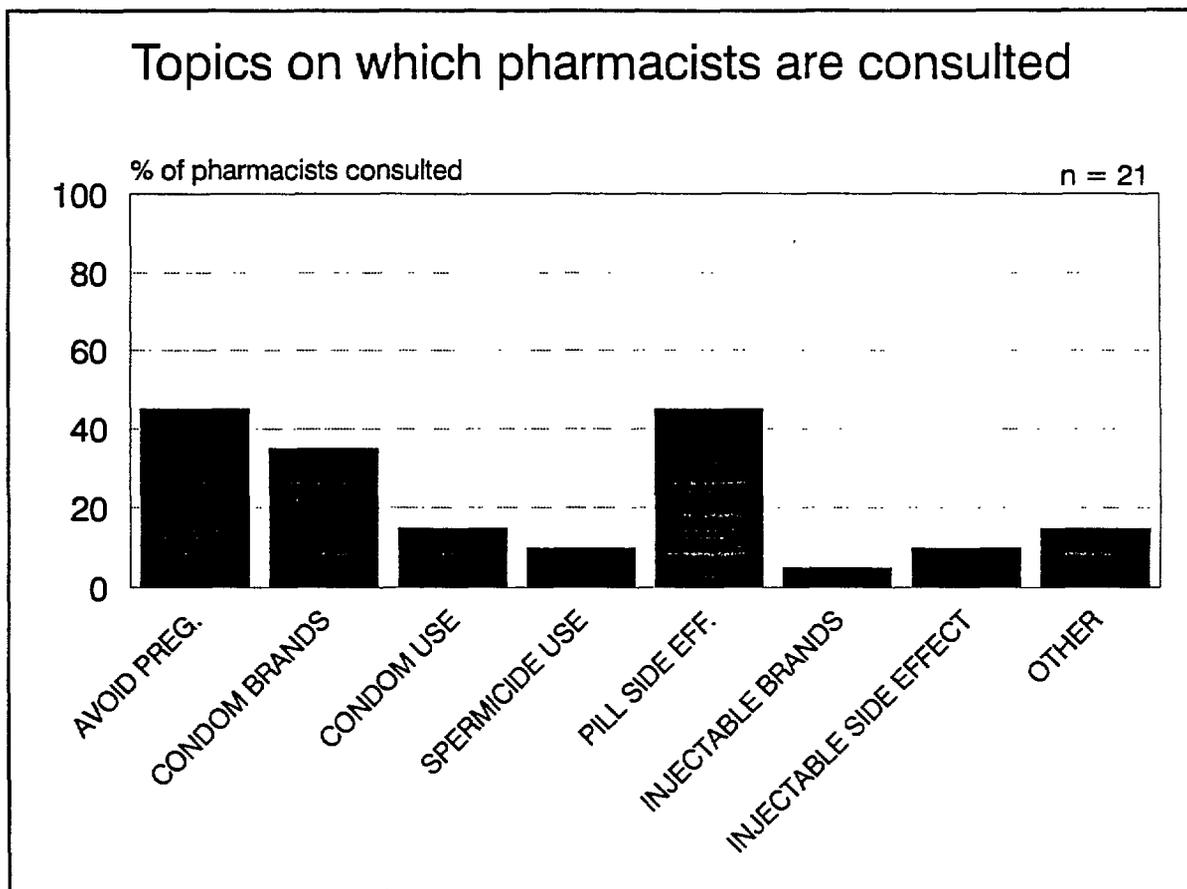


Figure 5

Clearly, pharmacists' FP training in Mombasa is inadequate to handle clients' requests. All the pharmacists interviewed here indicate that they would greatly benefit from an in-service training on FP.

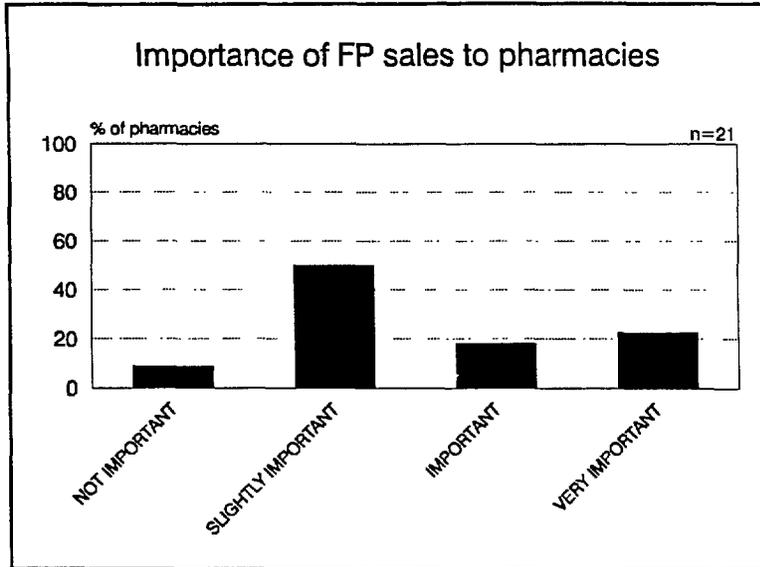


Figure 6

In addition, pharmacists generally recognize the contribution that sale of contraceptives makes to their business. Only 10% state that these sales are not important, and 23% indicate that contraceptive sales are very important to business (Figure 6).

However, the role of pharmacies in the distribution of contraceptives has not been widely recognized to date. The current findings indicate that pharmacies' participation in FP services in Mombasa needs to be developed, mainly through training of pharmacists, who would probably welcome this assistance given the importance they assign to FP sales.

Community-Based Distribution (CBD)

A total of 56 community based distributors are operating within Mombasa municipality, all within the NGO/PVO sector. This group includes 26 community service workers (CSWs), who are attached to the Mkomani clinics and are salaried extension workers. They report to the clinics on a daily basis and are assigned tasks that may include other services beyond the provision of family planning. There are also 26 depot holders, whose main function is to store and supply condoms. These are under the supervision of the CSWs and are not currently involved in the resupply of other contraceptives. These depot holders have not been trained in counselling for other

methods. The remaining four CBDs are unpaid workers for FPAK.

Although this type of service delivery has effectively increased the accessibility of contraception in other settings, the observed level of CBD activity in Mombasa is low. This identifies CBD as another service delivery mode with enormous potential in the city.

Overall status of SDPs

Physical infrastructure

Some SDPs have adequate basic physical infrastructures to provide an acceptable quality of services (Figure 7). The vast majority of SDPs have working electricity as well as counselling rooms, waiting rooms, clients' toilets, and examination rooms (although auditory and visual privacy was found to be inadequate in over 15% of examination rooms).

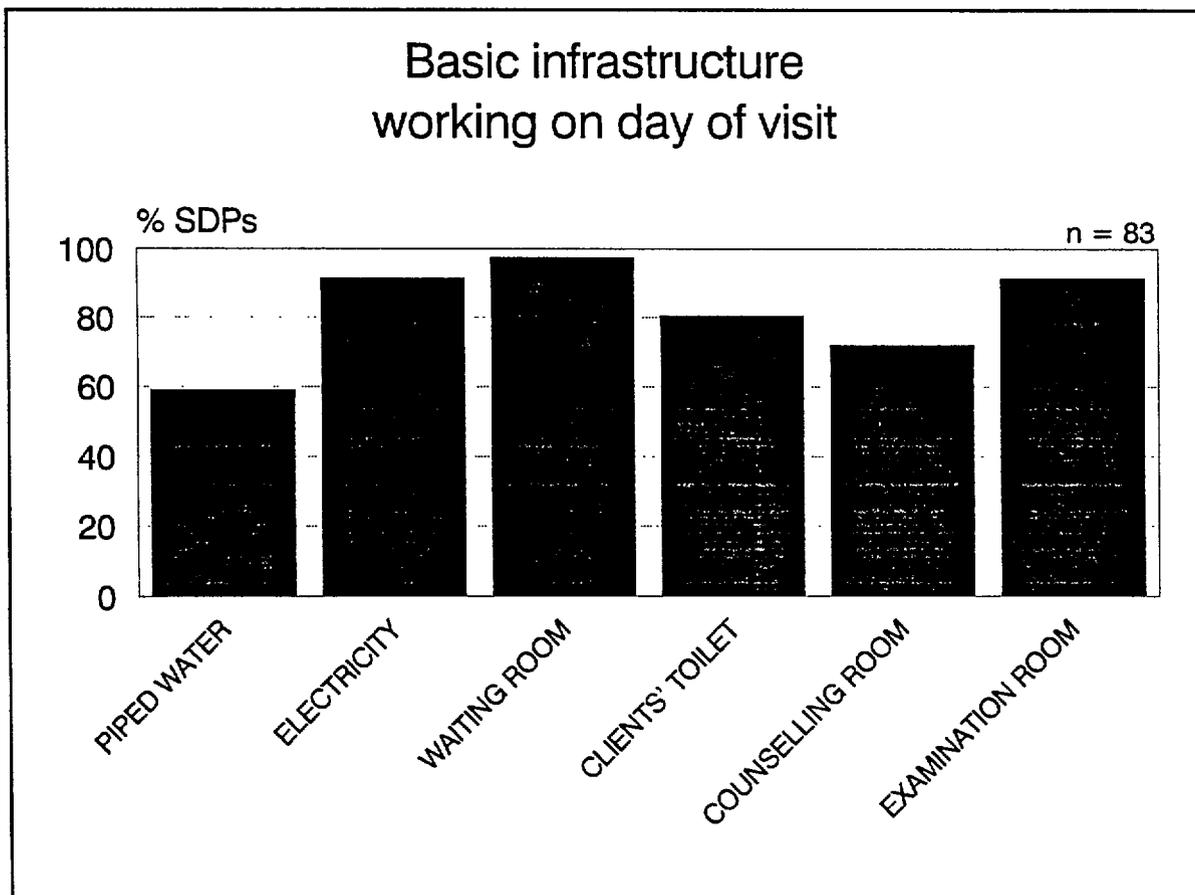


Figure 7

The major deficiency noted is in water: only 60% of the SDPs had running piped water

on the day of the visit. This may have been a temporary shortfall, as dissemination workshop participants noted that there was a general water shortage in Mombasa during that period.

In order to avoid cross-infecting clients, however, some clean water must be available in the examination room for staff to wash hands before and after examining a client. However, there was no water at all in the examination room in 30% of the SDPs visited. Among publicly-funded SDPs, 44% had no water of any kind in the examination room. One solution would be to institute low-tech means of assuring minimal water supplies at SDPs (hand-carried water, etc.).

In addition, more advanced facilities such as sluice rooms and laboratories were found in relatively few clinics. Sluice rooms (storage areas for soiled laundry and other materials) are absent in over 70% of SDPs. This facility is crucial to preventing cross-infections in clients and is a necessity for quality health care; dissemination workshop participants recommended that SDPs not be permitted to operate without a sluice room.

Laboratories are absent in more than 50% of the SDPs. Since laboratories are costly to maintain, however, some SDPs probably have access to centralized laboratories. In general, although laboratory tests are not strictly required for prescribing pills, injectables, and condoms, general reproductive health care does require laboratory work in the form of testing for STDs, conducting pap smears, etc. If one goal of the system is to integrate family planning with other reproductive health services, then access to laboratory services, via whatever mechanisms, will be paramount.

Method mix

The method mix at the visited SDPs is largely limited to pills, condoms and injectables, which are provided by over 80% of the SDPs. In contrast, surgical methods are provided by less than 15% (Figure 8).

