Chapter 5 Family Planning Services

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5.1 Background

The Kenya Service Provision Assessment 2004 (KSPA 2004) collected information on the availability of family planning (FP) services, on clients' perceptions of their experience in the facility, and on services received. This chapter provides detailed information gathered from family planning clients as they left the service facility, on their knowledge of a variety of topics related to their encounter with the provider, and on the family planning method they were prescribed or are currently using. It also looks at the components supporting quality family planning services, management practices supportive of quality services, and providers' adherence to standards for quality service provision. This information is also useful in assessing how family planning services are delivered and can be used to improve programmes to meet the needs revealed by the 2003 Kenya Demographic and Health Survey (KDHS 2003).

5.1.1 KSPA Approach to Collection of Family Planning Service Information

The use of contraceptive methods to plan families may be desirable for many reasons, including the following:

- Couples may wish to limit family size or delay a desired pregnancy.
- Appropriate spacing of births benefits maternal and child health. Studies have shown that spacing births at least two to three years part contributes significantly to decreasing infant mortality (Govindasamy et al., 1993; Rutstein, 2000). Although there are fewer studies on the effects of spacing births on maternal health, it is generally accepted that too frequent births result in maternal depletion of essential minerals and vitamins.
- Preventing pregnancies that may worsen chronic or acute illnesses, including HIV/AIDS, benefits women's health.

Key factors contributing to the appropriate, efficient, and continuous use of contraceptive methods (Murphy and Steele, 2000) include the following:

- The availability of a variety of contraception methods to address client preferences and client-specific suitability of method (from the point of view of society and health);
- Counselling and screening of clients for appropriateness of methods;
- Client education, using visual aids to increase information retention regarding options, side effects, and appropriate use of the method;
- Availability of infrastructure and resources necessary for providing quality family planning services: equipment for client examinations, guidelines and protocols, trained staff, a service delivery setting that allows client privacy, and procedures for preventing infections; and
- Availability of other health services relevant for family planning clients. These include education and services for sexually transmitted infections (STIs) and programmes geared toward groups with special needs to improve access and appropriate utilisation of family planning services.

Wherever maternal health, reproductive health, or child health services are provided, they should strive to increase the appropriate use of family planning and contraceptive services, including counselling.

This chapter uses information obtained in the KSPA 2004 to address the following central questions about the delivery of family planning services:

- What is the availability of family planning services?
- To what extent do the facilities offering family planning services have the infrastructure, resources, and supportive management required to support quality services?

5.1.2 Family Planning Services in Kenya

The Kenya family planning programme was launched in 1967. The programme has made substantial progress in expanding the use of modern contraception in Kenya in the more than 30 years since family planning was integrated into the maternal and child health services of the Ministry of Health, whose facilities offer most family planning services in Kenya. Family planning services are integrated into the MCH/FP clinics at dispensaries, health centres, and district and provincial hospitals. There are also family planning clinics in referral hospitals and mobile units.

Use of modern contraceptive methods by currently married women age 15-49 increased from 27 percent in 1993 to 33 percent in 1998 (KDHS 1993 and 1998). The injection is the most widely used method, followed by the combined oral contraceptive pill (15 percent and 10 percent, respectively). Pill users obtain their methods from either public sources (48 percent) or private medical sources (46 percent); very few get them from other private outlets such as shops and friends or relatives. More than 60 percent of all injection users get their injections at public sector facilities.

The family planning programme in Kenya has been relatively effective over time. The proportion of women using public sources has declined steadily from 68 percent in 1993 to 53 percent in 2003, while the proportion getting methods from private medical sources has similarly increased, from 25 percent to 41 percent in the same period (KDHS 1993 and 2003). As more sources are now available for users to obtain their services and methods, maintaining quality of care is increasingly important. Discontinuation is still an important problem in Kenya; nearly 40 percent of users discontinue their family planning method within 12 months. Pill users are most likely to stop using their method, with 46 percent discontinuing in the first year (KDHS 2003). Another issue related to quality of care is informed choice. Less than half of all users were informed about the side effects of their current method and of other methods they could use (KDHS 2003).

5.2 Availability of Family Planning Services

Methods of family planning differ in how they function, their effectiveness, their side effects, the ease with which they can be administered, and, in view of these issues, their acceptability and desirability to users. To meet the varying needs and demands for contraception, a variety of methods should be available at a frequency that meets common needs (Curtis and Bright, 1997).

According to the KDHS 2003, the modern methods most commonly used in Kenya are contraceptive injections, contraceptive pills, and female sterilisation. Other, less commonly used methods include implants, condoms, male sterilisation, intrauterine devices (IUDs), periodic abstinence (natural family planning), the diaphragm, spermicides, and emergency contraception (KDHS, 2003). In an effort to understand the context in which modern methods of contraception are used in the country, the KSPA asked facilities about the availability of family planning services.

Table 5.1 summarizes information on the availability of family planning services in Kenyan health facilities, and Table 5.2 shows how frequently these services are offered. Figure 5.1 provides details on the availability of different methods of contraception, and Appendix Tables A-5.1 through A-5.3 provide further details on method availability by type of facility and region.

Table 5.1 Availability of family planning services

Percentage of all eligible facilities offering the indicated methods of family planning, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Temporary methods of family planning (FP)		Percentage offering male or female sterilisation	Number of eligible facilities offering temporary or permanent methods of family planning (weighted)
	Percentage offering any modern method of family planning[1]	Percentage offering counselling on rhythm method		
Type of facility				
Hospital	83	48	46	28
Health centre	85	50	3	125
Maternity	87	40	17	20
Clinic	66	37	3	8
Dispensary	68	31	0	249
Managing authority				
Government	85	42	5	245
NGO	88	85	5	16
Private (for-profit)	59	33	11	61
Faith-based organisation	58	27	2	109
Province				
Nairobi	49	33	6	37
Central	83	53	4	50
Coast	73	45	10	49
Eastern	77	39	3	81
North Eastern	68	37	0	8
Nyanza	91	31	4	54
Rift Valley	72	33	4	124
Western	78	47	8	29
Total	75	38	5	430

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

[1] Any of the following: contraceptive pills (combined or progestin-only), injections (combined or progestin-only), implants, intrauterine devices (IUDs), male condoms, spermicides, diaphragm, or emergency contraceptive.

