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PD-AAJ-732

ISN. 1299

UNCLASSIFIED

PROJECT PAPER

PROGRAM FOR VOLUNTARY STERILIZATION

Project No. 932-0968

Cooperative Agreement  
with  
Association for Voluntary Sterilization

Development Support Bureau  
Office of Population  
Family Planning Services Division

UNCLASSIFIED

DS/POP/FPSD:DV, 5/28/81  
Revised 10/16/81\*  
(\* Financial Plan, Inputs,

Logical Framework)

PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add  
 C = Change  
 D = Delete

Amendment Number

DOCUMENT

CODE

3

2. COUNTRY/ENTITY

Interregional

3. PROJECT NUMBER

932-0968

4. BUREAU/OFFICE

S&T

36

5. PROJECT TITLE (maximum 40 characters)

Program for Voluntary Sterilization

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY  
 05 31 88

7. ESTIMATED DATE OF OBLIGATION  
 (Under 'B.' below, enter 1, 2, 3, or 4)

A. Initial FY 82

B. Quarter 1

C. Final FY 86

8. COSTS (\$000 OR EQUIVALENT \$1 = )

A. FUNDING SOURCE	FIRST FY 1982			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	9,500		9,500	78,500		78,500
(Grant)	( 9,500 )	( )	( 9,500 )	( 78,500 )	( )	( 78,500 )
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S.						
1.						
2.						
Host Country						
Other Donor(s)						
<b>TOTALS</b>	<b>9,500</b>		<b>9,500</b>	<b>78,500</b>		<b>78,500</b>

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) PN	J440	440		See Block 16		78,500		78,500	
(2)									
(3)									
(4)									
<b>TOTALS</b>						<b>78,500</b>		<b>78,500</b>	

10. SECONDARY TECHNICAL CODES (maximum 5 codes of 3 positions each)

450

460

11. SECONDARY PURPOSE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code

PVCN

TNG

B. Amount

\$60M

\$2.5M

13. PROJECT PURPOSE (maximum 430 characters)

To increase the number of developing countries in which high-quality voluntary sterilization services are institutionalized and routinely accessible to the majority of the population.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY Final MM YY  
 06 83 02 86 04 86

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000  041  Local  Other (Specify) 935

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a \_\_\_\_\_ page PP Amendment)

Note: Negotiation is authorized for a five-year Cooperative Agreement with the Association for Voluntary Sterilization. Incremental grant funding under the Agreement will begin in FY 1982. In addition to funds authorized by this Project Paper, previous A.I.D. authorizations from FY 1972 through FY 1981 have totaled \$54,506,000. The new cumulative authorization total for the FY72-86 life of project is \$133,006,000.

17. APPROVED BY

Signature

Title

Date Signed

MM DD YY

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM DD YY

PROJECT PAPER  
PROGRAM FOR VOLUNTARY STERILIZATION

PART I. SUMMARY AND RECOMMENDATIONS

A. Face Sheet (attached)

B. Recommendation: That grant funds be contributed to the Association for Voluntary Sterilization (AVS) to carry out the program activities of the International Project of AVS (IPAVS) and of the World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception (WFHA-AVSC), as follows:

Fiscal Year	1982	1983	1984	1985	1986
Grant Obligation (\$000)	9,500	12,000	15,000	19,000	23,000

C. Summary Project Description

1. Program Goal: Improved maternal and child health and decreased fertility in less developed countries.

2. Project Purpose: To increase the number of developing countries in which high-quality voluntary sterilization services are institutionalized and routinely accessible to the majority of the population.

Intermediate Purpose: To increase the number of developing countries in which voluntary sterilization is acceptable as a family planning and health measure.

3. Project Activities: To achieve the Project Purpose, the following activities will be undertaken:

a. The International Project will administer AVS assistance for the following:

- . voluntary sterilization service delivery;
- . training of medical and paraprofessional program personnel;
- . equipment: medical, hospital, audio-visual;
- . repair and maintenance of endoscopic equipment;
- . renovation of hospital space dedicated to fertility management services, including permanent methods;
- . public information and education on voluntary sterilization;
- . administrative and organizational costs of national leadership organizations; and
- . technical assistance: medical, communication, management, evaluation.

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h. Quantified projections of Inputs and the resulting Outputs follow:

<u>INPUTS</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>
1. Subgrants:					
a. Services, training IEC	5,554	6,396	8,136	10,552	12,564
b. Equipment, RAM centers	844	1,115	1,521	1,990	2,392
c. Nat'l leadership groups	773	1,053	1,558	1,973	2,389
2. Conferences:					
a. International	--	464	--	--	791
b. Other	176	77	250	271	184
3. Printed materials -- production, distribution	70	121	148	165	179
4. Technical Assistance to LNCs (consulting)	121	135	171	208	235
5. International leadership network development (select study groups, standing committees, international meetings)	77	135	171	208	239
6. Management:					
a. Headquarters	1,464	1,954	2,283	2,603	2,923
b. Regional offices	<u>421</u>	<u>550</u>	<u>762</u>	<u>950</u>	<u>1,104</u>
Totals :	9,500	12,000	15,000	19,000	23,000

**Note:** AVS's application for grant funding was for a total of \$93 million for the five-year program. A.I.D. proposes to support the program at a level of \$78,500,000. The reduced amount appears to be more realistic from the standpoint of the expected availability of funds; it is projected over the FY 1982-1986 period in a reasonable and manageable program growth progression.

<u>OUTPUTS</u>		<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>	
1. Service facilities in operation	No.	153	193	239	302	365	
	Countries	32	36	42	49	58	
2. Training facilities in operation	No.	81	102	127	148	193	
	Countries	21	24	28	33	39	
3. Persons trained: Medical	No.	360	457	566	717	867	
	Countries	30	34	39	45	54	
Paraprofessional	No.	256	352	403	570	617	
	Countries	12	14	16	18	21	
4. Dedicated clinical space equipped	No.	11	13	17	21	25	
	Countries	9	10	11	13	15	
5. RAM centers functioning	Countries	10	12	15	19	23	
6. National leadership groups functioning (WFHA-AVSC Members)	No. of Nat'l/Regional	32/3	35/3	38/3	40/4	42/4	
7. Professional publications produced:	a. guidelines, standards, policies	Titles	-	5	3	4	3
	b. study reports	Titles	2	3	4	5	5
	c. conference monographs	Titles	-	-	1	-	-
	d. promotional materials	Titles	4	8	8	8	8
8. Conferences conducted:	a. international	Number	-	1	-	-	1
	b. nat'l, regional	Number	7	9	12	14	17
9. VS subjects included in International Meeting programs	No. of Mtgs.	7	8	10	13	14	

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**NO.** 12 - 24

It is hoped that other social and economic development measures undertaken by the developing countries will help to provide greater opportunities for the productive employment and greater human fulfillment of their citizens. The fact remains, however, that present patterns of employment and productivity prevailing in most developing countries present most unfavorable prospects for (and are in large part a consequence of) the excess or unwanted children being born in these developing countries today.

D. Financial Plan

Budget projections for the five years of this project are shown in the following tables. Host country financial and in-kind contributions vary from country to country and are undeterminable.

	(in thousands of dollars)				
	1982	1983	1984	1985	1986
<u>INTERNATIONAL PROJECT:</u>					
1. <u>Management:</u>					
Personnel	\$ 854	\$ 1,142	\$ 1,339	\$ 1,566	\$ 1,708
Fringe Benefits	204	273	322	376	409
Travel	77	84	96	110	120
Consultants	65	97	114	152	163
Rent & Utilities	127	171	198	229	252
Services & Supplies	70	104	121	140	152
Equipment	17	19	17	20	21
Communications	50	64	75	90	98
	<u>1,464</u>	<u>1,954</u>	<u>2,282</u>	<u>2,683</u>	<u>2,923</u>
2. <u>Regional Offices:</u>					
Asia	183	233	312	389	451
Africa/Mear East	189	240	325	407	469
Latin America	49	77	125	154	184
	<u>421</u>	<u>550</u>	<u>762</u>	<u>950</u>	<u>1,104</u>
3. <u>Projects:</u>					
a. Subgrants for services, training, I&E, other; and Small Grants	5,555	6,396	8,136	10,552	12,564
b. Nat'l Associations	773	1,053	1,558	1,973	2,389
c. Equipment and Repair/Maintenance Centers	844	1,115	1,521	1,990	2,392
	<u>7,172</u>	<u>8,564</u>	<u>11,215</u>	<u>14,515</u>	<u>17,345</u>