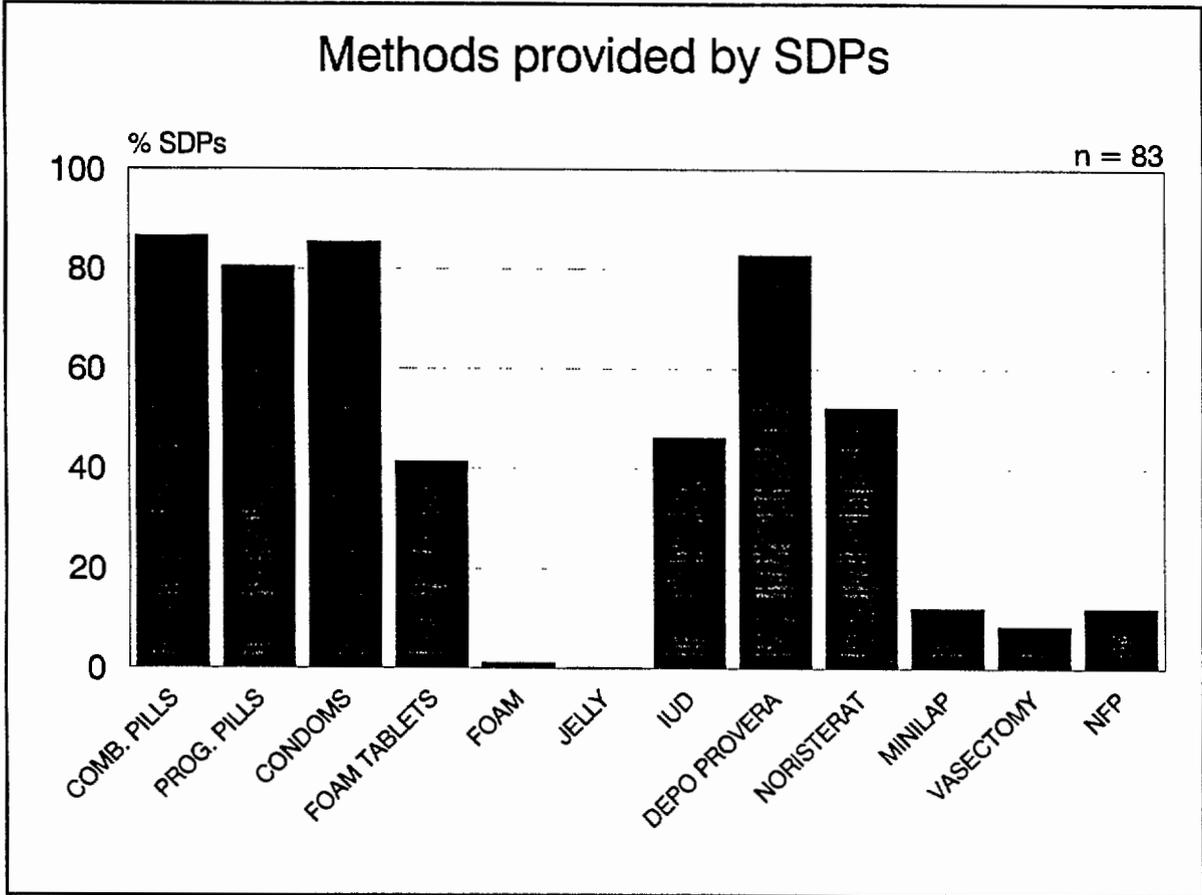


Figure 8

Limits on the methods offered at an SDP may well be a function of the equipment and supplies available: for example, 46% of the SDPs ostensibly offer IUDs but only 40% have adequate facilities for their insertion. The 1993 KDHS shows that of all currently married users of modern contraception in Mombasa, 21% use sterilization and 19% use

IUDs. The FPPMES shows that 10% of all current FP acceptors use sterilization and 16% use IUDs. These findings indicate that long-term and more effective methods are a very important part of the Mombasa method mix.

However, the physical infrastructure of the SDPs must be improved before more long-term methods can be introduced: surgical methods require operating rooms, a range of sterile surgical equipment and supplies, and infection prevention guarantees. These capabilities are particularly important in areas of high STD prevalence.

As noted earlier, the method mix has an enormous impact on future service requirements. The mix currently offered by Mombasa SDPs, heavy in resupply methods, will generate a larger burden on family planning services than a mix with more long term methods. This is not entirely inappropriate, as the DHS shows that in Mombasa women generally prefer spacing methods. However, if one goal is to reduce the future service burden, then women who are eligible to adopt long term methods must be responsibly encouraged to do so.

Publicity

Many family planning SDPs in Mombasa do not advertise their services well. More than 50% do not have any sign announcing their services at all (Figure 9). Of those with a sign, 49% are only in English although 39% of FP clients using these SDPs cannot read or understand English easily.

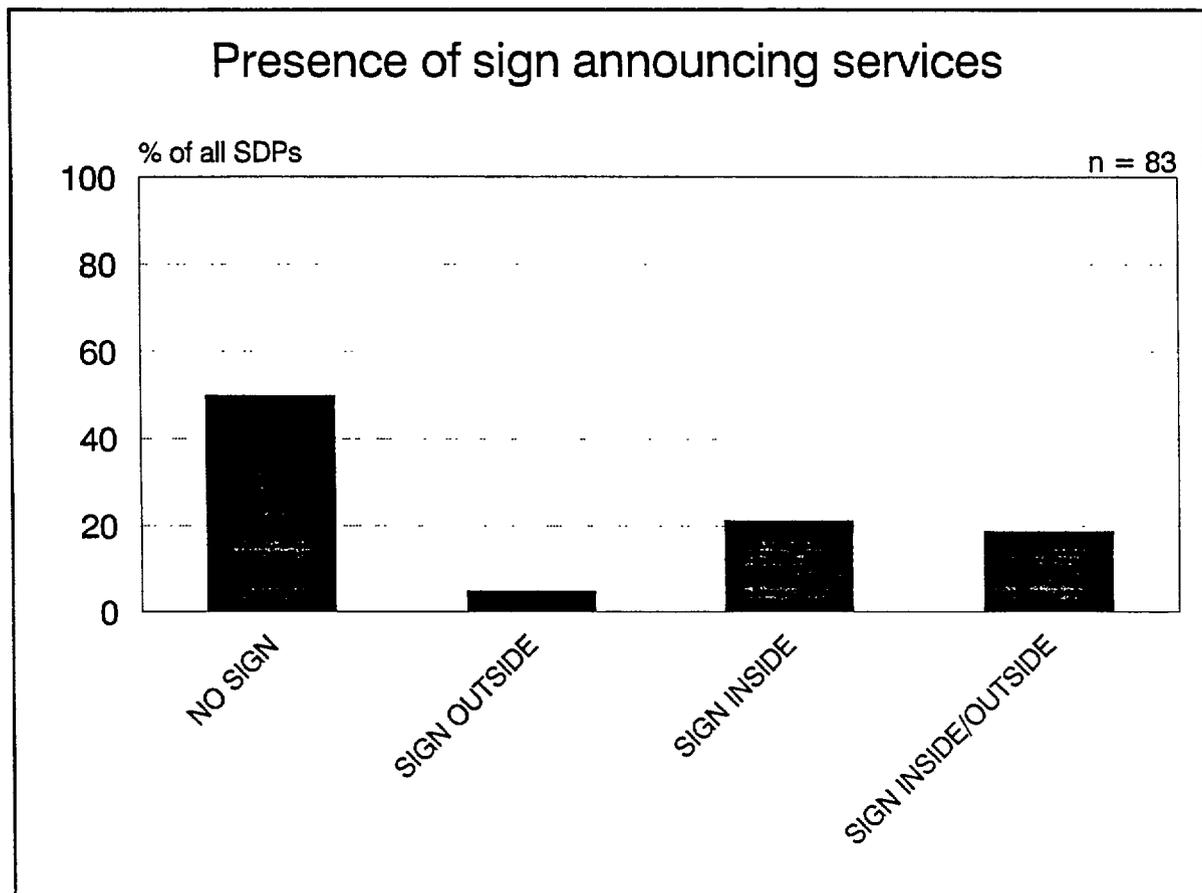


Figure 9

The National Council for Population and Development (NCPD) is in the process of developing a national logo for family planning services, which will be used to announce the presence of FP services at SDPs. Dissemination conference participants

recommended that the logo should be in various languages to facilitate client understanding, and it should be easily available to all SDPs providing family planning service.

IEC materials

There was a general lack of IEC materials at the various SDPs, and even when available a large proportion were in English. Only 13% had flip charts although the staff are expected to use them when counselling clients. In those SDPs with materials available, they were used with few clients. Only 12 (12%) of the staff interviewed for this study had attended some IEC training. Thus, there is a need to improve the supply and appropriateness of IEC materials and to train service providers in their use.

Record keeping and supervision

The NGO/PVO and public SDPs have a good record keeping system that facilitates client follow-up and commodity management, and about 90% of the SDPs use the statistics to prepare monthly reports. About 70% of private SDPs prepare such reports.

However, there is no single central repository for these reports. They are variously sent to the District Public Health Nurse, the Municipal Public Health Nurse, and other places. The District Population Officer does not receive any reports, although in Kenya the DPOs are responsible for all demographic information. This lack of centralized reporting compromises the usefulness of the recordkeeping system.

A large number of SDPs do not receive adequate supervision. Staff at 41% of the SDPs report that they had never themselves experienced a supervisory visit³, and at

further 10% of SDPs, staff report that the last visit was over six months previous. This problem is particularly marked in the private sector, in which staff at 55% of the SDPs had never experienced a visit. Moreover, there seem to be no standard supervision procedures or guidelines. Only 9% of supervisors made suggestions for improving services, and none offered praise for good work. Regular supervisory visits that follow standard procedures would probably improve the quality of care in Mombasa.

At the dissemination workshop it was suggested that all SDPs should routinely send their reports to the Ministry of Health, and that the Ministry should standardize and enforce supervision procedures. It was also suggested that on-site supervisory capabilities be developed.

Commodities and logistics

Several SDPs were stocked out of contraceptive supplies at the time of the study. More than a quarter of SDPs were out of POP and injectables, and between 10% and 20% of SDPs were out of COC, condoms, and IUCDs. Stockouts in the six months previous to the study were reported at between 3% and 10% of SDPs, depending on the method. Moreover, a sizeable number of SDPs had some expired stock on hand at the time of the study. About 15% of SDPs had expired COC or IUCDs, and about 4% had expired POP and injectables. None had expired condoms. These data show room for improvement in the commodities and logistics systems in Mombasa SDPs, particularly to alleviate the relatively frequent stockouts.

³ The staff interviewed fell into three categories of nurses: FP nurse, general nurse, and nursing aide. None of these are management positions, so it is possible that these staff were unaware of supervisory visits that did take place.

Staff characteristics

A total of 105 staff members were interviewed during this study. The largest proportion (50%) of the staff interviewed were from the private sector. Nurses form the majority of staff who are providing FP services (62%). Other non-clinical workers, such as clerks, nurses' aids and drivers, are also involved in the provision of FP services, and account for 13% of the service providers interviewed.

Nurse training in family planning services

In Kenya, training in FP services is provided to those nurses who have completed their basic training in general nursing. This in-service training has been modularized to cover the various aspects of FP programs.

Not all nurses interviewed have attended every FP module, but many have had training on prescribing the most common methods (Figure 10). Only about 13% attended modules on IEC, and only 2% on MIS, but 46% attended clinical service provider training, and 75% or more have had theoretical or on-the-job training for prescribing the pill and injectables. This finding shows that in basic training and on the job, nurses are fairly well trained in prescribing methods, but are not as well trained in ancillary issues of critical importance, such as IEC or MIS.