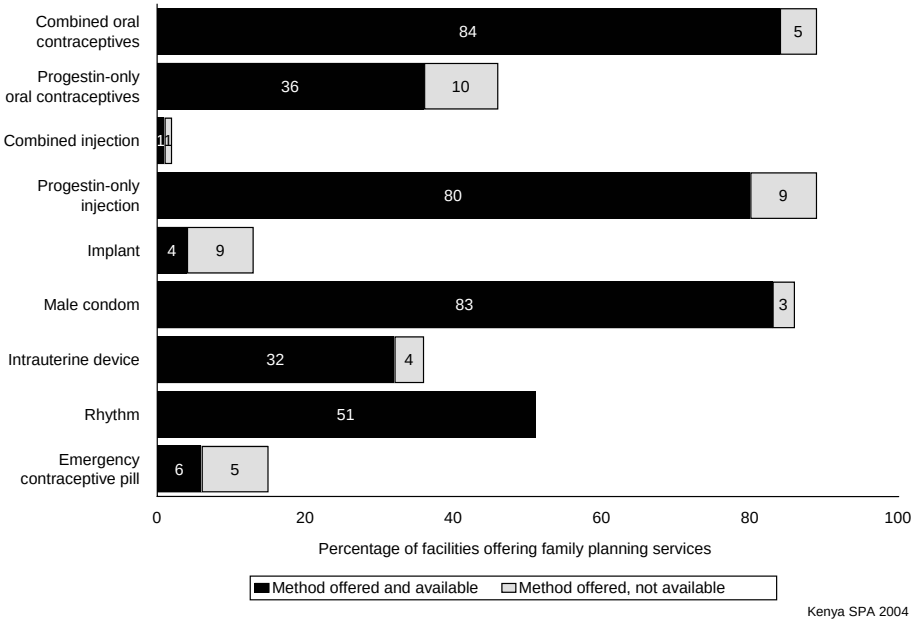
Contraceptive Method Mix and Method Availability

A facility that offers all methods of family planning is best able to meet the needs of clients. However, some variation is expected in which methods facilities offer, because of differences in provider qualifications and training, as well as the infrastructure required to provide the methods safely. Methods that can be provided safely with minimal training are pills, injections, and condoms, as well as counselling on periodic abstinence. Providing implants and IUDs safely, however, requires a higher level of skill and a more developed infrastructure.

Over the last five years, the proportion of eligible facilities offering any modern method of family planning has declined from 88 percent to 75 percent. The proportion of facilities offering counselling on the rhythm method, however, remained stable at 38 percent. Hospitals, maternities and health centres, and government and NGO facilities, are more likely to offer at least one temporary modern method of family planning. Facilities in Nyanza and Central provinces are also more likely to offer family planning methods than facilities in other provinces (Table 5.1).

The most commonly offered family planning methods in Kenyan facilities are the combined oral contraceptive, progestin-only injections, and the male condom, offered by almost 9 in 10 facilities (Figure 5.1). Most facilities that offer these methods had them available on the day of the survey. Surgical sterilisation as a family planning method is not commonly offered; only 5 percent of facilities (including 46 percent of hospitals) reported that they offer either male or female sterilisation. About 7 in 10 facilities offer at least four temporary family planning methods (Appendix Table A-5.1); dispensaries are less likely to offer a wide range of methods, with 59 percent offering at least four methods.

Figure 5.1 Temporary methods of contraception offered and availability of method on the day of the survey (N=322)



The proportion of facilities offering the implant method has increased slightly, from 8 percent in 1999 to 13 percent in 2004, although, as in 1999, supply remains a problem; only half of the facilities offering implants actually had them available on the day of the survey (Figure 5.1).

Emergency contraception is not technically considered a family planning method, but rather is considered a backup for unprotected sexual intercourse. Just 11 percent of facilities offer emergency contraceptive pills, and almost half of these did not have an emergency contraceptive method available on the day of the survey. Progestin-only pills, which can be used for emergency contraception, are also offered in 46 percent of facilities (a decrease from 77 percent in 1999), but there are supply problems with this method as well. The combined injectable method continues to be offered rarely (2 percent of facilities) and primarily by hospitals (10 percent). However, the progestin-only injection is available in 90 percent of facilities (Table A-5.1).

Frequency of Services

In addition to providing a range of methods, it is important that facilities offer family planning services regularly enough to meet client needs. As in 1999, almost all facilities that provide family planning services offer them five or more days per week (Table 5.2). Faith-based facilities and those in the Eastern Province offer family planning services less frequently than other facilities.

Table 5.2 Frequency of availability of family planning services

Percentage of facilities where any temporary methods of family planning (FP) are offered the indicated number of days per week, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities where family planning services are offered:[1] 1-2 days per week	3-4 days per week	5 or more days per week	Number of facilities offering family planning services (weighted)
Type of facility				
Hospital	5	3	92	24
Health centre	5	0	95	107
Maternity	1	2	96	18
Clinic	0	3	97	5
Dispensary	5	0	88	169
Managing authority				
Government	3	0	97	209
NGO	12	0	88	14
Private (for-profit)	1	3	96	36
Faith-based organisation	12	0	70	63
Province				
Nairobi	9	3	88	18
Central	12	0	88	42
Coast	1	0	99	35
Eastern	14	1	79	62
North Eastern	0	0	100	6
Nyanza	1	0	99	49
Rift Valley	0	0	91	89
Western	0	0	100	22
Total[2]	5	0	91	322

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

[1] Any of the following methods: oral contraceptives (combined or progestin-only), injections (combined or progestin-only), implants, intrauterine devices (IUDs), condoms, spermicides, diaphragm, emergency contraceptive or rhythm.

[2] Percentages may not add up to 100 percent since some facilities offer family planning services less frequently than once a week

Key Findings

Ninety-one percent of facilities offer temporary modern methods of contraception at least five days per week. They are most likely to offer progestin-only injections, pills, and the male condom.

The proportion of health facilities offering any temporary modern methods of family planning declined to 75 percent in 2004 from 88 percent in 1999.

About 7 in 10 facilities offer at least four commonly used family planning methods (such as combined oral contraceptives, progestin-only injection, male condom, and progestin-only oral contraceptives). Dispensaries are less likely to have such a wide range of methods; only 59 percent offer at least four methods.

5.3 Components Supporting Quality Family Planning Services

In order to provide family planning services, facilities must have adequate infrastructure and resources available to support quality counselling and examination of family planning clients; they should also have the equipment and supplies needed to provide each family planning method they offer. In addition, because family planning clients are sexually active, it is important to have STI services available to them.