	1982	1983	1984	1985	1986
<b>4. <u>Communication Materials:</u></b>					
(Hq. publications, reprints, A-V facilities)	<u>14</u>	<u>24</u>	<u>13</u>	<u>14</u>	<u>17</u>
Subtotals	\$ 9,067	\$11,086	\$14,273	\$18,166	\$21,388
<b><u>WORLD FEDERATION (Subgrant):</u></b>					
<b>5. <u>Conferences:</u></b>					
International	0	464	0	0	791
Other	176	77	250	272	184
<b>6. <u>Printed Materials:</u></b>					
Consultants	20	30	35	40	41
Production, printing, and distribution	39	65	100	110	122
<b>7. <u>Leadership Activities:</u></b>					
(i.e. Consultant Network, Committee Activities, Special Study Group Activities, Participation in International Conferences and Special Projects)	77	134	171	208	239
<b>8. <u>Technical Assistance:</u></b>	<u>121</u>	<u>134</u>	<u>171</u>	<u>208</u>	<u>235</u>
Subtotals	433	914	727	838	1,612
IP Subtotals	<u>9,067</u>	<u>11,086</u>	<u>14,273</u>	<u>18,166</u>	<u>21,388</u>
<b>GRAND TOTALS</b>	<b>\$9,500</b>	<b>\$12,000</b>	<b>\$15,000</b>	<b>\$19,000</b>	<b>\$23,000</b>

May 28, 1981

DRAFT

UNCLASSIFIED

PROJECT PAPER

PROGRAM FOR VOLUNTARY STERILIZATION

Project No. 932-0968

Cooperative Agreement  
with  
Association for Voluntary Sterilization

Development Support Bureau  
Office of Population  
Family Planning Services Division

UNCLASSIFIED

DRAFT

DS/POP/FPSD:DV, 5/28/81

DRAFT  
PROJECT PAPER  
PROGRAM FOR VOLUNTARY STERILIZATION

<u>CONTENTS</u>	<u>PAGE</u>
PART I. SUMMARY AND RECOMMENDATIONS . . . . .	1
A. Face Sheet . . . . .	1
B. Recommendation . . . . .	1
C. Summary Project Description . . . . .	1
1. Program Goal . . . . .	1
2. Project Purpose . . . . .	1
Intermediate Purpose . . . . .	1
3. Project Activities . . . . .	1
a. International Project . . . . .	1
b. World Federation . . . . .	2
c. Collaborative . . . . .	2
D. Summary Findings . . . . .	2
PART II. DETAILED PROJECT DESCRIPTION . . . . .	3
A. Background . . . . .	3
1. Funding History . . . . .	3
2. Accomplishments . . . . .	3
a. End-of-Project Evaluation, Part 1 . . . . .	3
b. End-of-Project Evaluation, Part 2 . . . . .	4
c. External Evaluation . . . . .	5
B. The 1980s . . . . .	6
C. Project Description . . . . .	6
1. Program Goal . . . . .	6
2. Project Purpose . . . . .	6
Intermediate Purpose . . . . .	7
3. Project Inputs and Outputs . . . . .	7
a. Input mechanisms . . . . .	7
b. Inputs and Outputs tables . . . . .	10 - 12

PART III. IMPLEMENTATION . . . . .	12
A. General Responsibilities . . . . .	12
B. Management . . . . .	12
C. Implementation Plan . . . . .	13
D. Implementation Procedures . . . . .	14
1. Proposal Requirements . . . . .	14
2. Approval Criteria . . . . .	15
3. Approval Procedure . . . . .	16
4. Accountability . . . . .	17
5. Quality of Services . . . . .	17
6. Country Policies . . . . .	18
7. Site Visits and Travel . . . . .	18
8. Institutionalization . . . . .	18
9. Coordination . . . . .	19
E. Professional and Consultant Personnel . . . . .	19
F. Reporting . . . . .	20
G. Evaluation . . . . .	20
PART IV. PROJECT ANALYSES . . . . .	21
A. Social Soundness Analysis . . . . .	21
B. Technical Analysis . . . . .	22
C. Economic Analysis . . . . .	23
D. Financial Plan . . . . .	25
E. Environmental Impact . . . . .	27

ANNEXES

- A. End-of-Project Evaluation, Part I
- B. End-of-Project Evaluation, Part II
- C. External Evaluation, Summary Conclusions
- D. Logical Framework
- E. Environmental Statement
- F. Statutory Checklist
- G. Letter of Application
- H. A.I.D. Policy Guidelines

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add  
 C = Change  
 D = Delete

Amendment Number

DOCUMENT CODE

3

2. COUNTRY/ENTITY

Interregional

3. PROJECT NUMBER

932-0968

4. BUREAU/OFFICE

DSB

36

5. PROJECT TITLE (maximum 40 characters)

Program for Voluntary Sterilization

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY  
05 31 88

7. ESTIMATED DATE OF OBLIGATION  
(Under 'B' below, enter 1, 2, 3, or 4)

A. Initial FY 82

B. Quarter 1

C. Final FY 86

8. COSTS (\$000 OR EQUIVALENT \$1 = )

A. FUNDING SOURCE	FIRST FY 1982			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	13,500		13,500	93,000		93,000
(Grant)	(13,500)	( )	(13,500)	( 93,000 )	( )	( 93,000 )
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S.						
1.						
2.						
Host Country						
Other Donor(s)						
<b>TOTALS</b>	<b>13,500</b>		<b>13,500</b>	<b>93,000</b>		<b>93,000</b>

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE	D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
			1. Grant / 2. Loan	1. Grant / 2. Loan	1. Grant / 2. Loan	1. Grant / 2. Loan	1. Grant / 2. Loan	
(1) PH	J440	440	See Block 16		93,000		93,000	
(2)								
(3)								
(4)								
<b>TOTALS</b>					<b>93,000</b>		<b>93,000</b>	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

450

460

.

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code

PVCN

TNG

B. Amount

570M

53M

13. PROJECT PURPOSE (maximum 480 characters)

To increase the number of developing countries in which high-quality voluntary sterilization services are institutionalized and routinely accessible to the majority of the population.

14. SCHEDULED EVALUATIONS

Interim

MM YY  
06 83

MM YY  
02 86

Final

MM YY  
04 86

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000

941

Local

Other (Specify)

935

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a \_\_\_\_\_ page PP Amendments.)

Note: Negotiation in FY 1981 is authorized for a five-year Cooperative Agreement with the Association for Voluntary Sterilization. Incremental grant funding under the Agreement will begin in FY 1982. In addition to funds authorized by this Project Paper, previous A.I.D. obligations from FY 72 through 81 have totaled \$49,906,000.

17. APPROVED BY

Signature

Title DS/POP, Acting Director

Date Signed

MM DD YY

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM DD YY

DRAFT PROJECT PAPER  
PROGRAM FOR VOLUNTARY STERILIZATION



PART I. SUMMARY AND RECOMMENDATIONS

A. Face Sheet (attached)

B. Recommendation: That grant funds be contributed to the Association for Voluntary Sterilization (AVS) to carry out the program activities of the International Project of AVS (IPAVS) and of the World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception (WFHA-AVSC), as follows:

Fiscal Year	1982	1983	1984	1985	1986
Grant Obligation (\$000)	13,500	15,500	18,000	21,000	25,000

C. Summary Project Description

1. Program Goal: Improved maternal and child health and decreased fertility in less developed countries.

2. Project Purpose: To increase the number of developing countries in which high-quality voluntary sterilization services are institutionalized and routinely accessible to the majority of the population.

Intermediate Purpose: To increase the number of developing countries in which voluntary sterilization is acceptable as a family planning and health measure.