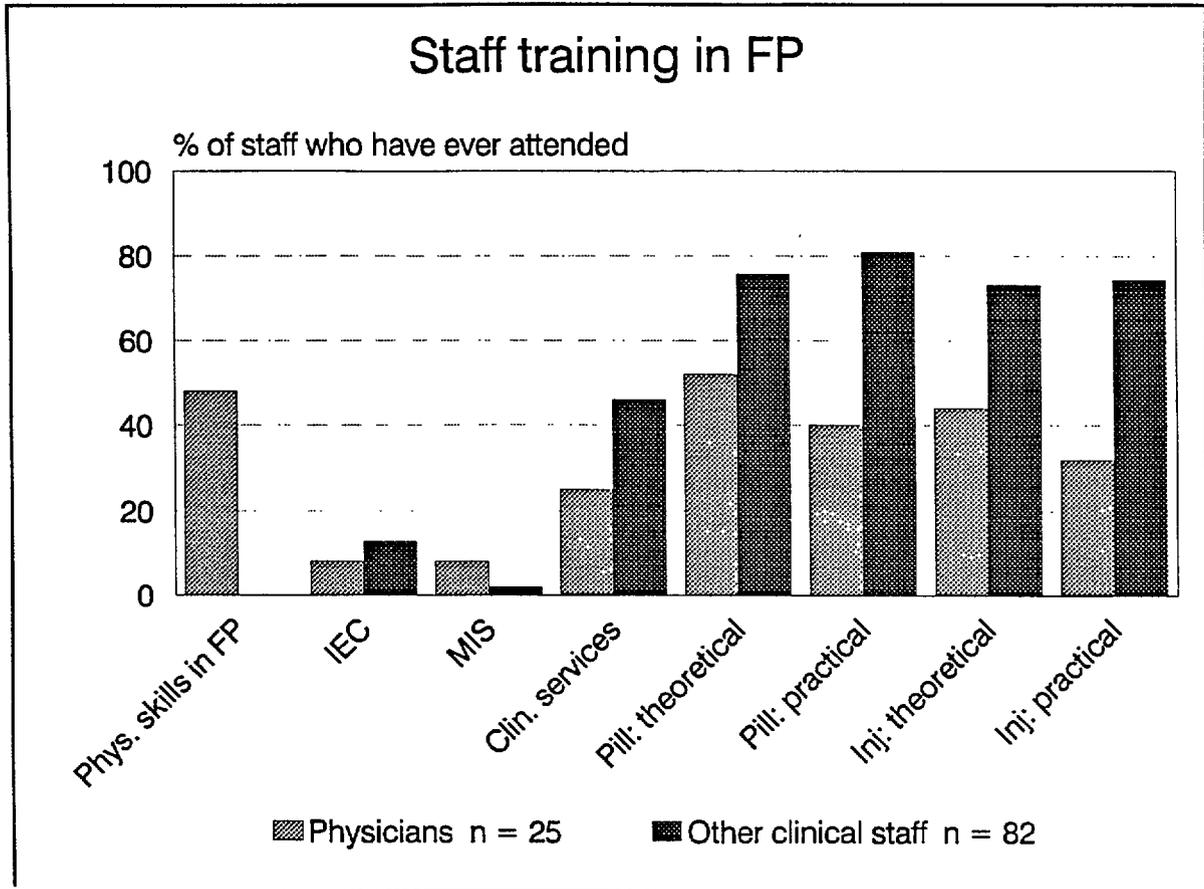


Figure 10

Physician training in family planning services

In general, physician training in providing FP services is at a moderate level. About half (48%) of doctors have ever attended physicians' skills training in FP, but only 8% have been trained in IEC, and 8% in MIS. A quarter of physicians report having attended a course in clinical service provider training. The proportion of physicians with practical or theoretical training for the most common methods (pills and injectables) runs between 32% and 52%, notably lower than for nurses (Figure 10).

Because nurses prescribe the bulk of contraceptives, this inequality of training is not entirely inappropriate. Overall, however, both nurses and physicians are in need of increased training on prescribing particular methods, and extensive training on the use of IEC materials.

Staff method preference

The majority of providers would recommend the pill (84%) and the injectable (75%) for spacing, compared to less than 50% who would recommend the IUD, condom, spermicide and NFP for the same purpose. These preferences may reflect the level of staff knowledge about methods, or simply which methods are available at SDPs. This method preference by the staff is reflected in the types of methods they report to have dispensed in the three months prior to the study, and is probably a major cause of the observed method mix in Mombasa, fully half of which is comprised of pills and injectables, according to the 1993 KDHS.

Client/service provider interactions

A total of 109 women attending the SDPs for FP services were interviewed about their experiences, and 101 client/provider interactions were observed by the project team. Most clients were seen in the government (49%) or NGO/PVO (37%) clinics. 66% of the clients were revisits, and 19% were new acceptors of family planning.

Client characteristics

The sample of women in this study is about the same age as, and a bit more educated than, the general WRA population in Mombasa. The mean age of study participants is 26, with a standard deviation of 4.5 years, which is similar to the general population. The DHS shows that 82% of Mombasa WRA have completed primary education or higher, whereas 94% of the women in this study have done so.

Moslems account for 23% of the client sample, a lower proportion than in the population of WRA as a whole in Mombasa (35%). This low proportion may have been due to the study's overlapping with the month of Ramadhan, during which Moslem women are not expected to be examined or receive injections.

Medical history and examination

The type of medical history taken and examinations performed on clients should clearly differ depending on the client's medical status, reproductive intentions, and method of choice. For this reason, it is difficult to establish a standard set of procedures that should be followed in every case, particularly for revisit clients. A woman does not require a pelvic examination, for example, every time she refills her oral contraceptives prescription. However, for the purposes of this study, the procedures listed in Figure 11 are taken to be a basic standard for new acceptors. For revisits, the 'optimum' level

for each procedure is debatable, but some information about quality of care is nevertheless discernable from these data.

During the client/provider interactions in Mombasa, history taking and examination of new clients was generally observed to be inadequate to facilitate decision-making by the service providers or clients (Figure 11). Information about the client's medical history, unusual vaginal bleeding/discharge, weight and pelvic pain was obtained for 50% or fewer of the new clients. Pelvic, breast, and general physical examinations were performed on half or a bit more of the clients. Date of last menstrual period was obtained in about 80% of the cases. By the standards set above, all of these measures should be 100% for new clients. For revisits, most of these indicators are lower, which is not necessarily inappropriate, as mentioned above.

At the dissemination workshop, the extent of history-taking and examination was felt to be a reflection of the supervision, staff training, staff time, staff motivation and availability of facilities to perform examinations. It was concluded that this issue needs to be addressed urgently.

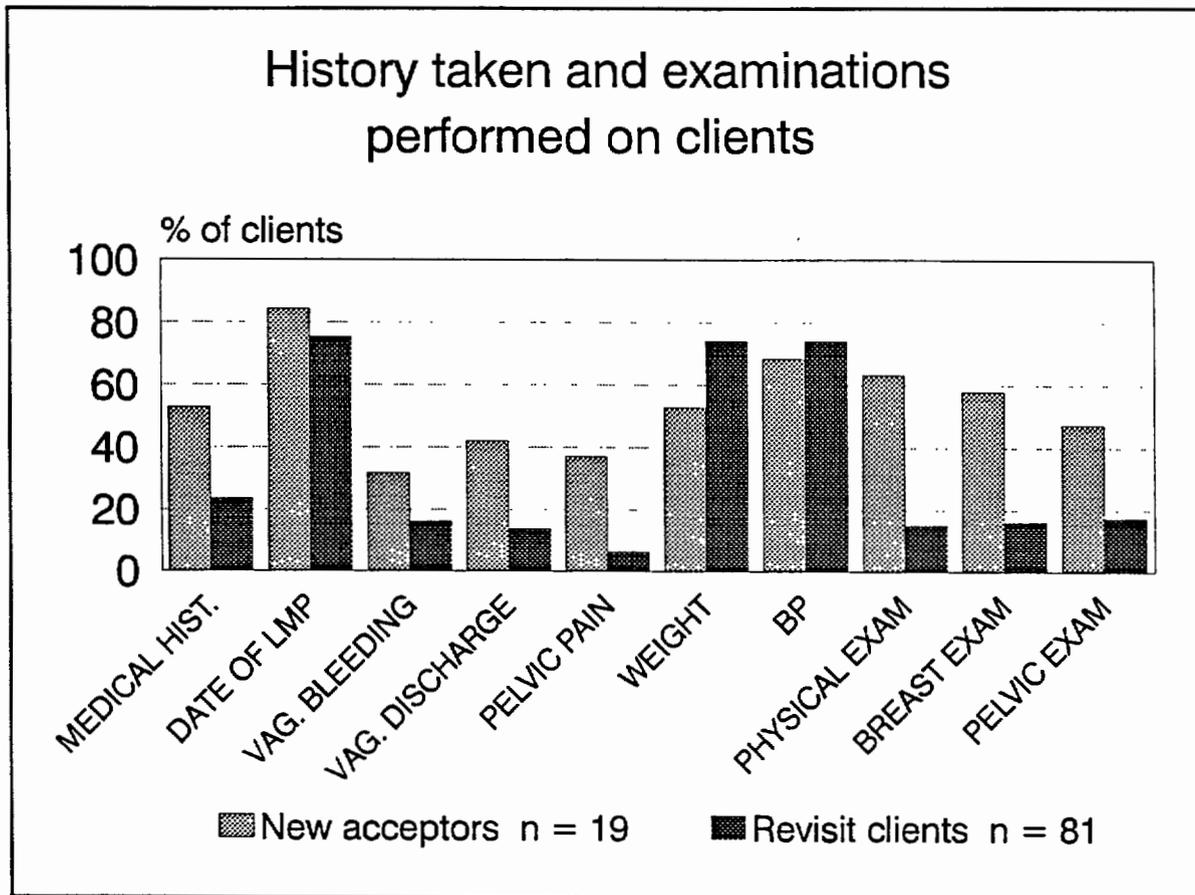


Figure 11

Information about contraceptive methods

Information about the various contraceptive methods was given selectively: less than 50% of new clients received information on the surgical methods, spermicide, Norplant® and natural FP. The information given about these methods was not satisfactory to 30% of clients, who indicated that it was not enough to make a decision. Despite the fact that some clients were not satisfied with the information they were given, a large number (46%) did not ask any questions about FP during their interactions with the service providers. This study did not investigate providers'

decision-making strategies, but the selection of information to provide to a client may reflect the providers' knowledge and preferences as well as the availability of methods at that SDP.

Follow-up

In the majority of the client/provider interactions, the provider collected adequate information to facilitate follow-up, and the clients were made aware of what was expected of them. Over 90% of new clients were told what to do in case of problems, 94% were given a date for a follow-up visit, and 82% were informed of the possibility of switching methods.

Client satisfaction

Despite the shortfalls noted during the observation of the client/service provider interactions, over 84% of clients reported that they had received the information and services they had desired.

Cost sharing

Family planning services are considered to be part of the primary health care program in Kenya and are expected to be provided free in the public sector. However, clients are often requested to contribute to the purchase of supplies, and 81% reported that they had paid for the services they had received. Over 50% of those women who did not pay for the services indicated that they would continue to use contraception if they were required to pay. Less than 50% of the clients were involved in any income generating activities, meaning that if they were to pay for the services, they would have to obtain funds from elsewhere. This may not pose a major problem as 64% of the clients were confident that their spouses would provide financial support if this was required (Figure 12).

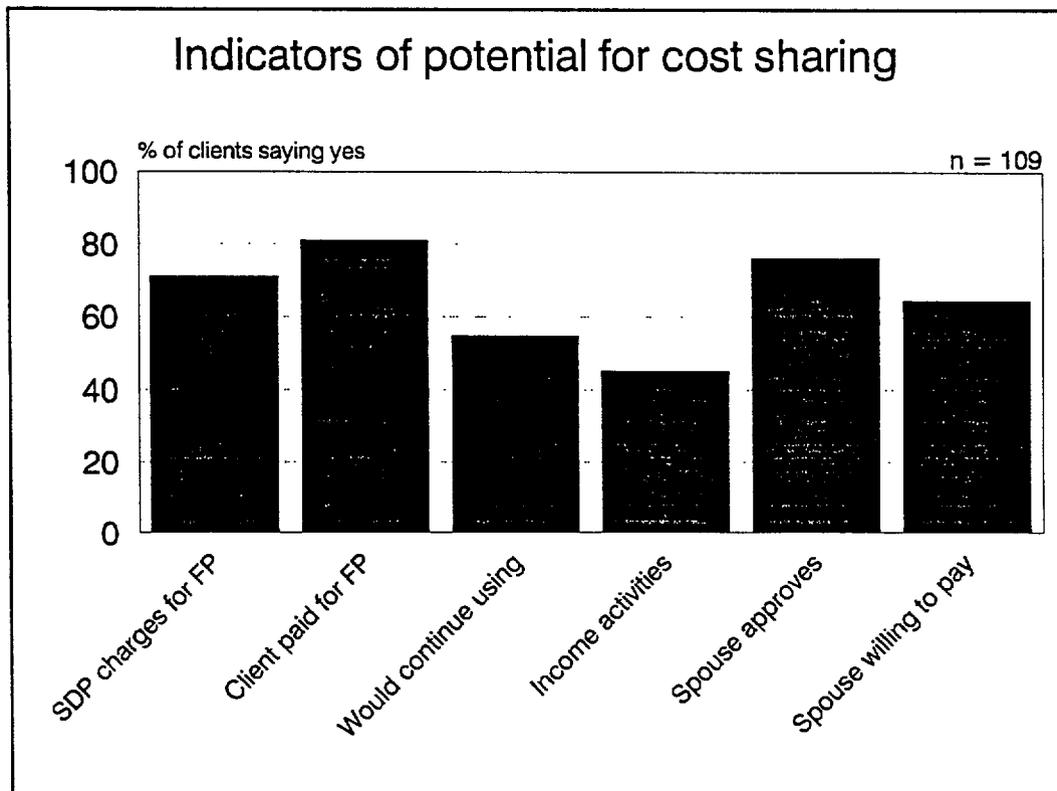


Figure 12

These results reveal a general willingness to pay for FP services in Mombasa: many women are already unofficially paying, the majority of those not paying would be willing to do so if necessary, and many spouses are willing to provide finances for FP. These circumstances indicate that there is a large potential for cost sharing in Mombasa, on which all sectors, including pharmacies, might base their expansion.