5.3.1 Infrastructure and Resources to Support Quality Assessment and Counselling of Family Planning Clients

To provide quality counselling to family planning clients, facilities should be able to provide some level of privacy, individual client health cards or records, written family planning guidelines or protocols, and family planning-related visual aids. Since counselling about family planning often takes place in a location different from where procedures (such as pelvic examinations and IUD insertions) are conducted, the conditions for counselling are assessed separately from those for procedures. Table 5.3 provides aggregate information on items to support quality counselling; information on the availability of each specific item needed for counselling is provided in Figure 5.2. Appendix Table A-5.4 gives details on the items assessed for each of the components for counselling, and Appendix Table A-5.5 provides details on available visual aids and guidelines, by type of facility.

Only 22 percent of facilities have all four of the above items (Table 5.3, Figure 5.2); this is principally because many facilities do not have written family planning guidelines. These items are almost unavailable in all facilities in Central and North Eastern provinces (Table 5.3).

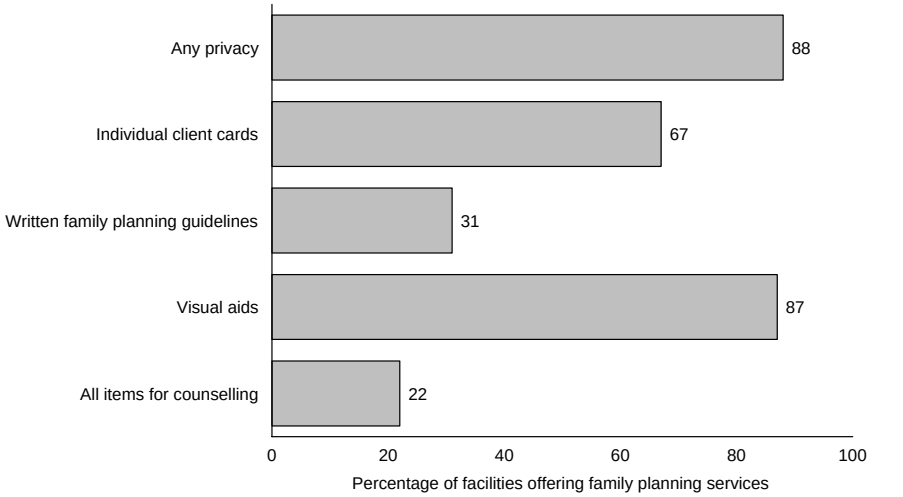
Family planning is often a sensitive issue for discussion. Providing counselling under conditions where clients can be reasonably assured that the conversation cannot be overheard improves communication and ultimately the likelihood that the method provided is suitable for the client. Privacy for counselling is almost universally available, with 88 percent of facilities (Figure 5.2, Table A-5.4) counselling family planning clients under conditions where both visual and auditory privacy are possible. Clinics are least likely to assure this kind of privacy (74 percent).

Individual cards or records for family planning clients are important for monitoring a client over time and for ensuring continuity of care. Because facilities often do not store client records, but rather give them to the clients to keep, the KSPA assessed the availability of blank cards for new family planning clients. Blank individual client cards were found at 67 percent of facilities (Figure 5.2). Maternities were least likely to have blank client cards (53 percent) (Table A-5.4).

The KSPA assessed whether facilities had written family planning guidelines or protocols, with information on eligibility screening and correct procedures for different methods. The guidelines were only considered available for use if they were in the family planning service delivery area or an immediately adjacent area. Only 3 in 10 facilities had family planning guidelines or protocols available (Figure 5.2).

Visual aids, which are important elements for good family planning counselling, are available in the service delivery area in 87 percent of facilities (Figure 5.2).

Figure 5.2 Items to support quality counselling for family planning
(N=322)



Kenya SPA 2004

5.3.2 Infrastructure and Resources for Examinations

Frequently a physical examination, sometimes including a pelvic examination, is necessary to determine whether a method is suitable, to insert a method, or to evaluate problems with a method. This requires an adequate level of infection control, as well as infrastructure and items needed for examining the client.

Table 5.3 provides aggregate information on items for infection control and pelvic examinations; Figure 5.3 gives information on the availability of each specific item needed for infection control and pelvic examinations. Details on the specific items assessed are provided, by type of facility, in Appendix Table A-5.4, and details on processing equipment are available in Appendix Tables A-5.6 through A-5.9.

Infection Control

The KSPA 2004 assessed the presence of items for infection control in areas where family planning examinations (such as pelvic examinations) and provision of methods (the implant, IUD, and injection) most often take place. Items assessed for infection control were hand-washing supplies, clean or sterile latex gloves, disinfecting solution, and a sharps box; all these items are available in the family planning service area in about 4 in 10 facilities. More facilities in Eastern province have all these items available (69 percent); as do about half of hospitals and dispensaries. However, only 5 percent of NGO-managed facilities have all the items needed for infection control (Table 5.3).

Facilities most often lack disinfecting solution and soap; these items are missing in 48 percent and 28 percent of facilities, respectively (Figure 5.3).

Table 5.3 Availability of infrastructure and resources to support quality services for temporary methods of family planning

Percentage of facilities with the indicated elements to support quality counselling, examination, and where providers offer STI treatment to family planning clients, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Percentage of facilities with: All items to support quality counselling[1]	All items for infection control[2]	Capacity for sterilisation/HLD processing[3]	Conditions for quality pelvic examination[4]	STI treatment provided by family planning providers	Number of facilities offering family planning services (weighted)
Type of facility						
Hospital	30	48	47	30	29	24
Health centre	21	31	26	10	62	107
Maternity	16	32	26	20	55	18
Clinic	28	42	11	23	88	5
Dispensary	23	48	5	2	74	169
Managing authority						
Government	22	47	13	8	65	209
NGO	18	5	71	3	61	14
Private (for-profit)	19	32	25	25	68	36
Faith-based organisation	26	35	10	1	69	63
Province						
Nairobi	41	40	45	27	44	18
Central	3	50	15	8	59	42
Coast	57	50	23	11	58	35
Eastern	15	69	1	1	63	62
North Eastern	2	2	3	2	61	6
Nyanza	18	39	6	11	71	49
Rift Valley	23	20	24	6	70	89
Western	20	33	18	9	91	22
Total	22	41	16	8	66	322

Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.