3. Project Activities: To achieve the Project Purpose, the following activities will be undertaken:

a. The International Project will administer AVS assistance for the following:

- . voluntary sterilization service delivery;
- . training of medical and paraprofessional program personnel;
- . equipment: medical, hospital, audio-visual;
- . repair and maintenance of endoscopic equipment;
- . renovation of hospital space dedicated to fertility management services, including permanent methods;
- . public information and education on voluntary sterilization;
- . administrative and organizational costs of national leadership organizations; and
- . technical assistance: medical, communication, management, evaluation.

b. The World Federation, with subgrants from AVS, will be responsible for the following activities:

- . development of guidelines and standards on all aspects of services, laws and regulations, professional and public education, and organizational development;
- . technical leadership assistance to governments and other agencies in their development of voluntary surgical contraception programs and policies, including provision of technical assistance from a roster of international consultants;
- . dissemination of technical and scientific information and guidance on service delivery systems;
- . awarding of administrative subgrants to national VS associations where there are program advantages over IPAVS's being donor, in AVS's judgment;
- . development of a consortium through the establishment of collaborative relationships with related international agencies; and
- . support or conduct of international, regional and national conferences.

c. During the period of the project, AVS, its International Project, and the World Federation will collaborate to address major unmet needs. These include:

- . study of and model development for extending services to underserved peripheral rural and remote areas;
- . introduction of voluntary sterilization services into countries in which services are not available or are restricted;
- . improvement of the quality of services; and  
improved approaches to public education and counselling of couples.

D. Summary Findings: AVS's nine years of well-documented experience in assisting developing country agencies, institutions, and governments to initiate and expand high-quality voluntary sterilization services as a normal part of health and family planning programs have demonstrated the efficacy of the approaches planned in this project. In the past five years, there has been a dramatic increase in the acceptability of contraceptive sterilization and in requests for assistance. AVS has demonstrated its capacity for differentiated response to widely varying social environments among developing countries. Based on this record, it is A.I.D.'s judgment that AVS can attain the desired end-of-project conditions by 1986.

## PART II. DETAILED PROJECT DESCRIPTION

### A. Background

#### 1. Funding History

In response to a growing demand for assistance in developing programs of voluntary sterilization in less developed countries, A.I.D. made a grant in 1972 (AID/csd-3611) to the Association for Voluntary Sterilization, a U.S. nonprofit, private-sector agency incorporated under the laws of New Jersey. The purpose of this project was to advance the acceptability and availability of voluntary sterilization as a basic component of family planning and health services programs throughout the developing world. AVS set up the International Project (IPAVS) as the mechanism for designing and carrying out a program to achieve this purpose.

A favorable evaluation of the first three years' program, under which \$3,526,000 of grant funds was obligated, led to a new A.I.D. grant (AID/pha-G-1128) in 1975, extended in 1977 for a three-year period and in 1980 for one year, ending in FY 1981. Total A.I.D. obligations under the second grant have totalled \$46,380,000, as follows:

FY 1975	-	\$ 1.5	million
1976	-	1.0	
1977	-	5.45	
1978	-	9.5	
1979	-	8.2	
1980	-	11.33	
1981	-	9.4	
Total	-	<u>\$46.38</u>	million

#### 2. Accomplishments

a. In a joint end-of-project evaluation in June, 1980, A.I.D. (DS/POP/FPSD) and IPAVS compared accomplishments with the 1977 Logical Framework projections of the previous Project Paper. The results are attached as Annex A. In summary, data available through the end of 1980 indicate that AVS has essentially achieved or exceeded Output targets for number of projects currently supported (154 vs. 85 projected by A.I.D. for the end of 1980); numbers of personnel trained (1,425 vs. 1,550, 1978 - 1980); number of countries receiving equipment grants (89 vs. 47 plus 28 receiving small equipment grants in 1978 - 1980 period); number of national and regional leadership groups existing (30 vs. 31 targeted); and number of conferences conducted each year. The principal shortfall was in the number of countries in which activities were being supported. At the end of 1980, there were active subgrants in 39 countries and proposals from an additional 10 countries were under review or development; the Logical Framework projection was 65 countries. AVS classified 14 countries as having "Major service projects leading to national V.S. programs," as compared to A.I.D.'s projected 25 countries.

At the level of Purpose ("To make high-quality voluntary sterilization services well known and readily available ...."), the indicator of achievement of purpose was arbitrarily defined as one service clinic for every approximately 200,000 population in each developing country where AVS "has provided major program support for three years or longer." Based on end-1979 statistics reported by the USAID Missions, eight of the twelve countries concerned meet the condition described. Two countries are in the 1/300,000-400,000 range. Indonesia is about 1/700,000; no clinic data are available from Egypt.

The overall, long-range Goal of the project is improved maternal and child health and reduced fertility rates. An examination of several indicators for 1970, 1975, and 1980 in the countries looked at in the Purpose-level evaluation shows generally favorable trends. It is assumed that increasing availability of voluntary sterilization during the past decade has contributed positively to these trends.

b. The other part of this evaluation, not addressed in the previous Project Paper and Logical Framework, was an attempt to identify indicators of attitudinal and public policy changes resulting in or favorable to greater acceptability and availability of voluntary sterilization. Some of these indicators are unquantifiable and impressionistic. Since many interacting forces are at work influencing these social changes, it is difficult to attribute a quantified share of the cause of such changes to program activities of IPAVS and its subgrantees. It does seem reasonable to assume, however, that the advent of an agency focused on surgical contraception, at that particular time in history, and operating in the manner it has, has interacted in a mutually reinforcing way with the other forces for change and that it has indeed been influential in bringing about the conditions described in this part of the evaluation. The results of the analysis are attached as Annex B.

In summary, changes in laws and their interpretation and application reflect the reversal in public attitudes which has occurred. At the beginning of the 1970s, the only laws thought to apply to sterilization were the criminal codes. The first two non-eugenic, nonrestrictive laws on voluntary sterilization were enacted in 1969 by Virginia and Singapore. Today, contraceptive sterilization is broadly seen primarily as a medical matter -- as an individual right, mainly in Europe and North America, or to legalize the most efficient method of family planning, in countries endangered by overpopulation. There are, of course, a number of countries in which sterilization is illegal, specifically or by interpretation, or permissible for only eugenic or medical reasons.

AVS has identified over 30 countries in which there have been explicit favorable policy changes, tacit changes, or movement in the direction of acceptance of contraceptive sterilization. They cite an encouraging

difference in the reception accorded IPAUS staff visitors in some countries as a further indicator of progress.

With Pakistani policy reversals which accompanied changes of government, India was left as the only country in which sterilization was a part of the government's national family planning program in 1972. In 1980, there are at least 19 countries with governmental sterilization programs. The IPAUS analysis cites specific examples of countries in which its activities were pivotal in this movement.

The analysis of the international conferences on voluntary sterilization reveals an increasing number of countries participating in each successive conference and gives examples of concrete effects: the beginning of projects in countries in which there had been no services; the inspiration of individuals who formed leadership groups; the implementation of ideas picked up from other countries' experiences.

IPAUS traces the direct influence of their activities on changes in the knowledge and understanding of sterilization among the medical profession and the general public during the past decade. These include the general use of the terms "voluntary sterilization" and "minilap," the widespread adoption of simpler and safer techniques, the use of local anesthesia and treating tubal ligations as out-patient procedures, and the broadening acceptance of the concepts of voluntarism and contraceptive sterilization as a basic health measure.

c. In September and October 1979, A.I.D. arranged for an evaluation of IPAUS's performance (as distinguished from an evaluation of subgrant projects) by a team of external evaluators. Their conclusions were:

- . The IPAUS program is well designed to achieve project objectives.
- . IPAUS activities are relevant to A.I.D. goals and adhere to A.I.D. policies and guidelines.
- . A.I.D. should continue to increase support to IPAUS because, in spite of tremendous progress, the bulk of the work of providing generally available voluntary sterilization services lies ahead.
- . IPAUS has the technical and managerial competence to administer a larger grant program.
- . The World Federation is an important professional organization which deserves continued support.

The summarized conclusions of the evaluation team are attached as Annex C.

## B. The 1980s

The great gains of the 1970s in voluntary sterilization have occurred mainly in Asia and Latin America. Virtually untouched are some South American countries and, with only a few exceptions, nearly all of the African and Middle Eastern nations.

Much remains to be done in many of the countries in which services are now available: expansion from limited to national coverage; upgrading of training and medical standards and the quality of services; and continued financial support where governments, private agencies, or the consumers of services themselves cannot yet assume the full cost of the programs.

In the rest of the world, generally the initial tasks are to educate the decision makers and opinion leaders in the nature and consequences of rapid population growth, the public health benefits of sterilization and, indeed, the importance of preventive health care; and to stimulate discussion of rational responses to these modern challenges to traditional values.

Under the previous grants, AVS has created resources with special advantages in overcoming cultural and political obstacles to the establishment of sterilization services. National leadership organizations, created and developed with AVS support and guidance, are ideally suited to design actions appropriate to the unique environmental realities of their respective countries. The international leadership network which is the World Federation -- an affiliation of the national associations -- carries authority and credibility and has access because of its international character, its professional credentials, and the prominence among its top leadership of developing country individuals.