Integration of STD/HIV management with FP service programs

Consultations for STDs in general are already provided at 75% of the visited SDPs, and 49% specifically provide IEC on AIDS. However, during the client/provider interactions, AIDS was discussed with only 6% of the new clients and none of the revisit clients. This shows that although policy may favor integration, very little if any has actually taken place.

The need for integration

The need for STD/HIV services among FP clients is great. The study participants have generally poor knowledge of symptoms, signs and modes of transmission of STDs, and up to 73% of those reporting past symptoms related them to possible STDs.

Some planners fear that integrating STD/HIV management with FP services would stigmatize the FP services and lead to low contraceptive use. However, 85% of the clients interviewed indicate that they would continue to visit the same SDP even if it started providing STD/HIV management. This is a strong argument for integration, and suggests that the stigma around STD services may not be as strong as expected.

Staff training in STD/HIV management

Most of the staff members interviewed (64%) have not attended any in-service training on the management of STD/HIV (Figure 13). Although most (78%) were exposed to some basic management concepts during their basic training, 57% of those exposed felt that it was not adequate to facilitate their management of STD/HIV.

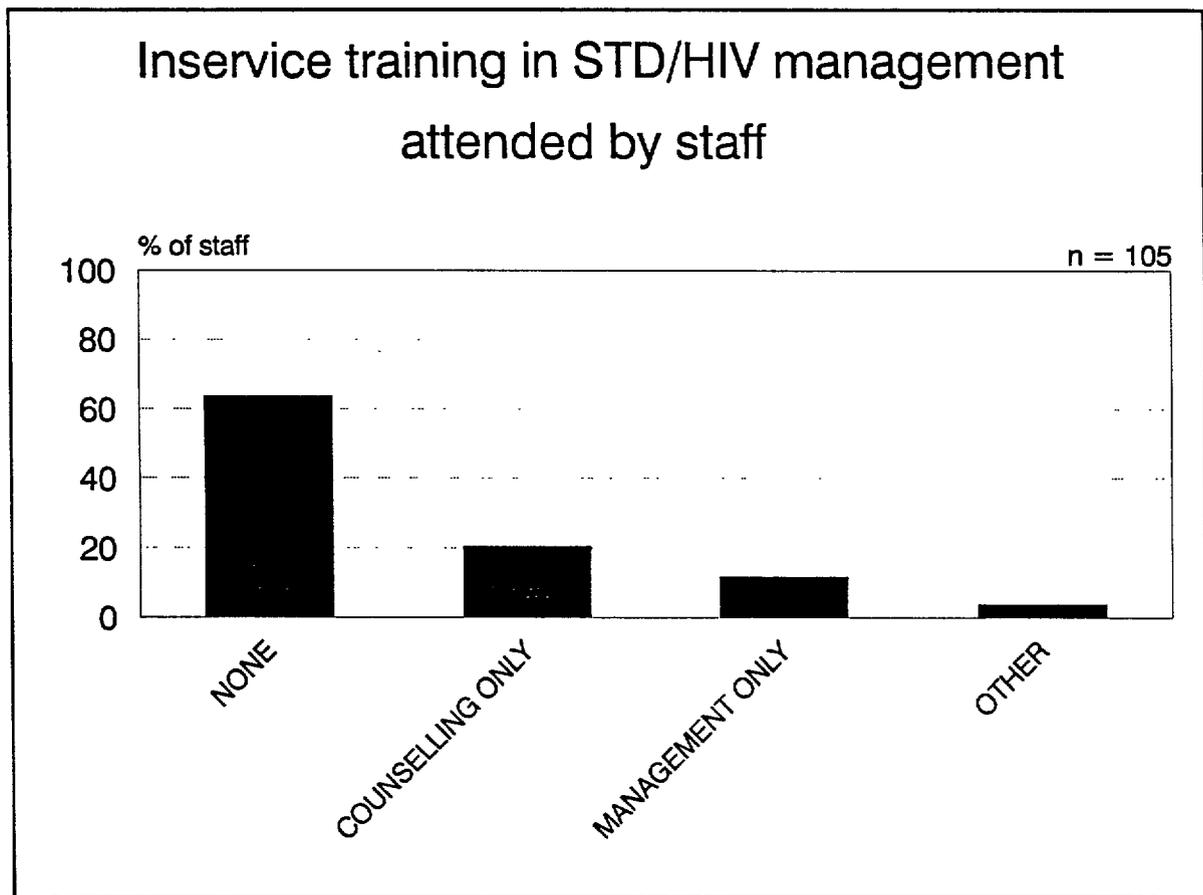


Figure 13

However, most of the staff providing FP services are trained and capable of performing pelvic examinations, which are crucial to STD diagnosis.

Staff knowledge of signs and symptoms of STDs

The lack of adequate training is reflected in poor knowledge of STDs/HIV by the staff. Most can name the common STDs but their knowledge of signs, symptoms and modes of transmission is inadequate.

Awareness of the common STDs is high. More than 90% of the staff are aware of AIDS, gonorrhoea and syphilis. A significant number are aware of candidiasis (63%) and trichomoniasis (52%). Only 30% of the staff are aware of chancroid as an STD, although in Kenya it is said to be the most common cause of genital ulcers seen in the health facilities. Less than 35% of the staff interviewed are aware of herpes and chlamydia infections as STDs. Their level of awareness improves after the STDs are mentioned, but for chancroid, chlamydia and herpes the proportion aware did not exceed 70% even after prompting.

The staff were also asked to name the signs and symptoms of the STDs they had named. Although 93% of the staff are aware that syphilis is an STD, less than 50% are able to name any of the common signs and symptoms, including genital ulcer, painless ulcer, skin rashes and

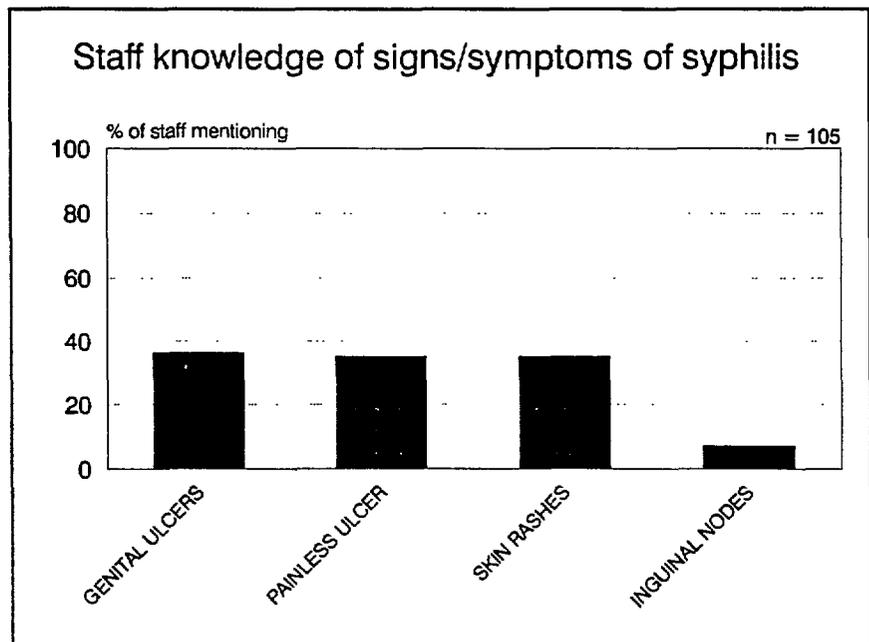


Figure 14

enlarged inguinal nodes (Figure 14). The knowledge of the signs and symptoms for the other common STDs is also poor.

Given this poor knowledge of the presentation of STDs, it is unlikely that these staff members will be able to provide an integrated STD/HIV service without additional training.

Facilities, equipment, and supplies for integration

SDPs will have to be reviewed for the facilities, equipment and supplies required to integrate services. Less than 50% of the SDPs have any type of laboratory, and only 40% have a microscope. Equipment required to examine clients, like specula, are also generally lacking in these SDPs.

Supervision and morale

At the dissemination workshop, low staff morale and lack of supervision were identified as major barriers to service integration. It was recommended that a needs assessment be undertaken to determine the training needs of the staff and appropriate refresher courses developed. In addition, morale-building exercises, reading materials, and adequate regular supervision should be provided to facilitate this integration.

Appendices

Appendix 1: Summary of findings from the Mombasa sub-sample of the 1993 Kenya DHS

Statement	Measure	Momb.	Other Urban	Rural
General characteristics of WRA				
The level of education among WRA is lower in Mombasa than other urban areas	% of WRA completed primary ed or higher	82%	93%	82%
Mombasa hosts a large Muslim Population	% WRA who are Muslim	35%	9%	3%
Fertility				
Mombasa TFR is similar to other urban areas, lower than rural	TFR	3.3	3.3	5.9
Mean CEB in Mombasa is similar to other urban areas, lower than rural	Mean children ever born	2.12	1.93	3.38
Mombasa WRA want more children than women in other urban areas.	Mean ideal number of children	3.6	2.8	3.8
Proximate determinants of fertility				
Like other cities, about half of Mombasa women are married or have a partner	%WRA who are married or have a boyfriend(live-in or not)	56%	55%	65%
However, WRA who are not in union are also sexually active in Mombasa, at a level between other urban and rural areas	%WRA who are not in the union and who are sexually active	31%	39%	22%
Frequency of intercourse is higher in Mombasa than elsewhere	%WRA in union who had intercourse >4 times in last month	31%	29%	17%

Statement	Measure	Momb.	Other Urban	Rural
As in the rest of the country, the majority of Mombasa WRA are first exposed to intercourse as teenagers	%WRA who were first exposed to intercourse at <20	83%	83%	90%
Fertility regulation				
In all three regions, knowledge of modern methods is high	%WRA who know of a modern method	98%	97%	96%
The Mombasa ever-use rates for modern methods is between other urban and rural areas	%WRA who have ever used a modern method	41%	48%	31%
The CPR for all WRA in Mombasa is between other urban and rural areas	%WRA currently using a modern method	23%	29%	19%
Of those women in Mombasa who are not using contraceptives a large portion are trying to become pregnant	%WRA who are not using a contraceptive and who list "trying to get pregnant" as the main reason for non-use	38%	11%	14%
Among non-users in all three areas, almost no one mentioned cost or inaccessibility as the main reason for non-use	%WRA who are not using a contraceptive and who list "cost" or inaccessibility " as the main reason for non-use	0%	0%	<1%
Mombasa's total unmet need is similar to other urban areas, less than rural areas.	%of WRA with unmet need to space or limit (DHS definition v626)	23.4%	25.1%	37.6%
Mombasa's unmet need has a higher proportion of spacers than in other regions	% of the unmet need that is for spacing	74%	59%	60%
Knowledge of contraceptive sources is quite high in all three regions	%WRA who know a source for a modern method	92%	90%	88%

Statement	Measure	Momb.	Other Urban	Rural
In Mombasa, there are large private and NGO sectors providing family planning services	%WRA who are current users and whose last source was a private or NGO SDP	56%		n/a

Appendix 2: Inventory of service delivery points in Mombasa

Municipal facilities

Bamburi Health Centre
Chaani Health Center
Ganjoni Health Center
Jomvu Kuu Health Center
Kisauni Health Center
Kongowea Health Center
KWA Jomvu Health Center
Magongo Health Center
Majengo Health Center
Makupa Sub-Health Center
Mkomani Harambee
Mtongwe sub-Health Center
Mvita Health Center(Vita Clinic)
Mwakinuge Dispensary
Mwembe Tayari Health Center
Old Town Dispensary (Old Town/Kaderboy Dispensary)
Shika-Adabu Health Center
Utange Sub-Health Center

Ministry of Health facilities

Coast provincial General Hospital (North Coast Hospital)
Likoni Health Center
NYS Dispensary
Port Reitz District Hospital
Railway Dispensary
Tudor Clinic