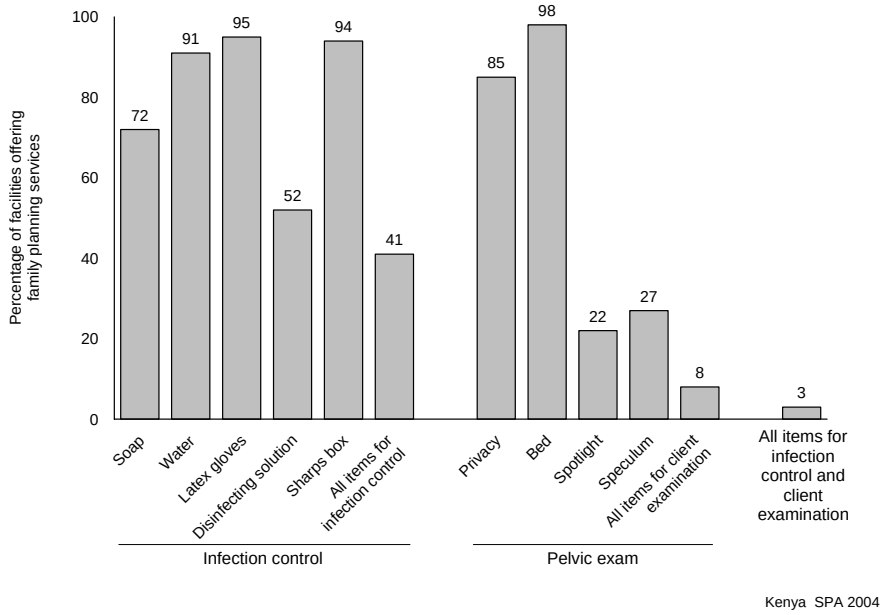
[1] Visual privacy, individual client cards, written guidelines related to family planning, and visual aids related to family planning

[2] Soap, water, clean latex gloves, disinfecting solution, and sharps box

[3] In location where family planning equipment is processed, equipment and knowledge of minimum processing time for sterilising or HLD processing and an automatic timing device were available.

[4] Private room (visual and auditory privacy), examination bed, examination light, and vaginal speculum

Figure 5.3 Conditions for quality examination of family planning clients (N=322)



Equipment for family planning services often requires sterilisation or high-level disinfection (HLD) so that it can be reused. According to Kenya standards, this means facilities must have functioning equipment, knowledge of the minimum processing time for sterilising (or HLD processing), and an automatic timer, available in the location where family planning equipment is processed. Overall, only 16 percent of the facilities meet these criteria (Table 5.3). These are mainly hospitals, NGO-managed facilities, and, to some extent, facilities in Nairobi province (Table 5.3). Seventy-eight percent of facilities send equipment to the main processing area in the facility for processing, and 17 percent process items in the family planning service delivery area (Table A-5.6). As noted in Figure 3.13, the most common weakness in processing capacity in facilities' central processing location is the lack of an automatic timer for boiling, which is the most commonly used HLD method.

Examination

The KSPA 2004 assessed items needed for conducting quality pelvic examination for family planning clients. The items assessed are a private room (for both visual and auditory privacy), an examination bed and spotlight, and the availability of a vaginal speculum. Fewer than 1 in 10 facilities in Kenya have all these items (Table 5.3). Hospitals, private for-profit facilities, and facilities in Nairobi province were most likely to have these items. The weak areas are lack of a vaginal speculum (73 percent) and lack of a spotlight (78 percent) (Figure 5.3).

5.3.3 Provision of STI Treatment for Family Planning Clients

Family planning clients, because they are sexually active, may be at increased risk of contracting STIs. Consequently, counselling for STI prevention, as well as diagnosis and treatment, are essential components of quality family planning care. It is particularly important to diagnose and treat STIs and other vaginal infections for women who use the IUD. Figure 5.4 provides information on items needed to provide STI services to family planning clients. Table A-5.9 provides details, by type of facility, on the STI service items, including medicines for treating specific STIs.

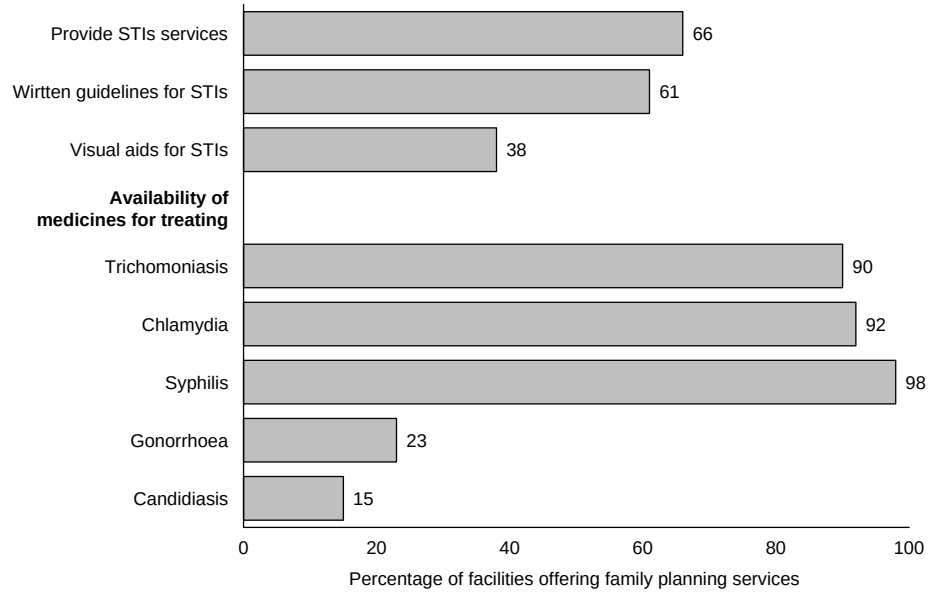
In two-thirds of facilities where family planning services are provided, providers diagnose and treat STIs (Table 5.3, Figure 5.4). Hospitals and facilities in Nairobi province are the least likely to have family planning providers diagnosing and treating STIs. This may be due to the fact that STI services in these facilities are considered more specialized and are organised separately, with different providers than for family planning.

Written guidelines for diagnosing and treating STIs are available in the family planning service area in 61 percent of facilities (Figure 5.4), with the World Health Organisation (WHO) syndromic approach guidelines found in 60 percent of facilities (Appendix Table A-5.5). Among the different facility types, dispensaries are the most likely to have these guidelines (70 percent).

Only 20 percent of facilities have STI-related visual aids for client education, (Table A-5.5), with hospitals most likely to have them available (33 percent).