## C. Project Description

1. Program Goal: Improved maternal and child health and decreased fertility in less developed countries.

A wide range of interacting social, economic, and physiological factors affect observed measures of fertility and maternal and child health, to be sure. However, sterilization, as the most effective method of fertility control, is a potent tool for prevention of the mortality, morbidity, and dysfunctions associated with maternal age and parity and birth order of children. It is expected that, as the proportion of couples in a population choosing permanent contraception increases, the beneficial effects will be increasingly reflected in measures of maternal and child health and in fertility rates.

2. Project Purpose: To increase the number of developing countries in which high-quality voluntary sterilization services are institutionalized and routinely accessible to the majority of the population.

Intermediate Purpose: To increase the number of developing countries in which voluntary sterilization is acceptable as a family planning and health measure.

Acceptability and availability of sterilization for contraceptive purposes throughout the world range from countries with strong government support and involvement (India, Korea, Bangladesh, Mexico and Tunisia are examples), to countries in which governments permit or rely on private-sector agencies to take the leading role (as in Indonesia, Colombia and Brazil), to countries which do not permit services or, in some cases, even discussion of sterilization (as in much of Africa and the Middle East).

In countries in which the Purpose has been achieved, the majority of couples will have the choice of a permanent method of fertility control as a realistic option. However, given the wide range of evolutionary stages among nations, gaining initial acceptability for surgical contraception is a more realistic aspiration in much of the world in the five-year time frame of this project; hence, the Intermediate Purpose.

3. Project Inputs and Outputs: On the evidence of the increasingly widespread acceptability of sterilization (with a 1979 estimate of 90 million couples throughout the world having chosen it as their method of controlling their fertility) and the judgments of successive teams of external evaluators, the basic approaches selected by AVS to increase the acceptability and availability of voluntary sterilization services are sound. They will be continued and built upon in this new project. Throughout the project period, AVS and A.I.D. will maintain continuous surveillance of the relative budgetary allocations among the service-related action projects; the political, strategic, and leadership development components of the program; and the costs of administering the program. The object will be to achieve a balance which is judged most likely to achieve the Project Purpose with the most efficient expenditure of time and funds.

a. The following mechanisms are to be employed in making inputs and monitoring program activities.

(1) The primary mechanism for financing activities which have potential for advancing aims of the project is the subgrant, with a formal agreement between AVS and the subgrantee. Action program subgrants are awarded to requesting private- and public-sector agencies and institutions for a variety of purposes:

- . Establishment and expansion of service programs.
- . Renovation and upgrading of dedicated space.
- . Supply of surgical, operating room, and emergency life saving equipment.
- . Information and education campaigns.
- . Training of physicians and paraprofessionals.

- . Repair and maintenance of endoscopic equipment.
- . Incorporation of fertility management education and training into medical school curricula.

Subgrants are also used for the administrative support, organizational development, and leadership development activities of national associations. Subgrants require prior A.I.D. approval.

(2) A useful adjunct to the subgrant is the "Small Grant." Small Grants, with a ceiling of \$7,500 (up from \$5,000 in the previous project to accommodate price increases and inflation), are awarded, without prior A.I.D. approval, for short-term specialized training or participation in international meetings of developing country individuals and for small quantities of medical and audio-visual equipment and educational materials to developing country institutions and agencies.

(3) AVS will make use of professional and technical consultants for occasional or short-term needs which do not justify employment of full-time grantee or subgrantee staff. These may be consultants to headquarters or regional office staffs or to subgrantee organizations.

(4) World Federation activities will be funded through subgrants from AVS. Some of the World Federation's work plan for the next several years, as approved at the its General Assembly in May, 1980, will be carried out by the executive, standing and ad hoc committees, composed of volunteer professionals who are members of their respective national associations. The committees rely on correspondence and occasional meetings to conduct their work. Staff support is given by specially assigned professional and clerical personnel located at AVS's New York Headquarters. The committees' work plans include development of guidelines, standards, and informational materials for the guidance of governments, member associations, and international and national health and family planning agencies. Subjects of these planned publications include the following:

- . Standards/guidelines: medical care/management of complications  
training content/physician qualifications  
clinical facilities and equipment  
client counselling/informed consent
- . Role of paramedics
- . Incentives and disincentives, as related to voluntary participation
- . Legal status of sterilization
- . Standardization of nomenclature and definitions
- . Standardization of statistical recording and reporting
- . Leadership group formation, management, and programming
- . Information/education
- . Technological and scientific developments in sterilization and reconstructive surgery

(5) The World Federation will plan, sponsor and conduct international conferences on voluntary sterilization. These conferences have been instrumental in making the subject of sterilization more familiar and

better understood around the world. Participation in past conferences was as follows: about 50 persons, principally from developed countries, at New York in 1966; 374 from 64 countries at Geneva, 1973; 261 from 66 countries, Tunis, 1976; and 402 representatives from 73 countries at Seoul in 1979. It is expected that two international conferences will be held during this project period, in 1983 and 1986. In addition, the Federation will support and/or sponsor national and regional conference on an occasional basis.

(6) WFHA-AVSC will seek to establish relationships with and participation in a variety of international agencies and meetings. Examples: NGO status with U.N. specialized agencies; U.N.-sponsored conferences and forums; and international professional meetings in the medical, population, health, education, communication, legal, legislative, and economic and social development fields.

(7) Management of the Cooperative Agreement and its activities will be carried out by the professional and support staff at headquarters and in regional offices. The regional office for Asia was established in May, 1979, in Dacca, Bangladesh. The second regional office, located in Tunis, Tunisia, for Africa and the Middle East, became operational in the latter half of CY 1980. The establishment of a regional office for Latin America is planned for 1982.

Outputs follow: b. Quantified projections of Inputs and the resulting

<u>INPUTS</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>
1. Subgrants:					
a. Services, training IEC	7,900	8,263	9,763	11,663	13,656
b. Equipment, RAM centers	1,200	1,440	1,825	2,200	2,600
c. Nat'l leadership groups	1,100	1,360	1,870	2,180	2,597
2. Conferences:					
a. International	--	600	--	--	860
b. Other	250	100	300	300	200
3. Printed materials -- production, distribution	104	156	178	183	195
4. Technical Assistance to LDCs (consulting)	172	175	205	230	255
5. International leadership network development (select study groups, standing committees, international meetings)	110	175	205	230	260
6. Management:					
a. Headquarters	2,083	2,521	2,739	2,964	3,177
b. Regional offices	<u>581</u>	<u>710</u>	<u>915</u>	<u>1,050</u>	<u>1,200</u>
<b>Totals :</b>	<b>13,500</b>	<b>15,500</b>	<b>18,000</b>	<b>21,000</b>	<b>25,000</b>

<u>OUTPUTS</u>		<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>	
1.	Service facilities in operation	No. Countries	218 32	248 36	287 42	334 49	397 58
2.	Training facilities in operation	No. Countries	115 21	131 24	152 28	177 33	210 39
3.	Persons trained:						
	Medical	No. Countries	514 30	586 34	679 39	792 45	942 54
	Paraprofessional	No. Countries	366 12	417 14	484 16	564 18	671 21
4.	Dedicated clinical space equipped	No. Countries	15 9	17 10	20 11	23 13	27 15
5.	RAM centers functioning	Countries	14	16	18	21	25
6.	National leader- ship groups functioning (WFHA-AVSC Members)	No. of Nat'l/ Regional	32/3	35/3	38/3	40/4	42/4
7.	Professional publica- tions produced:						
a.	guidelines, standards, policies	Titles	-	6	3	4	3
b.	study reports	Titles	3	4	5	5	5
c.	conference monographs	Titles	-	-	1	-	-
d.	promotional materials	Titles	5	10	9	9	9
8.	Conferences conducted:						
a.	international	Number	-	1	-	-	1
b.	nat'l, regional	Number	10	12	14	16	18
9.	VS subjects included in International Meeting programs	No. of Mtgs.	10	10	12	14	15

10. Changes reported:

a. National policy laws, regulations, "climate"	Countries	-	6	8	10	12
b. Program Improvements: e.g. standards, staff competence, administration	Programs/ projects	-	8	10	12	14

It should be noted that numbers of sterilizations performed is not a suitable measure of performance in this project. AVS reports procedures performed under its service and surgical training subgrants. However, many more cases, not reported to AVS, are handled by doctors trained in AVS-funded projects or in institutions equipped by AVS with which AVS has no continuing relationship. Similarly, there is no way to measure differences in caseload or in demand for services resulting from AVS-funded information and education efforts directed towards policy makers and the general public.