Non-governmental and private voluntary facilities

Bamburi Cement Ltd. Clinic
Baobab Clinic
Bomu Clinic (Mkomani Bomu)
Changamwe Hospital (Changamwe Clinic)
Changamwe Hospital Extension-Voi Clinic(Voi Clinic, Voi Sisal)
FPAK A
FPAK B
Green crescent maternity (Green Crescent Nursing Hospital)
Kenya Trade and Development Clinic
Marie Stopes
Mkomani Clinic
Mombasa Ukumbusho
Mombasa Ukunda Clinic

Mombasa Ukunda Extension
Mtongwe Clinic
Mtongwe Crescent Medical Aid
Mtopanga Crescent Medical Aid
Mtopanga Clinic
Sayyida Fatima
St Luke's Kaloleni Hospital

Private (profit making) facilities

Dr Acharya
Alfa Medical Clinic
Dr. S. Amin
Ann's Medical Clinic
Awadh Nursing Home
Dr. Awuma
Dr. Bakarani
Bakarini Hospital
Bakarini Maternity and Nursing Home
Dr. Bhutia
Bokole Domicillary and Health Services
Changamwe Hospital
Dr. Chania
Dr. Chymia Clinic
Corner Hospital
Dr. Devani
Family Medical Center
Dr. Gitambo
Green Crescent Maternity
Harambee Clinic
Dr. Kagutta
Dr. Kamau
Dr. B. Kanyi
Dr. Karuba
Dr. Khalwale
Dr. Kirima
Dr. Kotak
Dr. Lema
Likoni Nursing Home
Mainland Maternity
Makupa Maternity and Nursing Home
Makupa Nursing Home
Dr Mala
Mawani Medical Clinic
Dr. Mgutta
Dr. Modi
Mombasa Hospital
Dr Mominyi
Msikiti Noor Medical Clinic

Dr.Muasa Wa Mooki
Dr Mumbo
Dr. P. Munuva
Dr. Muriga
Mutopanga Medical Clinic
Dr. R. Mutunga
Dr. P.C. Patel's Clinic
New Post Road Clinic
New Mvita Nursing Home
Dr. Nathani (Dr Nathwani)(Mombasa Medical Center)
Dr. Ndosi
Mr Ngone
Nyali Nursing Home
Dr. Nyanyi
Dr. Odongo
Dr. Ogutu
Dr. Onomgo
Pandya Hospital
Dr Parker
Dr. Rahims Clinic
Dr.Rati Shar
Dr. Saeed
Salama Medical Center
Dr. Gita Shah
Dr. R. Shah
Dr. Shangai
Dr. Sharma
Dr. Sharma
Dr. Soni
Dr. Tayabali
Tudor Nursing Maternity
Tumaini Private Medical Clinic
Utubora Clinic
Dr. Vama
Dr. Varia
Dr. (Mrs) Varia
Dr. Varma
Dr.(Mrs) Sushil Varma
Dr. Vibhakar
Vibakhar Maternity/Nursing Home
Dr. Vora

Appendix 3: Mombasa dissemination workshop group presentations

Note: Table references in this appendix do not match table numbers in the main text.

Group 1: Status of SDPs and management systems

1. Types of SDPs

All health facilities should be registered and those providing family planning services listed to give a meaningful status in the district. The physical distribution of the facilities is considered to be satisfactory.

2 Presence of a sign announcing family planning service availability

The current effort of NCPD to introduce a national family planning logo for the country should incorporate this. In addition bill-boards showing where health facilities are situated should also be available in both English and Kishwahili.

3. Basic infrastructure existing at SDP on day of visit

- i. It was noted with concern that the water shortage revealed by the data presented is an issue of contention. It was also noted that this is a municipal problem, and as such it was very difficult to seek for actions to be carried out by the municipality at this juncture. A recommendation was made that as more thought is given to the alleviation of this problem for Mombasa as a whole, SDPs should construct water storage facilities to be used when the water shortage is at its worst. The issue of operating SDPs without adequate supplies of water was also tackled with concern.
- ii. The absence of sluice rooms in some of the SDPs visited was also an issue of concern. This is considered a priority area. No SDP should be allowed to operate without a sluice room.
- iii. Laboratories should be available to SDPs as this would greatly assist in the day to day activities. In instances where SDPs do not have laboratories due to inadequate funding bases, it was thus recommended that a situation where joint laboratories are set up is pretested. These laboratories would then be equipped with trained personnel and equipment and greatly decrease funding considerations.

4. IEC materials

The minimum materials referred to in this situational study should be available in all SDPs. In as far as possible, these materials should exist in both English and Kishwahili. In addition to this, samples of contraceptives should also be available to service providers for use during client counselling.

5. Examination area

There is need to improve client privacy considerations in SDPs.

6. Equipment/commodities

This table needs to establish the level of health facilities and services, including personnel trained in family planning.

7. Methods provided by SDPs

There is need to check the underlying causes of why methods 1, 2, 3, 4, and 6 are not being provided 100 percent in the SDPs observed. There is also need to find out why the Norplant® method did not seem to be represented during these observations. In addition, it was the general consensus that natural methods should not have been included in the analysis.

8. Recordkeeping

- i. There is need to encourage private practitioners to continue with service provision with good records kept. The Ministry of Health should be considered the overall supervisor to follow up reports, improve supervision and re-supply of commodities.
- ii. There is need to revisit the data and qualify what is meant by multiple visit cards and single visit cards.

9. Supervision

Since there seems to be very little supervision carried out, there is need to create site supervisors, whose role would be fully developed by the particular SDP in question in collaboration with the overall supervisor (the Ministry of Health).

10. Integration of services

It was generally observed that there seems to be a lot of segmentation of services, especially in the private sector.

Group II: Status of human resources to service family planning programmes

- Table 1** The distribution is skewed with the majority of staff interviewed coming from the private sector. As such it was the general consensus that these results are not representative because most of them reflect services in the private sector rather than the government. The sampling procedures that were used favored private clinics and most of these are located on the island.
- Table 2** The majority of staff providing services are nurses from private sector. The data representing services being provided should be further broken down into central, local and government parastatals so as to give a clear picture of the workload.
- A recommendation was made that the organizations that take care of private clinics should make sure that all relevant service providers undergo the basic training.
- Table 3** Results show that most service providers have attended the MCH/FP course. It is recommended that these results are further broken down by course and designation.
- Table 4** Most service providers provide pills, injectables and condoms as short-term methods at the expense of long-term and permanent methods because they are easy to dispense.
- Table 5** There was some error in feeding the data and therefore the table should be re-done. For example a client does not need to undergo medical examination to use a condom.
- Table 6** Service providers working in the clinics are conversant with the basic principles of family planning.
- Table 7** The table suggests that women in Mombasa District are using abortion as a method of family planning to regulate their fertility. This conflicts with the government policy and should have been prevented in the first place.

Group III: Client/service provider interaction

1. The large number of Christians as compared to Moslems presenting for family planning services at various SDPs was mainly because this analysis was carried out during the month on Ramadhan.
2. An observation was made that some clients cannot read nor understand either English or Kishwahili. It was thus recommended that every SDP adopts some form of illustrative information for this particular group.
3. The issue of poor history taking was noted with concern. There is need to emphasize the importance of proper history taking for all clients who present at the SDP. This would thus bring in the elements of supervision, staff training and staff motivation.
4. It was noted that IEC materials are not adequately supplied at SDPs. In addition where available these materials are not fully utilized by service providers. There is need to address this.

Group IV: Integration of STD/HIV/AIDS and cost sharing issues

1. It was noted with concern that there seem to be low levels of knowledge of STD by service providers. To combat this, the following recommendations are made:
 - a. That each SDP carry out a Needs Assessment Exercise to find out what type of knowledge on STDs is required by staff.
 - b. That appropriate refresher courses be developed and offered to staff having to deal with STDs.
 - c. That reading materials be provided for staff.
 - d. That supervision modalities be improved.
 - e. That during counselling, in as far as possible, staff should be encouraged to interact with clients in a language that they understand.
2. For cost sharing issues, various members within the group had mixed feelings and thus no consensus was reached.

List of participants

Name	Designation	Address
J.M.Mwirigi	D.O. Mombasa Island	Box 98288 Msa
Dr. J.A. Onyango	In-Charge Service Delivery	Mkomani Clinic Box 95683 Msa
F.M. Katumo	Chief- Tononoka	Box 90430 Msa
J. Masara Nchogu		Box 90233 Msa
Dr. Chula	Medical Officer	Mun Council Msa Box 90441 Msa
Dr. J.M. Othigo	Medical Officer	Coast General Hosp
Ms M. Oredo	VSC Theatre	Coast General Hosp
Mr. S. Aswa Ndili	District Statistical Officer (outgoing)	Central Bureau of Statistics, Box 83059 Msa
Ms. E. M. Chibeu	Medical Records Technician	Port Reitz Hosp Box 90502 Msa
Mr. A. Ndolo	Storeman I	Medical Supplies Coordination Unit Box 43335 Msa
Ms. I. Lenga	Nutritionist	Port Reitz Hosp Box 90502 Msa
Ms A. Ruria	Prov Health Education Officer	PMO's Office
Dr. T. Mboya Okeyo	Medical Officer /Epidemiologist	Nat AIDS/STD Control Programme Box 19361 Nairobi
Dr. Isaac Achwal	Senior Programme Officer	FPAK, Box 30581 Tel 215676/7/8/9 Nairobi
Dr. Amina Twahir	Director	Mkomani Clinic Society Box 95683 Msa

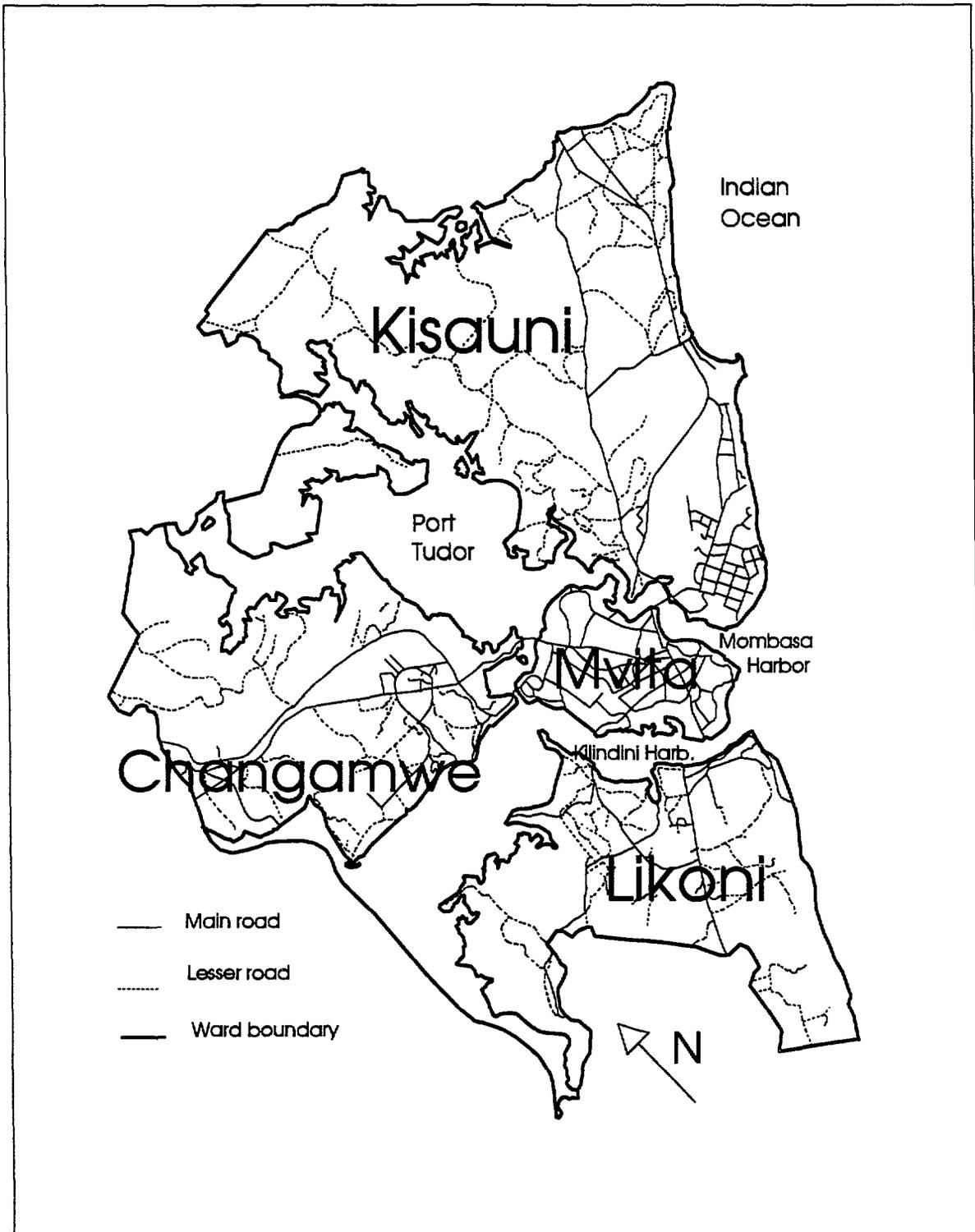
Name	Designation	Address
Mr. C. Thube	Health Economist USAID	Box 30137 Nairobi
Mr D. O'Brien	Evaluation Officer JSI/SEATS Project	1616 N. FT Myer Drive Arlington VA USA
Dr. Omondi Odhiambo	Research Associate	FHI, Box 38835 Nrb Tel. 713911
Mr. E. W. Barasa	District Officer	Box 90430 Msa
Mr. Juma Kibwana	Chief-Bamburi	Box 12095 Msa
Ms. A. Thairu	Senior Nursinf Officer	Port Reitz Hosp Box 90502 Msa
Ms J. Mutua	Nursing Officer I	Medical Training Center, Box 87946 Tel 220513 Msa
Mr O. Mwinyipembe	Chief	Box 90430
Ms T.K. Mburugu	Nursing Officer	Coast Gen Hospital Box 95009 MSA
Ms W. M. Mjambili	Senior Nursing Officer	Coast Gen Hospital
Ms. J.M.A. Oburu		Port Reitz Hosp
Dr Chidagaya	District Medical Officer	Port Reitz Hosp Mombasa
Mr. N. M. Kimeu	Assist Prog Officer	FPAK, Box 98223 Tel 3116937 Msa
Ms. H.R. Nyaga	MCH/FP Supervisor	Mun Council Msa Box 9044 Mombasa
Ms J. M. Arome	Co-ordinator CBD Prog	Mkomani Clinic Soc Box 95683 Msa
Ms A.Z. Mbogo	Nursing Officer	Marie Stopes Clinic, Box 84711 Tel 220323 Msa
Ms E. L. Njoroge	Nursing Officer	Changamwe Hosp Box 98631 Msa