Medicines for treating trichomoniasis, chlamydia, and syphilis are almost universally available in facilities offering family planning services (Figure 5.4), while medicines for gonorrhoea and candidiasis (a more common infection) are available in only 23 percent and 15 percent of facilities, respectively (Figure 5.4).

Figure 5.4 Conditions to support quality STI services for family planning clients (N=322)



Kenya SPA 2004

Key Findings

Privacy for family planning counselling services and visual aids are commonly available (about 9 in 10 facilities). Guidelines and protocols for family planning, however, are not available in almost two-thirds of facilities.

All assessed items for infection control are available in the family planning service area in 41 percent of facilities, with disinfecting solution the most commonly missing item (missing in 48 percent of facilities)

Only 16 percent of facilities have the capacity for quality sterilisation or HLD processing of family planning equipment.

All the furnishings and equipment needed for quality pelvic examinations are available in only 8 percent of facilities.

Medicines for treating trichomoniasis, chlamydia, and syphilis are universally available in facilities offering family planning services (about 9 in 10), while medicines for candidiasis and gonorrhoea are less available (15 and 23 percent, respectively).

5.3.4 Availability of Equipment and Supplies for Specific Methods

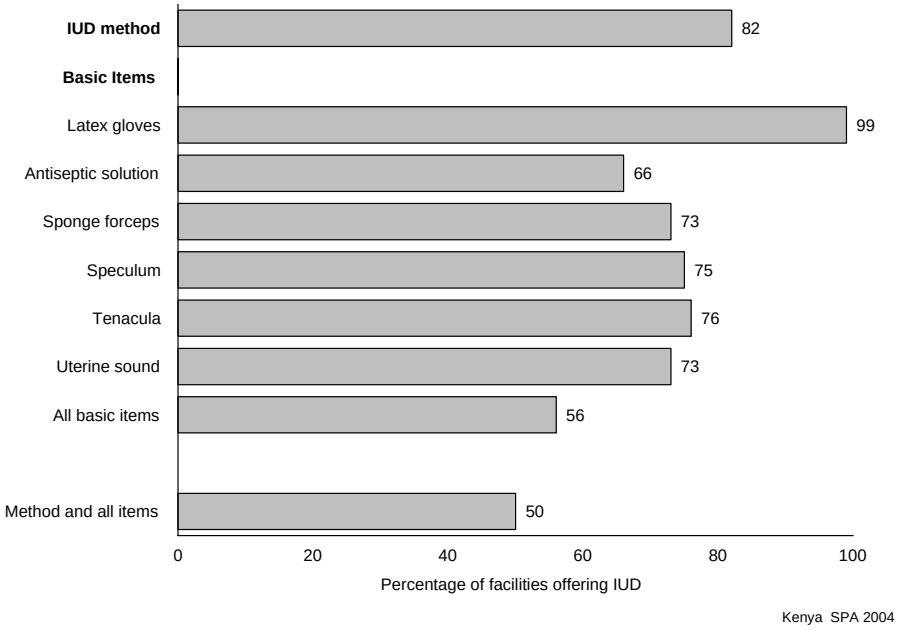
To provide different contraceptive methods safely, and to monitor the client, facilities need a variety of equipment. Figure 5.5 shows what items facilities have available for providing IUDs. Appendix Tables A-5.10 through 5.12 provide additional detail on the availability of equipment and supplies for specific methods, including the IUD and implant methods.

Among facilities offering IUDs, 82 percent have the IUDs themselves, 56 percent have all the basic equipment necessary for insertion and removal, and only 50 percent have both the IUD itself and all the basic items (Figure 5.5). Only 11 percent of the facilities have IUDs and all basic items, and also satisfy all KSPA-defined conditions[1] for quality insertion and removal of IUDs (Table A-5.10). Latex gloves, one of the basic items, are universally available in all facilities offering IUDs (Figure 5.5, Table A-5.10).

Women receiving oestrogen-containing family planning methods benefit from blood pressure and weight monitoring. Among facilities providing methods containing oestrogen, 80 percent have a blood pressure apparatus and 92 percent have an adult weighing scale (Table A-5.10). Almost all maternities and clinics have a blood pressure apparatus, but many health centres do not. Among facilities providing injectable contraceptives, 96 percent have sterile needles and syringes (Appendix Table A-5.10). It should be noted that in Kenya, each progestin injection vial is supplied with a syringe; so it is possible that the 4 percent of facilities without sterile needles and syringes were facilities that did not have progestin injections available the day of the survey (Figure 5.1).

[1] Conditions here refer to all infection control items, visual privacy, an examination bed, an examination light and the method

Figure 5.5 Equipment for IUD insertion and removal (N=117)



Key Findings

Blood pressure equipment is available in 80 percent of facilities offering family planning methods containing oestrogen, and 92 percent of such facilities have a weighing scale.

Sterile needle and syringes were available in almost all the facilities offering injectable contraceptive methods.

Fifty percent of the facilities that report offering IUDs have the method and all the basic items needed for IUD insertion. However, only 11 percent have the method, all the basic items, and all the conditions necessary for quality IUD insertion and removal.

Latex gloves are universally available in facilities offering IUDs.

5.4 Management Practices That Support Quality Family Planning Services

Management practices for supporting quality family planning services include documentation and records, practices related to user fees, and staff supervision and development.

Summary information on management practices is provided in Table 5.4. Figure 5.6 shows topics for in-service training and when providers received training. Utilisation statistics for family planning services are provided in Appendix Table A-5.13. Information on user fees charged for family planning services is provided in Appendix Tables A-5.14 through A-5.16. Details on in-service training and supervisory activities from the provider's perspective are provided in Appendix Tables A-5.17 to A-5.19.

5.4.1 Facility Documentation and Records

The KSPA assessed whether facilities had up-to-date family planning client registers; such registers are most often the source of data for health information systems. A register was defined as up-to-date if there was an entry within the past seven days, and the latest entry reported the method or service provided and

the client's status (first visit or follow-up visit). Seventy-six percent of family planning facilities had an up-to-date register (Table 5.4); these were most commonly government and NGO-managed facilities (88 percent and 98 percent, respectively). Registers were less commonly found in private for-profit facilities (38 percent). Facilities in North Eastern province were also unlikely to keep up-to-date client registers, which were available in only half of facilities.