PART III. IMPLEMENTATION

A. General Responsibilities

AVS is primarily a funding agency; it is not operational except in its dissemination of information and provision of technical assistance. It rather attempts to develop indigenous institutional capability to formulate policies and to plan and administer services. AVS will be responsible for developing strategies, allocating resources, and administering assistance to activities aimed at achieving the objectives of the project described in Part II above and in full compliance with A.I.D. policies and guidelines. (Policy Determination No. 70, "A.I.D. Policy Guidelines on Voluntary Sterilization," 6/14/77; and Addendum to PD-70, 2/9/81, are attached as Annex H.)

A.I.D. will monitor the implementation of the program funded under its Cooperative Agreement with AVS, give prior approval to proposals for specific project activities, ensure conformity with U.S. Government policies and priorities, and make periodic evaluations of the effectiveness of the selected approaches and of progress towards attainment of project objectives.

B. Management

The AVS Board of Directors; the International Committee, which reviews and approves subgrant proposals; and the Biomedical Committee will continue to contribute significantly in their volunteer capacities to the general policy direction of AVS's international assistance programs.

Program planning and execution will be done by: (1) the International Project staff at headquarters and the regional offices under the overall direction of AVS-appointed Executives; and (2) the committees and the Secretariat of the World Federation under the overall direction of the WFHA-AVSC Executive Committee.

### C. Implementation Plan

Over the past nine years, the kinds of activities AVS has selected to support and the manner in which that support has been given have been found by A.I.D. and external evaluators to be suitable and effective. Based on analysis of this experience and of changing international and individual country needs, AVS will continue to refine and evolve approaches responsive to the varying environments encountered.

A relatively new factor in the field of voluntary sterilization is the emergence of an international nongovernmental organization with a categorical focus. As mandated by the previous A.I.D. grants, the World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception was established in 1975 as the World Federation of Associations for Voluntary Sterilization. It is a legal entity registered under the laws of Pennsylvania and has a membership of 30 national and regional associations from developing and developed countries. In 1980, the World Federation was granted nongovernmental organization (NGO) consultative status by the U.N. Economic and Social Council in the latter's biennial meeting to consider applications. Similar status had previously been granted to the World Federation by the U.N. Fund for Population Activities. With increasing stature and credibility, the World Federation is expected to play a role of growing importance in the years ahead.

AVS has completed its study of available options concerning the respective roles of the International Project and the World Federation in implementation of this project and has proposed the following. AVS wishes to continue its strong international involvement for the foreseeable future. Having built up considerable experience and competence in its International Project staff, AVS proposes to continue to develop and implement operational projects through the International Project. These include subgrants in support or service delivery, training, renovation and equipping of clinical facilities, information and education, administration of national leadership organizations, repair and maintenance of equipment, and technical assistance to subgrantees.

Complementing the operational side of the program is the crucial set of activities which may be characterized as theoretical, political and strategic. This is the role projected for the World Federation for the period of this project. Specifically, it includes development of standards and guidelines, technical assistance to governments and other agencies, dissemination of technical and scientific information, development of a consortium relationship with related international organizations, and support or conduct of conferences. In extra-

ordinary cases, where International Project, as a U.S. agency, may not be permitted to develop or fund operational projects, the World Federation may become the implementing/funding agency.

AVS funding of the activities implemented by the World Federation will be through the subgrant mechanism, with World Federation proposals processed through International Committees and A.I.D. approvals in the usual manner. The World Federation, as a separate entity, will be encouraged to seek additional funding from other sources as it sees fit.

The two major elements of the program -- service delivery systems and their supporting activities, on the one hand, and influencing national policies and improving standards, on the other -- are interdependent and mutually reinforcing. Since perceptions of surgical contraception vary widely among and within countries, approaches to gaining for sterilization its rightful place among established social services must be tailored to each situation. In some cases, it may be a legitimate use of funds under this project to support maternal and child health services, infertility diagnosis and treatment, and health and medical education when they are linked with voluntary surgical contraception. However, the primary objective remains the advancement of the acceptability and availability of voluntary sterilization services.

AVS will continue to support the renovation and equipping of operating and patient recovery rooms dedicated to surgical contraception, because in many countries existing surgical facilities are overtaxed by demand for curative care. Subgrants of equipment and for endoscopic equipment repair and maintenance capability will continue to expand service availability and ensure maximum benefit from investment in costly equipment.

From time to time, A.I.D. may suggest to AVS technical and/or advisory services or other activities it may wish AVS to undertake. (However, AVS has the option to decline such suggested activities.) AVS will then develop and submit to A.I.D. a proposal in accordance with established procedures.

#### D. Implementation Procedures

##### 1. Proposal Requirements

In general, AVS subgrant funding proposals are to be submitted in four copies to the Project Manager in the Office of Population, A.I.D., at least 60 days before the desired effective date. AVS will make suitable adjustments for subgrant proposals in those countries in which the government and/or USAID lead-time requirements for approval exceed 60 days. Normally, on-going projects are funded for one year at a time. For each subsequent year's funding, the proposal approval and subgrant agreement processes are repeated.

The subgrant proposal format in use under the previous project has proven functional and will continue to be used. The following is an outline of a representative proposal:

Summary Section

Project Title  
Grantee  
Project Director  
Budget Duration  
Budget Amount  
Summary of Objectives

Narrative

Program Goal  
Program Need and Background  
Previous Years' Accomplishments (for ongoing projects)  
Program Objectives and Description  
Project Implementation

Budget

In-Country costs  
U.S. costs

In proposals for continuation funding of on-going projects, AVS will include in summary format the effective dates and funding levels of prior-year subgrants as a part of the discussion of accomplishments to date. Country and subgrantee background information need be only briefly summarized and updated in refunding proposals.

Funding for travel, per diem and other costs of World Federation committee meetings and annual General Assemblies will be budgeted in the World Federation subgrant. Travel in conjunction with these meetings will be subject to A.I.D.'s established international travel approval requirements.

2. Approval Criteria

AVS will make judgments on the relevance and feasibility of proposals from developing countries in light of the objectives of this project; AVS's standing policies, guidelines, and priorities; and availability of resources. A.I.D.'s approval will be based on its determination that the proposed activity is consistent with the objectives of this project and with A.I.D.'s voluntary sterilization policies and guidelines; that the country of implementation is eligible for U. S. assistance and is one in which the activity is important; and that the project appears to be feasible and at an acceptable level of cost-effectiveness.

A.I.D. requires assurance that the government of the country concerned approves of the proposed activity. This may be formal, written approval or implicit in the evidence of subgrantee's prolonged voluntary sterilization activities or the government's use or support of subgrantee's services. In countries where the government permits private-sector voluntary sterilization

services to exist but -- for whatever reasons -- is not willing to go on record as formally sanctioning sterilization, communication to AID/W of the U. S. Mission's determination that such is the case will satisfy this requirement.

### 3. Approval Procedure

a. Upon AVS's submission of a subgrant proposal to the A.I.D. Project Manager (the Cognizant Technical Officer), as described in III.D.1. above, the latter will circulate copies for review and concurrence to the concerned Office of Population and regional bureau technical officers and to the U. S. Mission population officer. These concurrences, based on the criteria cited in III.D.2., will form the basis of A.I.D.'s written approval to AVS.

b. Upon receipt of A.I.D. approval, AVS will execute a formal agreement with the subgrantee. This agreement sets forth the project objectives and work plan, mutual responsibilities, voluntarism and informed consent requirements, accounting and audit requirements, proscription of abortion, covenants and conditions precedent, and budget. Any change in the standard contractual provisions for subgrants requires prior approval of the A.I.D. Contracts Management Office.

c. The existing waiver under which AVS may allow subgrantees to purchase commodities available in their respective countries under a specified limit has greatly facilitated rapid and economical implementation and will be continued. The present \$5,000 limitation will be increased to \$7,500 per subgrantee per year because of inflationary trends. In addition, AVS will be authorized to allow forty (40) subgrantees in years 1 and 2 of this project, forty-five (45) in year 3 and 4, and fifty (50) in year 5 to procure up to an additional \$7,500 worth of locally available commodities, that is, to a total of \$15,000 per subgrantee per year.