Name	Designation	Address
MsJ. Omito	Field Coordinator FP	KMA, Box 90434 Msa
Ms Mary Mujomba	Assist Prog Officer	CAFS Box 60054 Nrb
Dr A.B. Maggwa	Programme Officer	CAFS Box 60054 Nrb
Ms E. S. Naggawa	Programme Officer	CAFS Box 60054 Nrb

Appendix 4: Maps of Mombasa

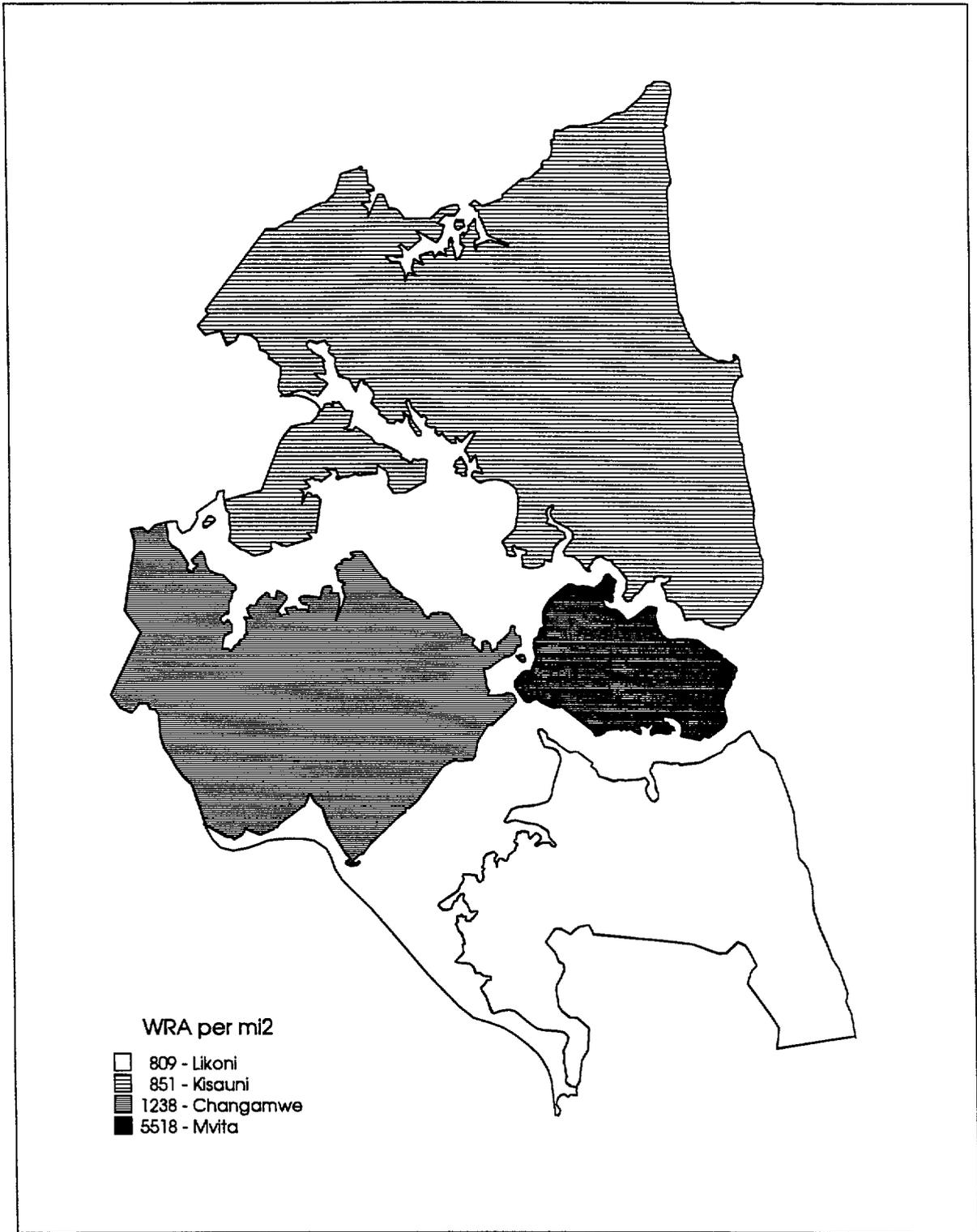
- Map 1: Mombasa, Kenya
- Map 2: Density of women 15-49 in Mombasa, by division
- Map 3: All SDPs in Mombasa
- Map 4: Government clinics in Mombasa
- Map 5: Municipal clinics in Mombasa
- Map 6: NGO/FPAK clinics in Mombasa
- Map 7: Private clinics in Mombasa
- Map 8: Pharmacies in Mombasa
- Map 9: Clinics in downtown Mombasa (Mvita)