Table 5.4 Management practices to support quality services for temporary methods of family planning

Percentage of facilities with up-to-date family planning (FP) registers, percentage where there are some user fees for family planning services, percentage with the indicated supportive management practices, by type of facility, managing authority and province, Kenya SPA 2004

Background characteristics	Facilities that offer family planning services		Number of facilities offering family planning services (weighted)	Percentage of facilities where at least half of the interviewed family planning service providers:		Number of facilities with interviewed family planning service providers (weighted)[3]
	Percentage with observed up-to-date client register[1]	Percentage with user fees for family planning services		Received in-service training during past 12 months[2]	Were personally supervised during past 6 months	
Type of facility						
Hospital	72	60	24	29	70	23
Health centre	85	44	107	32	84	107
Maternity	57	94	18	36	78	16
Clinic	56	93	5	37	64	5
Dispensary	73	49	169	35	93	157
Managing authority						
Government	88	42	209	29	88	201
NGO	98	31	14	18	99	14
Private (for-profit)	38	95	36	42	76	34
Faith-based organisation	52	62	63	49	85	59
Province						
Nairobi	84	72	18	54	89	18
Central	81	57	42	38	80	41
Coast	71	54	35	43	69	35
Eastern	64	58	62	23	97	58
North Eastern	49	11	6	24	68	5
Nyanza	82	57	49	31	95	48
Rift Valley	78	44	89	33	83	80
Western	85	28	22	30	98	22
Total	76	51	322	34	87	308

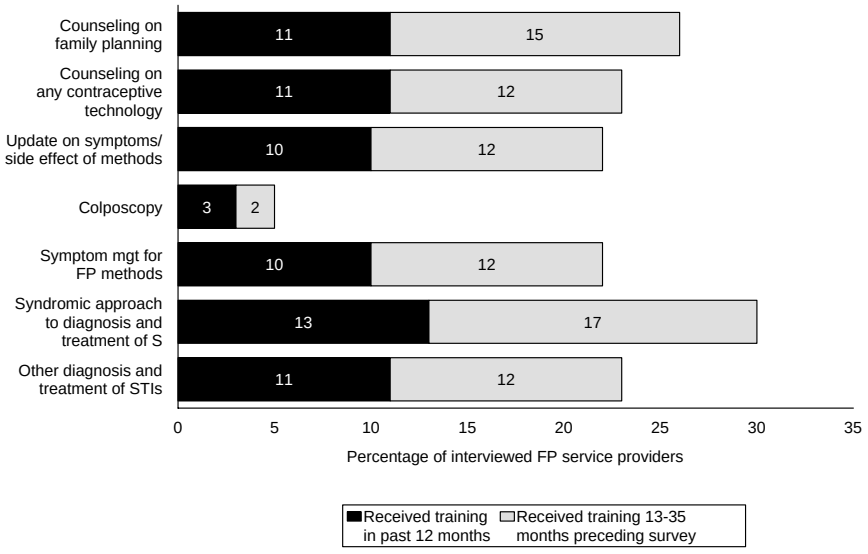
Note: Refer to Table 1.1 for the actual number of facilities included in survey and analysis. Weighting results in small numbers for some categories of facilities.
[1] Register has entry within past seven days and indicates visit status (first or follow-up) and service provided.
[2] This refers to structured in-service sessions and does not include individual instruction received during routine supervision.
[3] Includes only providers of family planning services in facilities offering family planning services.

5.4.2 Practices Related to User Fees

According to government policy, family planning services in government facilities should be free. However, government facilities can and do charge a registration fee for the client card, while private facilities usually charge a consultation fee. There should be no charge for any government-supplied contraceptive method administered, whether in government or private facilities. The KSPA found that about half of facilities offering family planning charge some type of user fee for family planning services. This is com-

mon in maternities and clinics (94 percent and 93 percent, respectively), and, not surprisingly, in private for-profit facilities (95 percent). It is also common in facilities in Nairobi province (72 percent) (Table 5.4). When offering family planning counselling sessions, approximately 2 in 10 facilities charge fees, with hospitals, maternities and clinics most likely to do so (36 percent, 40 percent, and 46 percent, respectively). Twelve percent of government facilities charge for family planning counselling, and, rather surprisingly, less than half of private for-profit facilities do (Table A-5.14). A rather small proportion of government and NGO-managed facilities (8 and 6 percent, respectively) charge for the actual methods; however, this varies by facility type, with maternities, clinics, and private for-profit and FBO facilities more likely to charge clients for family planning methods.

Figure 5.6 In-service training received by interviewed family planning service providers, by topic and timing of most recent training (N=853)



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5.4.3 Staff Development and Supervision

Staff Development

The types of contraceptive methods that are available change over time, as does knowledge of the benefits and side effects of different methods. In-service training for providers aims to improve the quality of counselling, management of complications or side effects, and providers' judgment and skills in assessing which contraceptive methods are most suitable for clients' needs.

A facility is defined as having routine staff development activities if at least half of the interviewed family planning service providers at a facility have received any structured in-service training (excluding on-the-job training that may be received during discussions with supervisors) relevant to family planning during the past 12 months. Overall, 34 percent of facilities meet these criteria for providing routine staff development activities. Staff in primary-level facilities and maternities, in facilities in Nairobi province, and in FBO-managed facilities are more likely to receive this training (Table 5.4). The most common in-service training topics covered are counselling on family planning and on any contraceptive technology, updates on symptoms/side effects, and the syndromic approach to diagnosis and treatment (Figure 5.6). More details can be found in Table A-5.17.

Supervision

Supervision of individual staff members helps to promote adherence to standards and to identify problems that contribute to poor quality services. If at least half of the interviewed family planning service providers in a facility have been personally supervised in the past six months, the facility is defined as providing routine staff supervision. Similar to the findings for other services, supervision of family planning providers is common, with 87 percent of facilities meeting the criteria for providing routine staff supervision (Table 5.4). Family planning providers who were supervised in the six months prior to the survey reported that their supervisors universally checked records, observed their work, discussed problems, provided feedback, and gave verbal praises. The supervisors rarely delivered supplies or gave written praises during the visits.

Key Findings

Up-to-date registers are available in three-fourths of facilities, commonly in government and NGO-managed facilities, and rarely in private for-profit facilities.

Only a third of facilities provide routine staff training for family planning providers, but approximately 9 in 10 facilities provide routine staff supervision.

5.5 Adherence to Standards for Quality Service Provision

To assess whether providers adhere to standards for quality service, KSPA personnel observed family planning client-provider consultations. The observation checklists used are based on commonly accepted guidelines for screening, counselling, and conducting procedures for family planning clients; they collected information on whether the consultation process answered the following questions:

- Did providers discuss essential topics relevant to determining the appropriateness of the various methods discussed, and did providers conduct the physical examinations needed to screen clients for method appropriateness?
- Did the conditions and procedures followed for provision of specific methods meet the criteria defined for quality?