With A.I.D. encouragement, in several countries AVS has begun to consolidate numerous single-location subgrants to the same subgrantee under a single combined subgrant where practicable. For such consolidated subgrants, the local commodity purchase limitation will be calculated at \$4,000 per unit, with the consolidated project administrative office constituting one unit and each static project site one unit. A network of eight clinics, with an administrative office and a repair and maintenance center, for example, would comprise ten units and could be allowed up to \$40,000 in local purchases in one year. Pharmaceuticals, contraceptives, and motor vehicles are not eligible for local purchase, nor are imported articles specially ordered by or for the subgrantee.

From time to time, the A.I.D. Grant Manager may review these authorizations and propose individual waivers or general revision of the ceilings where this may be in the interests of A.I.D. or AVS. AVS will report in its Annual Report the subgrants given authority to purchase more than \$7,500 and the amounts and types of commodities purchased.

d. Small Grants under \$7,500 may be awarded by AVS without prior A.I.D. approval for training in the U. S. or third countries, for participation in international meetings, and to provide small amounts of

equipment. For surgical equipment, AVS will keep on file qualifications of the surgeon(s) who will use the equipment, data on the physical facility and its equipment in which surgical procedures will be performed, and the recipient's certification that services will be provided only to persons requesting them on an entirely voluntary basis.

#### 4. Accountability

AVS will maintain books, records, documents and other evidence and accounting procedures and practices sufficient to reflect properly that any funds provided by A.I.D. were expended exclusively for the purposes of the subgrant. Such records shall be maintained for a period of three years following the expiration of the subgrant.

AVS shall assure that upon termination of each subgrant (except for: (1) subgrants of less than \$7,500, (2) solely equipment or training subgrants, or (3) if the cognizant audit agency of A.I.D. will do the audit) an audit is conducted on the subgrantee's records by an independent public accountant with a national certification, similar or equivalent to a certified public accountant. If AVS determines that an audit is not possible or feasible, it will submit to the Contracts Management Office of A.I.D. alternatives which will achieve the same objective. AVS will include in each of its subgrants a clause by which AVS assures A.I.D.'s right to audit. AVS shall also require that the subgrantee make available any further information that is requested by AVS with respect to questions concerning the audit. The report of independent audit shall be submitted to AVS and will be retained by AVS as part of the subgrant records. The purpose of the audit shall be to determine the propriety and necessity of the subgrantee's expenditures in terms of the purposes for which the funds were made available, and the adequacy of the subgrantee's financial management.

For all subgrant institutions using A.I.D. funds to provide voluntary surgical contraceptive services, AVS will ascertain that the institution providing voluntary sterilization services maintains patient records for three years and will make them available, as necessary, for inspection and verification by AVS. These records should include the following identifying data:

1. Name of patient
2. Residence of patient
3. Age and sex of patient
4. Number of pregnancies and number of living children
5. Date procedure performed and location
6. Name of procedure
7. Notes on physical findings
8. Signature of physician performing procedure
9. Documented evidence of informed consent.

#### 5. Quality of Services

Personnel who perform sterilization procedures must be well-trained and highly qualified according to local medical standards. Equipment provided will be the best available and suitable to the field situation in which it

will be used. Sterilization services should be considered as an integral component of total health care services, and should be performed with respect for the overall health and well-being of clients.

#### 6. Country Policies

Voluntary sterilization program activities must be carried out within the framework of host country policy and practices. In monitoring the consistency of voluntary sterilization programs with local policy and practices, AVS and A.I.D. will take particular note of program activity among cultural, ethnic, religious or political minorities to ensure that the principle of informed consent is being observed and that the rights of minorities are protected.

#### 7. Site Visits and Travel

Beyond their necessity for project identification and development, project monitoring, and medical and technical assistance, site visits by staff members are valuable for keeping program personnel in touch with reality, developing relationships, transferring project planning and management skills, and enhancing interest in and understanding of permanent contraception. Newly appointed personnel accompany experienced staff members as part of a planned staff development program. Similarly, observation tours by AVS International Committee and Biomedical Committee members prepare them to make informed judgments in their tasks of proposal approval and policy and standards formulation. Standing A.I.D. travel regulations apply, including prior concurrences of U.S. Missions in the countries to be visited and prior approval of grant-funded travel by the A.I.D. Project Manager. Regional IPAVS representatives will obtain prior U.S. Mission concurrences directly for travel within their respective regions without AID/Washington approval. However, AID/Washington approval will be required for travel to the U.S. or to other regions.

#### 8. Institutionalization

AVS and A.I.D. share the objective of institutionalizing voluntary contraceptive sterilization services as a normal part of preventive health services and supported fully by domestic resources. AVS's encouragement of subgrantees with ongoing programs to become self-supporting occurs in widely differing environments. Some of the subgrantees are governments or quasigovernmental institutions. Others are private-sector organizations and institutions -- some established, mature, and with broad mandates of which surgical contraception is only one component; others are newly formed with a narrow focus on voluntary sterilization. Host governments are on different long-range courses, some leading eventually to basically private-sector health systems, others in which social services will always be primarily in the public sector. Similarly, there are vast differences among developing countries in the level of government commitment to social services and equity; in the economic ability to make adequate social investments; in the private sector's ability and will to support service programs; in the buying power of the majority of people, especially for what are essentially preventive services; and in the relative priority status of curative and preventive health services. Therefore, both the capability and the direction and pattern of institutionalization and self-reliance vary greatly.

A key factor in institutionalization is the development of strong national leadership groups which have the authority of professional expertise and commitment to social service and the legitimacy and stature associated with their linkage to an international network. This indigenous resource will remain and be influential beyond any termination of external support. A measure of institutionalization will be the ability and willingness of countries to assume an increasing share of the support costs of these leadership associations; and when voluntary sterilization is fully accepted and available, to scale down their structures and programs or phase out. AVS and the World Federation will encourage such transitions where analysis suggests they are warranted without endangering service quality and availability.

While AVS will encourage the mobilization of domestic resources, permitting a planned withdrawal of its funding, decisions to terminate support will be made on a case-by-case basis. To avoid depriving couples of services, a rigid application of an arbitrary cut-off schedule will not be required.

#### 9. Coordination

AVS will continue to use the formal and informal communication links with other agencies assisting family planning efforts in developing countries to ensure that their respective activities complement each other. A common pattern of collaboration with the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO), for example, is for the latter to fund physician training costs and AVS to support service costs, including costs of procedures performed during training. These two agencies agree mutually which will assume responsibility for supporting the equipment repair and maintenance center in any given country. Coordination is advanced by periodic joint meetings with A.I.D. as well as by direct interagency communication. When possible, joint planning of future overseas activities is recommended where this will result in mutual reinforcement or significant program or conference cost reductions. Similarly, AVS frequently supports the voluntary sterilization component of a comprehensive family planning/family health project, the other parts of which are assisted by the International Planned Parenthood Federation, Family Planning International Assistance, or The Pathfinder Fund.

On another level, the respective A.I.D. project managers of centrally funded grants and contracts and the mission population officers have monitoring responsibility to ensure that centrally funded activities are mutually reinforcing and congruent with host country and A.I.D. program objectives.

#### E. Professional and Consultant Personnel

Curricula vitae of senior staff members (chiefs of the major organizational units or divisions and above at headquarters; expatriate staff at regional offices) and of consultants will be sent to the A.I.D. Project Manager for record purposes. The Project Manager will be provided the opportunity of prior review and comment on the selection of top-level executive staff (currently the positions of Executive Director, the Director of International Programs and the chief medical officer). The posting of expatriate staff to regional offices in developing countries requires the prior concurrence of the respective U.S. Missions.

## F. Reporting

Not later than three months after the completion of the grant year, and annually thereafter, AVS will submit to the A.I.D. cognizant technical office a report in twenty (20) copies covering International Project- and World Federation-managed activities during the completed grant period. The report should describe activities, accomplishments, and problems in the areas of program development and execution. It should include a critical analysis of the progress being made in achieving the aims of the grant and should indicate in what ways the original plan was followed or should be modified.

All financial reports and vouchers for payment and reporting of expenditures will conform to standard A.I.D. regulations and procedures.

AVS will continue to require subgrantees providing services to report promptly to AVS the fact and the circumstances of deaths associated with voluntary sterilization procedures and will, in turn, relay such reports to the A.I.D. project manager.