Map 1: Mombasa, Kenya

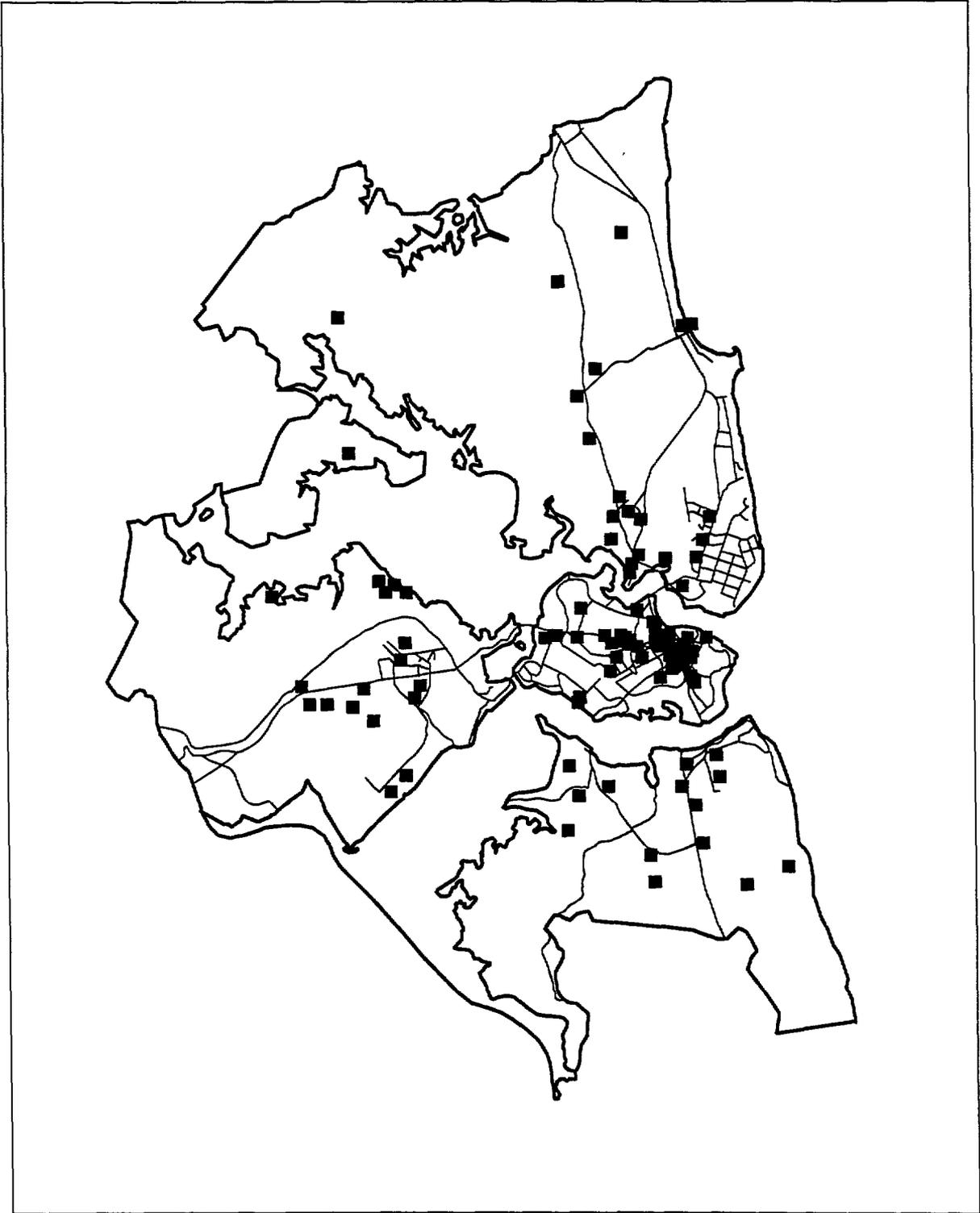


Approx. scale: 1 inch = 2 miles

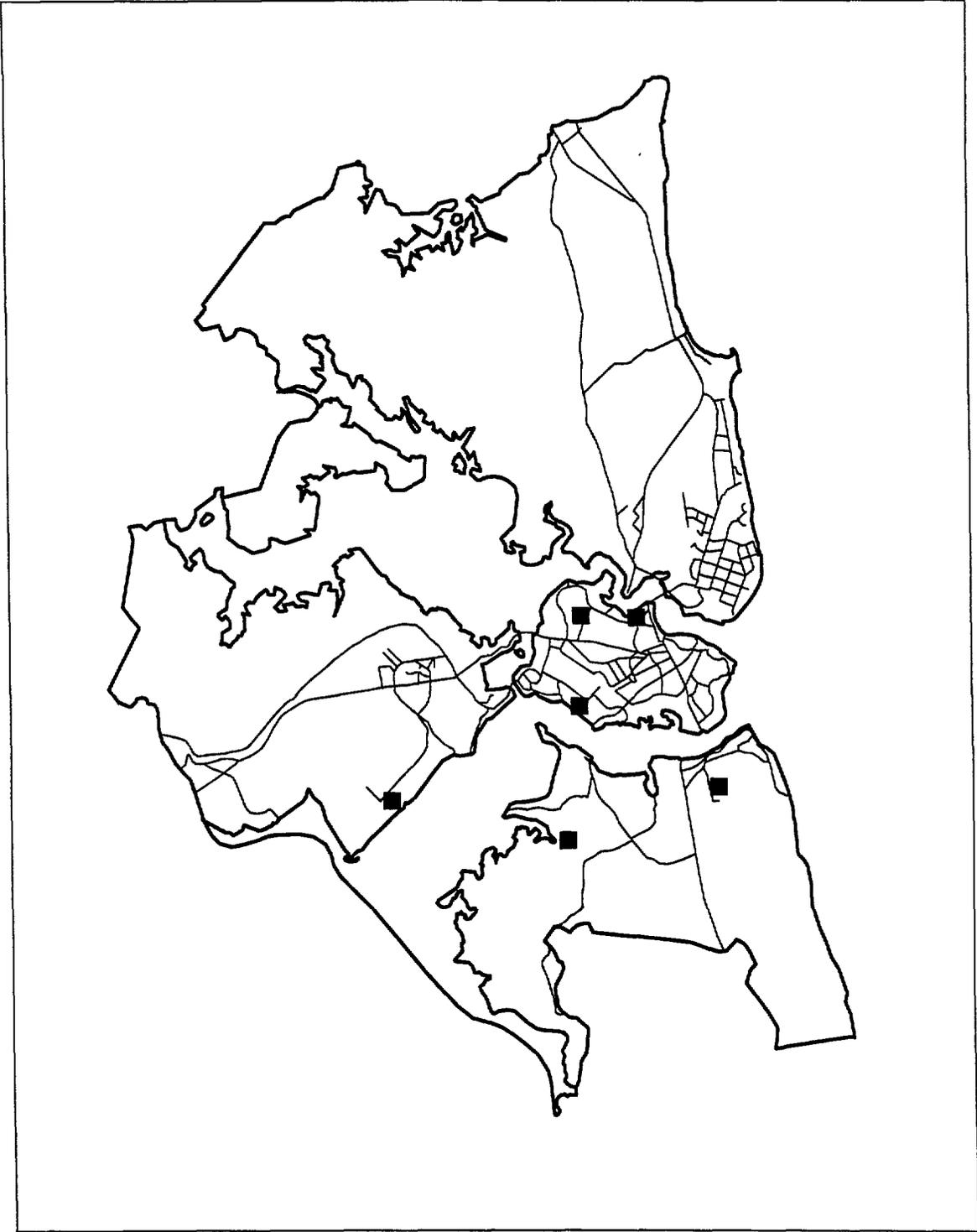
Map 2: Density of women 15-49 in Mombasa, by division



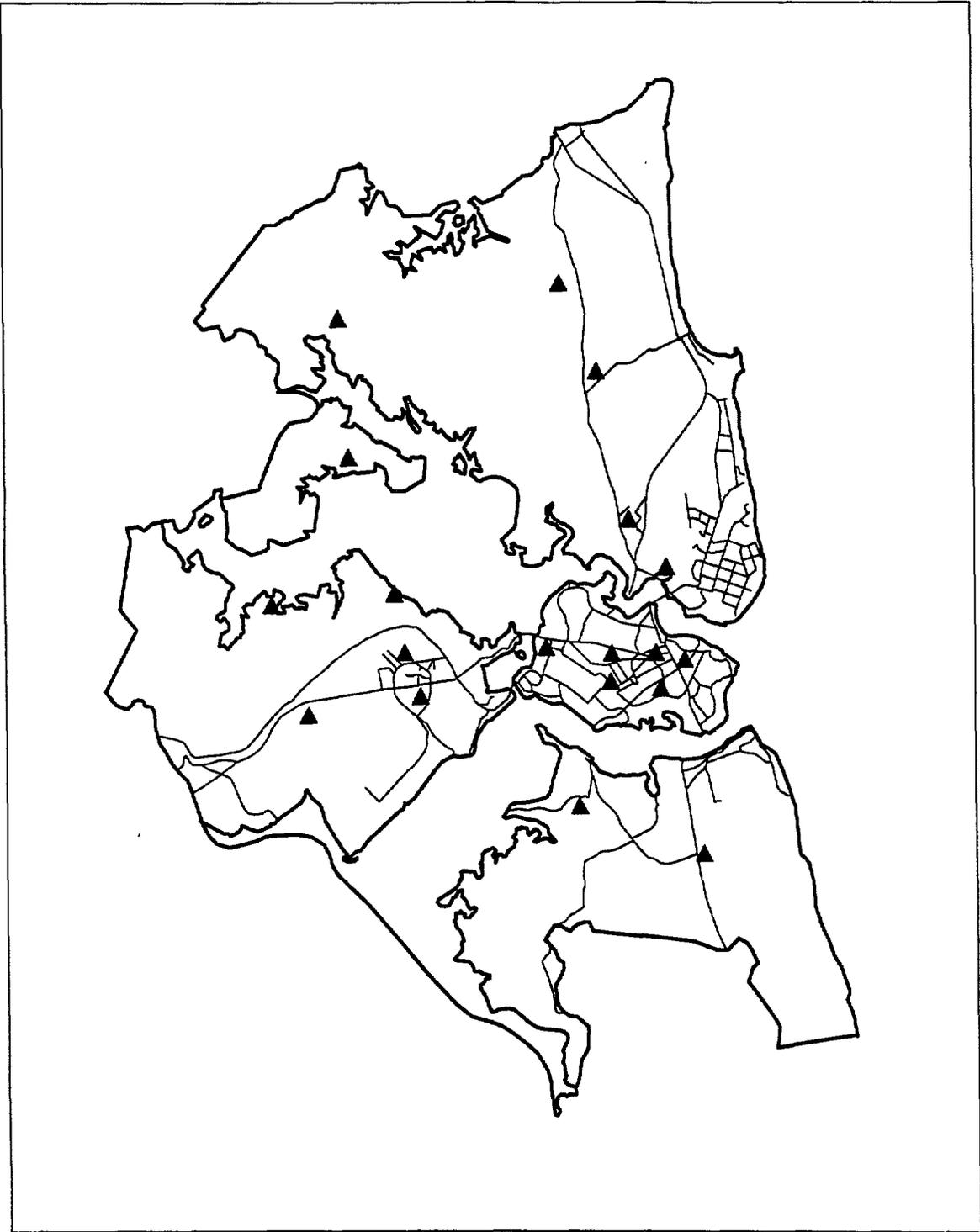
Map 3: All SDPs in Mombasa



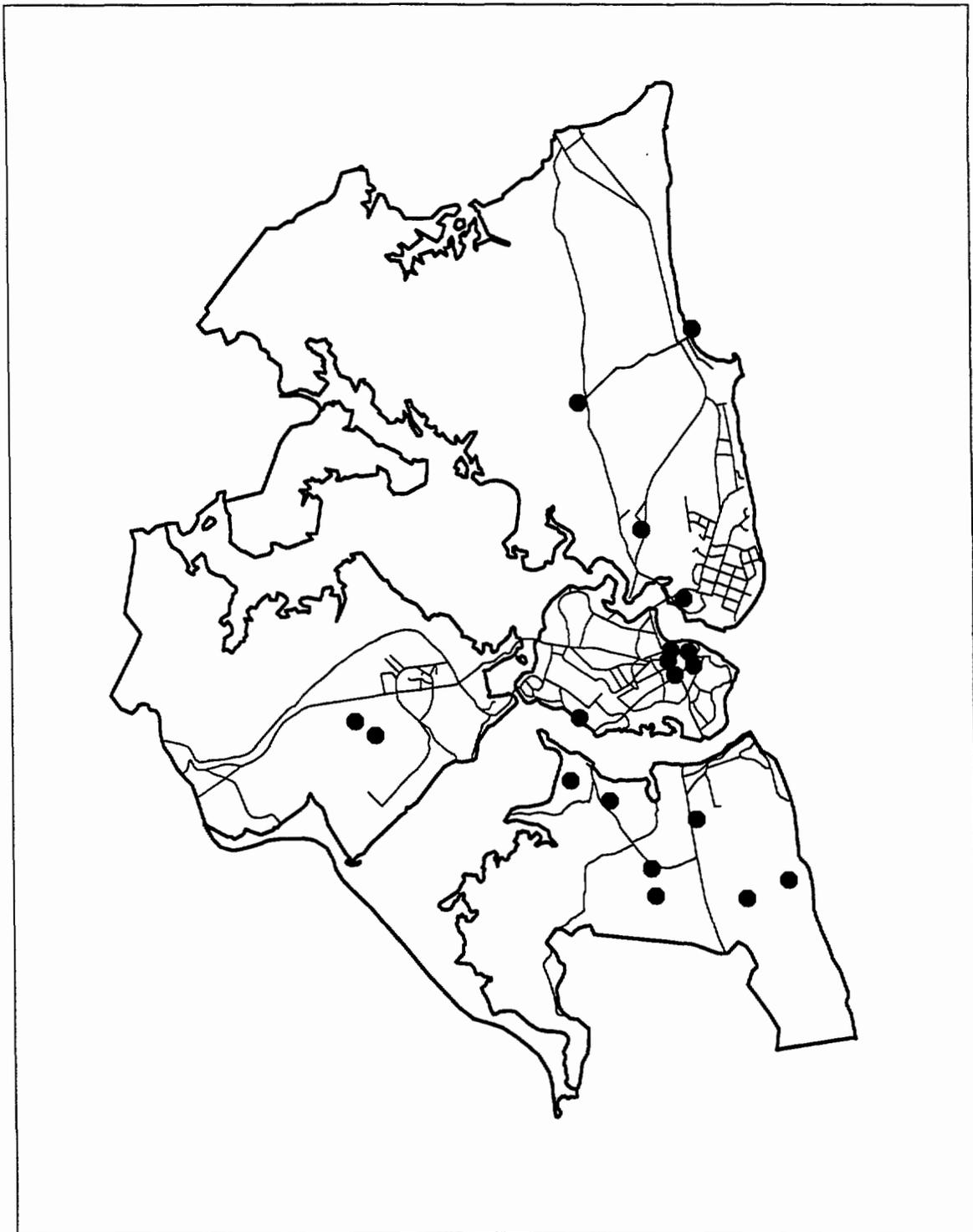
Map 4: Central government clinics in Mombasa