The observers noted what information the provider shared and whether an examination was conducted. They did not assess whether the information was correct, or whether findings were appropriately interpreted.

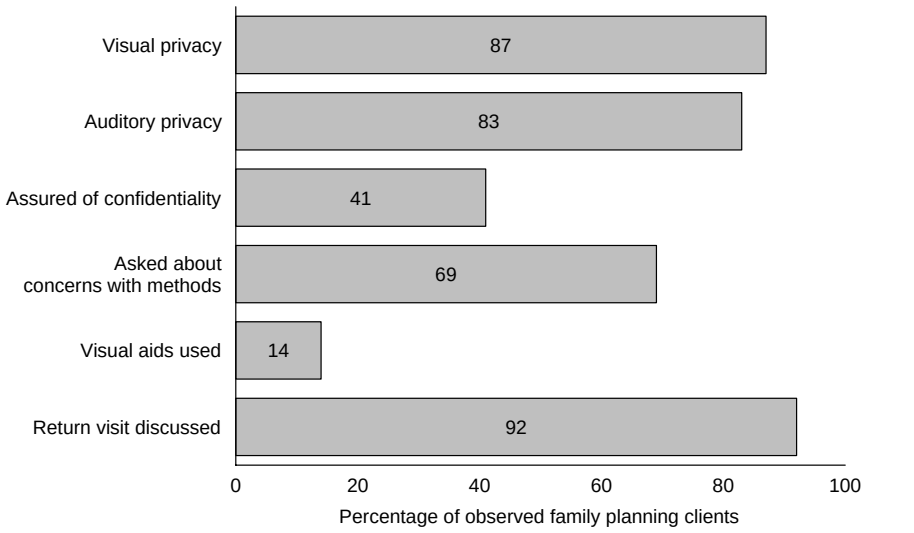
A total of 537 female clients were observed at 322 facilities. This was the first visit for 29 percent of the women; 71 percent were follow-up clients. Five percent of clients had never been pregnant (Appendix Table A-5.20). Exit interviews were conducted with all observed family planning clients. When two methods were prescribed or received, the client was assessed for knowledge about both. Clients who left the facility with no method, but had prescriptions for a method, were also assessed for their knowledge about the prescribed method.

Further details on clients' status and their principal reason for visiting the clinic are provided in Appendix Table A-5.21. Appendix Table A-5.22 gives details on the primary method provided, prescribed or discussed during this visit.

5.5.1 Assessment of Relevant History, Examination, and Counselling

Figure 5.7 provides information on components related to counselling, Figure 5.8 provides information on what client history elements the provider assessed for first-visit family planning clients, and Figure 5.9 gives information on consultations where clients received hormonal methods or procedures. Details on consultations for first-visit clients are provided in Appendix Tables A-5.24 through A-5.26. Information from observations related to specific methods or examinations is provided in Appendix Tables A-5.27 and A-5.28.

Figure 5.7 Observed conditions and content for family planning counselling (N=537)



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5.5.2 Counselling and Client Assessment

Privacy is very important for quality family planning counselling. Eighty-seven percent of observed family planning counselling sessions were conducted under conditions where there was visual privacy; 83 percent of clients had auditory privacy (Figure 5.7). In only 41 percent of counselling sessions were clients explicitly assured that the information they shared was confidential. Providers explicitly asked clients about concerns with their methods in about 7 in 10 sessions. Return visits were discussed during 92 percent of sessions. Providers rarely used visual aids during family planning consultations (14 percent).

Individual client cards are necessary to monitor a family planning client over time and to document relevant history so that it does not need to be collected multiple times. Frequently, health services are organised in such a way that measurements of blood pressure, weight, and other components of a consultation take place before the provider responsible for the consultation sees the client, and the information is recorded on a client card. This means an individual client card or chart is also important for ensuring that information collected before the consultation is available to the provider. During the observed family planning consultations, the provider reviewed the client card for 81 percent of clients and wrote on the card after the consultation for 95 percent of clients (Appendix Table A-5.23). These practices are less frequent in maternities than in other facility types.

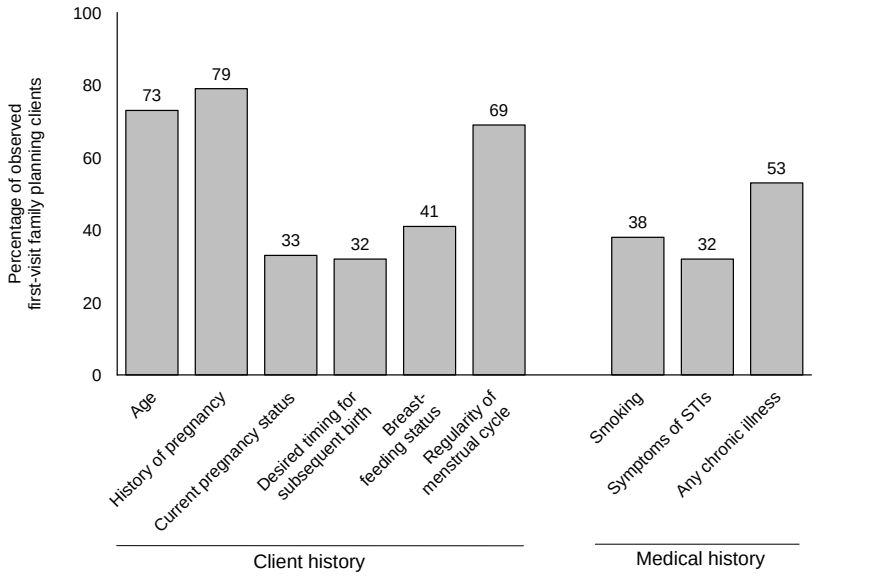
During a client's first visit, providers are expected to elicit relevant personal and health history that will provide the information they need to make an informed recommendation on contraceptive methods; they should also screen clients for the appropriateness of specific methods. Providers asked the client's age and

prior pregnancy history during 70 percent of first visits (Figure 5.8). They were least likely to check on current pregnancy status (either by asking the client or through laboratory testing) and desired timing for the next pregnancy (33 percent and 32 percent, respectively). Knowing a client's breastfeeding status is essential when determining the suitability of different methods of contraception, but providers only asked 41 percent of clients whether they were breastfeeding (Figure 5.8). Relatively few providers assessed clients' medical history to determine their risk status for different family planning methods. About 4 in 10 of the observed first-visit clients were asked whether they smoke, and about 3 in 10 were asked whether they had symptoms of STIs. A little over half were assessed for chronic illnesses. Traditionally, smoking has not been common for women in Kenya, so assessment may not have been stressed in provider training, but smoking is a particularly important risk factor for certain methods.