## G. Evaluation

A.I.D. will arrange two comprehensive external evaluations during the project period -- on or about June 1983 and February 1986 -- by a highly qualified team of experts or qualified organizations acceptable to AVS and A.I.D. While the specific scopes of work will reflect A.I.D.'s perceptions of its project management needs at the time of the evaluations, it is expected that they will focus on AVS's program management performance and on progress towards objectives.

From time to time, A.I.D. may request special evaluations of AVS's management of the grant or of selected subgrant projects according to grant management requirements. At the end of the project period, AVS and A.I.D. will conduct an in-house comparison of actual accomplishments and expected results as set forth in the Logical Framework Summary of the Project Design.

AVS plans its own continuous evaluation of the planned respective roles of the International Project and the World Federation. The AVS Executive Committee has acted as follows: "At the end of the five-year period, AVS will review again whether they should bring together both the theoretical and operational components under a unified international agency." To get the information needed for such a determination, "... it was decided that AVS should develop and appoint an evaluation committee to evaluate and to develop criteria for evaluating WFHA-AVSC and the International Project."

These evaluation plans may be altered during the course of the project period to conform to A.I.D. directives unrelated to this specific project.

**PART IV. PROJECT ANALYSES**

**A. Social Soundness Analysis**

Sterilizations performed to save lives or by private physicians for well-to-do clients have long been available in most countries, but on a limited scale. Contraceptive sterilizations, available -- and affordable -- to the majority of people, are a recent phenomenon.

When AVS entered the international field in 1972, sterilization was a part of national government health and family planning services only in India. As the decade closed, at least 19 countries had national voluntary sterilization programs, and surgical contraception had become the world's most commonly used method of birth control. A social change of considerable magnitude is in progress and is moving with unanticipated speed.

The following countries and sterilization prevalence rates are evidence that voluntary sterilization is compatible with a wide range of social, economic, and religious environments:

Colombia	8%	Malaysia	4%
Costa Rica	19	Panama	22
Dominican Republic	12	Philippines	4
El Salvador	18	Sri Lanka	10
India	5	Taiwan	13
Jamaica	8	Thailand	17
Korea, Republic of	18	Tunisia	6

(Source: Population Reference Bureau, from late-1970s surveys.)

There are still a number of countries in which sterilization is not available, for a variety of reasons: legal prohibition, religious opposition, official pronatalist policy which prohibits all family planning, suspicion of U.S. motives in promoting family planning and/or voluntary sterilization, and political timidity in the face of uncertainty about popular support. These policies are subject to modification and reversal, however, as the experience of the 1970s shows. It is relatively common that the manifest acceptability and demand for voluntary sterilization among the public and its support by the medical profession, as demonstrated in small private-sector service projects, give political leaders sufficient confidence to adopt policies making sterilization widely available. Reinforcing this process are the U.N. member states' Bucharest declaration of 1974 that all couples and individuals have the basic human right to the information, education and means to act on their fertility decisions effectively; the greater understanding national leaders gain in international conferences and information exchanges; and the observed actions and experience of other nations.

There is a safeguard in this project against activities' being carried out in countries without the knowledge and approval of the respective governments. As a part of the approval process, Missions are requested to assure A.I.D./Washington that the host government has indicated their nonobjection -- explicitly or implicitly -- to proposed subgrants.

Family planning is one of the most important public health measures potentially available in developing countries to improve maternal and child health. For those developing country couples who already have all the children they want, voluntary sterilization is unquestionably the single most effective method of family planning.

The primary and immediate beneficiaries of AVS-supported projects are women and children. Reducing developing country women's burden of excessive and unwanted fertility improves health by lowering the risks that too frequent births and births of high parity inflict on both mothers and children. The observed trend towards expansion of services to nationwide coverage is increasingly benefiting the rural people who comprise about 80 percent of the developing world's population. When a husband or a wife chooses voluntary sterilization, the economic and health effects of this decision have beneficial implications in terms of outside employment possibilities for the woman, improved care and nutrition for children already born, more possibility of educating children, reduced need for the government to provide future jobs for a constantly expanding work force and, in general, more possibility of the developing country government's being able to meet the human needs of its citizens.

#### B. Technical Analysis

Female sterilizations performed under local anesthesia as outpatient procedures have been made practicable in developing countries by the relatively recent techniques of laparoscopy, culdoscopy, and minilaparotomy. Vasectomy, of course, has always been an outpatient procedure.

The development of outpatient procedures under local anesthesia has removed two major obstacles to the availability of female voluntary sterilization in the developing countries. These are: (1) the scarcity of anesthetists; and (2) the great difficulty most developing country women have in being away from home overnight.

The development and acceptance of a ring or band for tubal occlusion, and the adaptation of the laparoscope for application of the ring (replacing occlusion by electrocautery) have reduced the risks of the procedure and, some believe, increased the chances of successful reversal should that become necessary. A simplification of the laparoscope, the laproscator, has reduced the cost of the equipment and its maintenance. The use of endoscopic techniques is restricted to obstetricians/gynecologists or, at a minimum, experienced physicians with special skills in abdominal surgery. This is a limiting factor in those developing countries with a shortage and maldistribution of obstetricians/gynecologists.

The application of minilaparotomy as an outpatient technique of interval female sterilization has been rapidly accepted in many countries. It is a relatively low-risk, simple technique which can be used by trained nonspecialists, making it especially suitable in largely rural developing countries with few medical doctors. In a few countries, there has been satisfactory experience in the use of trained paramedics, under medical supervision, to perform vasectomies and

minilaparotomies. These have been experimental or limited-coverage projects, but the feasibility of wider application of this approach for countries with severe shortages of medical personnel continues to be examined in various parts of the developing world.

The development of outpatient techniques has lowered the risks and the costs of procedures and sharply reduced hospital bed occupancy time. These characteristics have also increased the acceptability of surgical sterilization to clients.

The skills and knowledge necessary for the delivery of high-quality services can be taught and, with the assistance of AVS and JHPIEGO, in-country training programs are operating successfully in many countries. Similarly, the technical expertise and management capability have been developed in the developing countries where they are needed to maintain and repair endoscopic equipment.

Research is continuing in nonsurgical methods of achieving fertility termination, but no such techniques are expected to become available for general use in the near future. Attempts at reversing male and female sterilizations have had only limited success, although microsurgical techniques have increased the success rate in highly selected cases. Studies and experimentation in techniques of reconstructive surgery as well as sterilization to enhance the probability of successful reversal are continuing. In the meantime, A.I.D. and AVS agree that sterilization must be labeled permanent and irreversible.

In brief, there is a range of technology now available which can ensure the availability of effective, low-risk services in settings ranging from major medical centers to rural clinics and camps.

### C. Economic Analysis

Sterilization is a fertility termination method chosen typically by older, multiparous parents who have completed their desired family size. Termination of subsequent childbearing by women who are sterilized or married to sterilized husbands has a positive economic impact on their family and their larger community.

Firstly, risks to a mother's and child's health and life increase dramatically as the number of births passes three or four. These risks are heightened once a mother passes the age of 30, and are further exacerbated by conditions of poverty prevalent in the developing countries. A large number of pregnancies, in rapid succession, can bring illness and death to a woman poorly prepared nutritionally for pregnancy. Undernourished, often anemic, and generally weakened by the biological burdens of excessive reproduction, these women become increasingly vulnerable to death during childbirth or to simple infectious diseases at any time.

The psychological/emotional costs of maternal illness and death and the death of a new child are inestimable; but these conditions have economic costs as well. In many developing countries the primary income-producing unit is the family, with the wife-mother often engaged in family-centered activity crucial to maintenance of the family's earnings. The lost income or lost in-kind income consequent to her sickness or death is a real cost attributable to excessive

childbearing. Further, the costs of medical care for pregnancy-induced morbidity; costs for hospital/clinic or medicines for child delivery; costs of neonatal care; and costs related to mortality represent savings realizable by termination of excess fertility.

These savings are also realized within developing country health service infrastructures. In many countries up to 50 percent of hospital beds are occupied by pregnancy-related cases. In medical facilities with limited space, supplies and staff, this can result in a serious form of "competition" for medical attention between those people and persons seeking care for other diseases or injuries.

Many countries, particularly those implementing national family planning programs through their national MCH/health programs, have identified anticipated savings in the health sector as an important argument for government support of family planning efforts. Thailand, for example, compared the costs of its family planning program through 1990, and estimated that program costs would be less than the savings which would result in the health sector alone as a result of the reduced demands on health services resulting from decreased maternal/infant morbidity and mortality and fewer births.