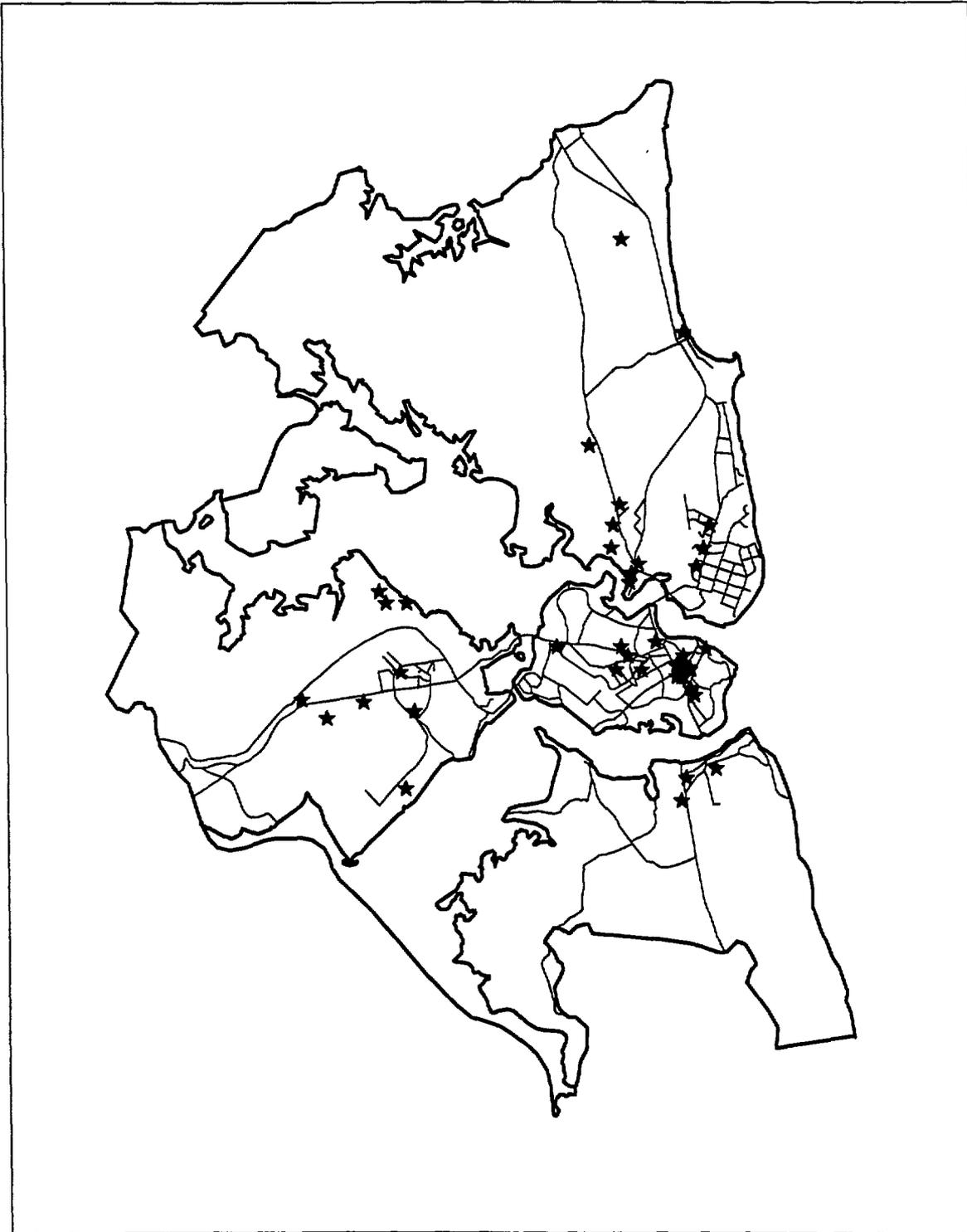
Map 5: Municipal clinics in Mombasa



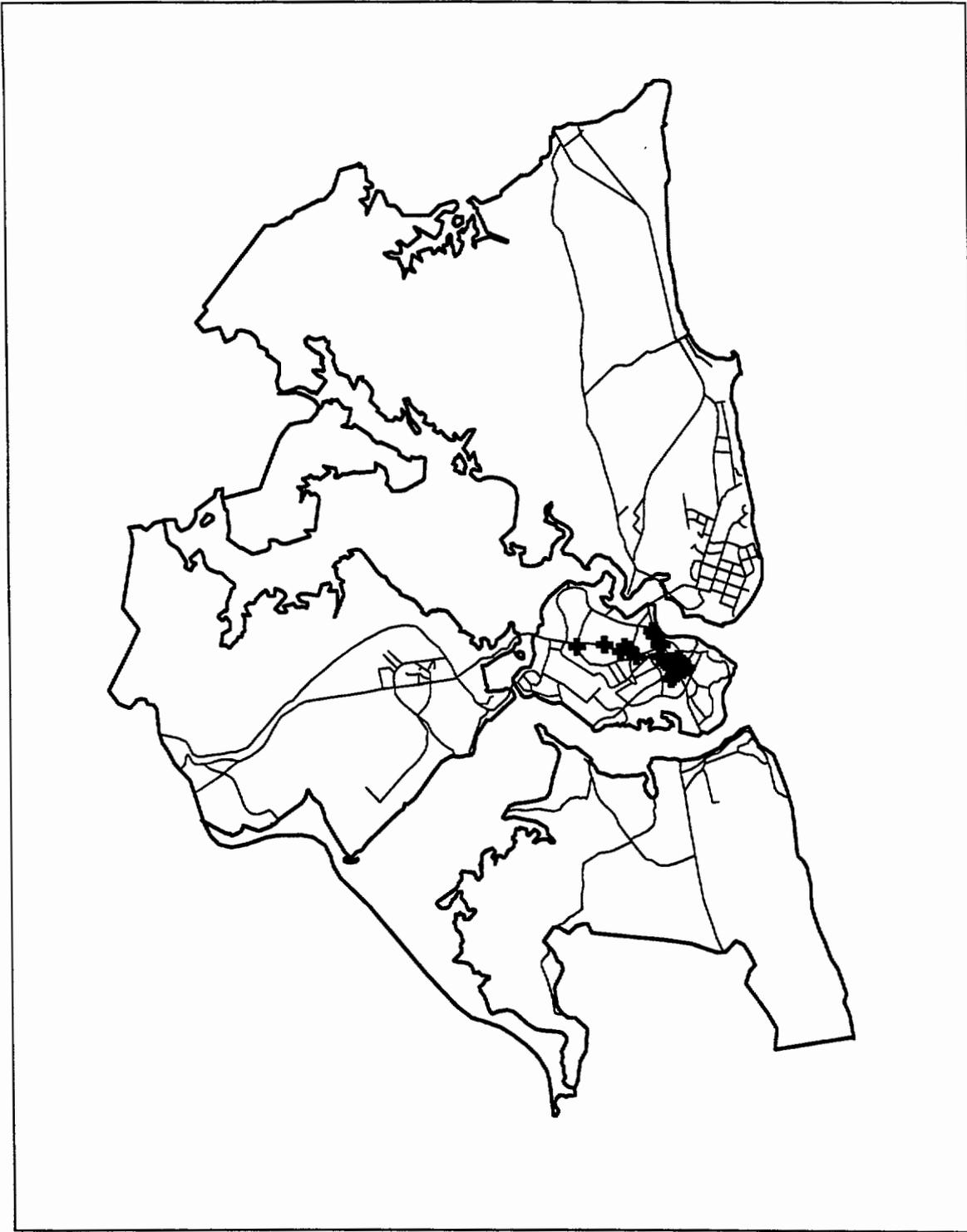
Map 6: NGO/FPAK clinics in Mombasa



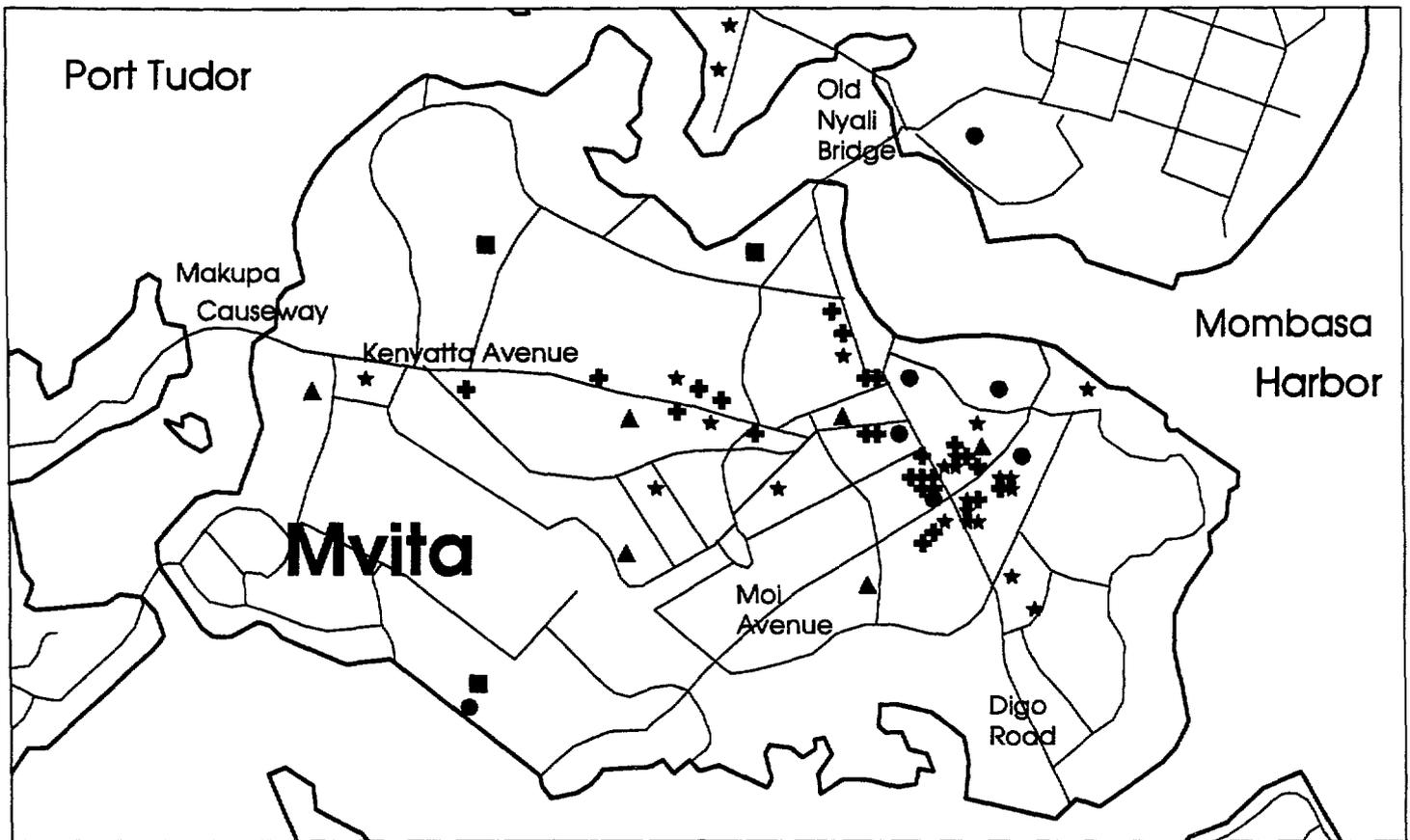
Map 7: Private clinics in Mombasa



Map 8: Pharmacies in Mombasa



Map 9: Clinics in downtown Mombasa (Mvita)



Approx. scale: 1 in. = 2/3 mile

- Federal clinic
- ▲ Municipal clinic
- NGO/FPAK clinic
- ★ Private clinic
- ⊕ Pharmacy

Appendix 5: Technical note on estimating CPR with FPPMES

In Mombasa, the FPPMES (Family Planning Program Monitoring and Evaluation System) was used to generate three estimates of CPR: 'crude', 'adjusted', and 'peak'. Each of these estimates is described in detail below.

Crude CPR

First, service statistics on distributed commodities were gathered from SDPs in Mombasa. Some SDPs were found to be missing data for a particular month or quarter, and these data were filled in with method-specific averages from that site. For example, suppose the Ganjoni Health Center distributes an average of 2000 condoms per month in January through October of 1993. If the data for November and December is missing, then the number of distributed condoms is simply estimated as the average, 2000.

In addition, because data are scarce for some SDPs in the FPPS and private sectors, some reports for the late months of 1992 or the early months of 1994 were used for 1993 data. So the *timing* of these data is approximate.

After the service statistics were made complete in this way, they were entered into the FPPMES, which calculated a 'crude' CPR of 25%.

Adjusted CPR

Service statistics were not available for all SDPs, and the 'adjusted' CPR accounts for these SDPs with no data. Essentially, those SDPs with no data were estimated as distributing the average number of commodities distributed by those SDPs with data.

For example, there are 20 SDPs in the Municipal sector in Mombasa, and service statistics were available for 18 of them. In all, the 18 reporting SDPs distributed 108,000 cycles of pills in 1993. This means each SDP distributed an average of 6,000 cycles per year. The two SDPs that did not report are then estimated to have distributed 6,000 cycles of pills in 1993, bringing the total distribution to 120,000 (108,000 + 6,000 + 6,000).

In this way, the contribution of non-reporting SDPs was estimated, and the results were again entered into FPPMES. This 'adjusted' CPR in Mombasa was calculated as 33%.

Peak CPR

The FPPMES gives estimates of CPR in six-month intervals. For Mombasa, two years' worth of distribution data were available, so in all the FPPMES generated four estimates of CPR (first six months of 1992, second six months of 1992, first six months of 1993, and second six months of 1993). For each of these four estimates, the contribution of the various sectors is established.

For example, in the first six months of 1992, municipal clinics generated about 16 percentage points of the CPR, government SDPs generated about 4 points, and FPPS about 14 points, for a total adjusted CPR of 33% (with rounding).

By the first six months of 1993, this mix had changed. Municipal clinics, for example, generated only 11 percentage points of CPR. This means that the municipal clinics are *capable* of supporting 16 points of CPR, as demonstrated in 1992, even though in 1993 they generated only 11 points⁴. For the municipal sector, 16 percentage points of CPR is its 'peak' performance.

In this way, the 'peak' capacity of each sector is determined. The sum of these capacities gives an estimate of the peak CPR for Mombasa as a whole. At base, this peak estimate gives a CPR that *could be achieved if every sector were currently operating at its demonstrated peak level*. For Mombasa, this peak CPR is 39%.

⁴ Note that the denominator (WRA) is the same in both years, so these percentages can be directly compared.