Providers asked only 35 percent of first-visit clients about their husband's attitude toward family planning or about other factors related to the husband that might affect the client's STI risk or method choice (Appendix Table A-5.25). Providers discussed condom use to prevent STIs with 34 percent of first-visit clients, and they discussed condoms as a dual family planning method during 11 percent of first visits. Considering the current drive toward reducing HIV/AIDS rates, these percentages are rather low.

Use of visual aids during first visits is rare; it was most common in hospitals (56 percent) (Appendix Table A-5.25).

Figure 5.8 Observed elements of client history for first-visit family planning clients (N=154)



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Key Findings

Visual and auditory privacy during family planning counselling existed in 87 percent and 83 percent of counselling sessions, respectively; however, providers verbally assured clients of the confidentiality of their consultations less than half the time.

Providers do not thoroughly assess relevant client history that might influence whether a family planning method is appropriate. Less than half of first-visit clients were assessed for current pregnancy or breastfeeding status, chronic illnesses, and risk factors such as STI symptoms or smoking.

Visual aids, though available in 87 percent of facilities, are rarely used during family planning counselling sessions.

5.5.3 Method-Specific Assessments and Examinations

For clients receiving methods with oestrogen, whether oral or injectable, monitoring for hypertension should be a component of care, as should weight monitoring; gaining weight may be an indicator of fluid retention and a factor in hypertension. Among these clients, 71 percent had their blood pressure measured[2] and 87 percent had their weight measured (Appendix Table A-5.26).

5.5.4 Counselling of Clients

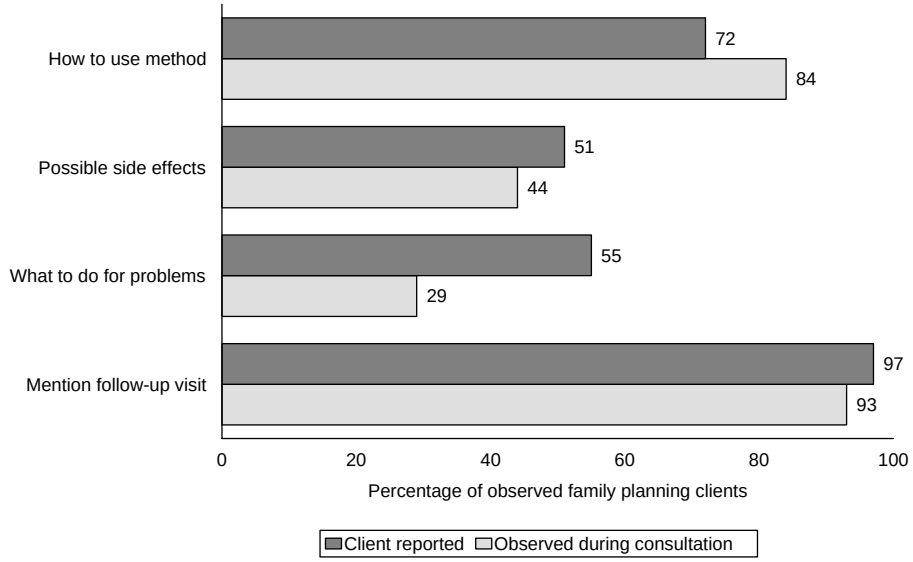
Whether they are new contraceptive users or continuing users, clients should receive certain information during consultations. The provider should explain or review with the client how to use the method, the possible side effects, what to do for problems, and when the client should return for a follow-up visit.

Details on components of counselling that were observed and reported by clients are presented in Appendix Tables A-5.27 and A-5.28.

KSPA data can be used to compare what was observed during a consultation to the client's exit interview about the same consultation (Figure 5.9). Client reports were most likely to agree with the observed data on whether the provider mentioned possible side effects of the method and discussed a follow-up visit. Data on other areas was more inconsistent. For example, whereas 84 percent of providers were observed discussing with clients how to use their method, a smaller percentage (72 percent) of clients reported that this happened during the consultation. On the contrary, as opposed to 29 percent of cases when the provider was observed discussing what to do in case of problems, 55 percent of clients actually reported this to have taken place. Clients may have received this information during prior visits or at the pharmacy when receiving their methods.

[2] If the client was observed in a facility where blood pressure is measured systematically prior to the consultation, the client was assumed to have her blood pressure measured, even if this was not observed for the particular client.

Figure 5.9 Information provided to hormonal method users, by client report and by observation (N=516)



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Key Findings

Among all clients receiving methods with oestrogen, where monitoring for hypertension should be a component of care, 71 percent had their blood pressure measured.

There were some inconsistencies between client reports and observation of the information provided to hormonal method users; however, at most half of clients either reported or were observed being counselled about possible side effects or what to do for problems.

5.6 Client Opinion from Exit Interviews

After the observed consultation, the client was asked to participate in an exit interview during which the interviewer asked for her opinions on issues commonly related to client satisfaction. Specifically, clients were asked if they had a problem with their method upon their arrival at the facility and whether the provider discussed the problem with them. The client was first asked to identify issues without prompting. Then the client was asked to comment on whether specific issues were a big problem, a small problem, or not a problem at all for them.

Few issues were considered big problems, and usually only by a small proportion of interviewed clients. Long waiting time to see the provider was a big problem for 23 percent of clients. Fewer clients (6 percent) considered lack of medicines or supplies to be a big problem, while only 4 percent considered the operating hours of the facility to be a problem (Appendix Table A-5.29).

Further details on client opinion are provided in Appendix Tables A-5.29 and A-5.30. Appendix Table A-5.31 provides information on the educational backgrounds of observed and interviewed clients.

When asked if this was the nearest facility to their home, about 2 in 10 of the interviewed clients said that it was not. These were more likely to be clients at maternities (69 percent) and those who were attending private for-profit facilities (53 percent). Similarly, clients in facilities in Nairobi province (49 percent) are more likely to visit facilities not nearest to them. The main reasons clients gave for not attending the nearest facilities to where they live were that those facilities were more expensive (23 percent) and lacked medicine (15 percent) (Appendix Table A-5.30).