Economic effects attributable to declines in excess or unwanted fertility have been discussed extensively in recent years. These effects include changes in the youth-age dependency ratio (fewer consumers to producers), resulting in higher per capita income and declining rate of increase in demand for government services, permitting a shift toward greater public outlays for productive investment; increase in female labor force participation rates; improved labor productivity via better nutrition, health, housing, etc., (by feedback effect of increased per capita income); and acceleration of absorption of idle manpower in the labor force.

A sterilization program, therefore, has economic advantages as both a public health and a fertility reduction activity. Compared to these economic benefits, however, are economic costs. These include, primarily, the cost of the sterilization program itself (personnel, equipment, administrative costs, operating expenses, etc.), plus the income or "product" which would not be produced by children who will not be born. The first cost item -- program cost -- can be identified with some certainty. The other cost -- lost income and product -- is difficult to estimate; but some considerations suggest that it would be a "minus" cost. Recalling that sterilization is typically chosen by older persons who have completed their desired family size, it is likely that many of these women -- if denied access to sterilization -- would seek to terminate subsequent pregnancies by abortion (legal or illegal). In these instances, there would be no "lost" product. There would, in fact, be an additional cost to the individual and the country in maternal morbidity, or possibly death, lost maternal income, and health service costs associated with the abortion or its aftermath. If, on the other hand, the pregnancy is carried to term and the child survives the greater mortality risks associated with multiparity; and if the child survives to the point at which he/she can become productive (e.g., early teens), he/she commences to return the costs of child-rearing. However, further recalling that these births represent "excess" fertility, it should be noted that excess family fertility results collectively in rates of population growth in excess of a country's capacity to adequately prepare or train for productive employment. One consequence of this excess fertility is unemployment and/or underemployment, which can reduce the value of the product generated by persons "excess" to a family's and a nation's optimum economic objectives, to nearly zero, or even minus.

It is hoped that other social and economic development measures undertaken by the developing countries will help to provide greater opportunities for the productive employment and greater human fulfillment of their citizens. The fact remains, however, that present patterns of employment and productivity prevailing in most developing countries present most unfavorable prospects for (and are in large part a consequence of) the excess or unwanted children being born in these developing countries today.

D. Financial Plan

Budget projections for the five years of this project are shown in the following tables. Host country financial and in-kind contributions vary from country to country and are undeterminable.

	(in thousands of dollars)				
	1982	1983	1984	1985	1986
<u>INTERNATIONAL PROJECT:</u>					
1. <u>Management:</u>					
Personnel	\$ 1,150	\$ 1,469	\$ 1,607	\$ 1,730	\$ 1,856
Fringe Benefits	275	353	386	415	445
Travel	103	109	115	122	130
Consultants	87	125	137	168	177
Rent & Utilities	170	222	238	253	274
Services & Supplies	94	135	145	155	165
Equipment	23	25	21	22	23
Communications	67	83	90	99	107
	<u>2,083</u>	<u>2,521</u>	<u>2,739</u>	<u>2,964</u>	<u>3,177</u>
2. <u>Regional Offices:</u>					
Asia	251	300	375	430	490
Africa/Near East	260	310	390	450	510
Latin America	70	100	150	170	200
	<u>581</u>	<u>710</u>	<u>915</u>	<u>1,050</u>	<u>1,200</u>
3. <u>Projects:</u>					
a. Subgrants for services, training, I&E, other; and Small Grants	7,900	8,263	9,763	11,663	13,656
b. Nat'l Associations	1,100	1,360	1,870	2,180	2,597
c. Equipment and Repair/Maintenance Centers	1,200	1,440	1,825	2,200	2,600
	<u>10,200</u>	<u>11,063</u>	<u>13,458</u>	<u>16,043</u>	<u>18,853</u>

	1982	1983	1984	1985	1986
<b>4. <u>Communication Materials:</u></b>					
(Hq. publications, reprints, A-V facilities)	<u>20</u>	<u>31</u>	<u>16</u>	<u>16</u>	<u>18</u>
Subtotals	\$12,884	\$14,325	\$17,128	\$20,073	\$23,248
<b><u>WORLD FEDERATION (Subgrant):</u></b>					
<b>5. <u>Conferences:</u></b>					
International	0	600	0	0	860
Other	250	100	300	300	200
<b>6. <u>Printed Materials:</u></b>					
Consultants	28	40	42	45	45
Production, printing, and distribution	56	85	120	122	132
<b>7. <u>Leadership Activities:</u></b>					
(i.e., Consultant Network, Committee Activities, Special Study Group Activities, Participation in International Conferences and Special Projects)	110	175	205	230	260
<b>8. <u>Technical Assistance:</u></b>	<u>172</u>	<u>175</u>	<u>205</u>	<u>230</u>	<u>255</u>
Subtotals	616	1,175	872	927	1,752
IP Subtotals	<u>12,884</u>	<u>14,325</u>	<u>17,128</u>	<u>20,073</u>	<u>23,248</u>
<b>GRAND TOTALS</b>	<b>\$13,500</b>	<b>\$15,500</b>	<b>\$18,000</b>	<b>\$21,000</b>	<b>\$25,000</b>

E. Environmental Impact

As the world population grows, the potential for disrupting the earth's ecosystem grows with it. Already, (1) desertification due to excessive grazing; (2) deforestation and resultant flooding caused by excessive demand for wood as cooking fuel and for additional land; and (3) pollution of water supplies due to heavily concentrated human habitation and industrial activity are just three of the devastating environmental effects of our current excessive rate of world population growth. Any modality which safely and significantly reduces this rate of population growth will have a favorable impact on the environment. Voluntary sterilization is an example of such a modality.

END-OF-PROJECT EVALUATION

Program for Voluntary Sterilization (932-0966)  
Grant No. AID/pha-G-1128  
(Association for Voluntary Sterilization)

PART I

I-A)	Inputs and Outputs	Submitted by AVS to AID/W
I-B)		June 30, 1980
I-C	Purpose	Prepared by AID/W, DS/POP/FP&D
I-D	Goal	August 19, 1980

PART I-A: OBJECTIVELY VERIFIABLE INDICATORS \*

This part of the evaluation compares actual performance/results with the quantitative projections made in 1977, when Grant No. AID/pha-G-1128 was developed. Thus the document was subdivided into objectives that could be measured according to the logical framework that was presented by AID/Washington, i.e. inputs, outputs, purpose status and assumptions. The objectives extracted from the grant document, AID/pha-G-1128, are summarized and numbered in this introduction. The numbers on each matrix correspond to the numbers used in the summary of objectives. Each goal or objective from the grant document is restated at the top of each page, where it is analyzed in a matrix format according to the "objectively verifiable indicators". \*

1. IPAVS will refund and enlarge existing successful projects and award subgrants to promising new and innovative projects.
2. Major IPAVS initiated service programs in 25 countries will lead to national programs of support for V.S.
  - High quality outpatient VS services known and available for a significant proportion (1 clinic/200,000 pop.) of the population of each LDC where IPAVS has over a 3-year period helped to provide such services:
  - Providing such services as an integral part of the health and family planning program of the LDC.
  - At least 100 potentially self-sustaining IPAVS subgrants providing services in countries around the world.
3. IPAVS will continue to provide increasing amounts of major surgical equipment including:
  - Provision of over \$2 million worth of IPAVS equipment and commodities annually.
4. IPAVS will also arrange facilities and personnel for in-country maintenance and repair of such equipment in 35 countries by 1980:
  - With 40 repair technicians in place.
  - And maintenance facilities established in 22 countries.

\* Note: This list of objectives is from the 1977 Project Paper, not the Grant Agreement, hence is not strictly suitable for evaluation of achievement. US's comparison of accomplishments with these objectives contains much detailed information, however, and is therefore annexed as a

5. Training for physicians and paramedicals (health support personnel) in V.S. to be extended to 50 countries in response to host country requests:
  - Training programs initiated in approximately 40 countries.
  - Training up to 1500 physicians and paramedicals (health support personnel).
6. Further support for information and education.
7. At least one international conference on V.S. will be held in 1980 and will emphasize vasectomy and the male role in F.P. programs and the importance of outpatient procedures.
  - Up to 20 regional and national conferences in support of V.S. will have been held during the 3-year period.
8. Further development and support of NAVS's is envisioned from the present level of 17 such associations to 30 by 1980.
9. Existence of a strong WFAVS.
  - Increased members
  - Role definition
  - Defined activities
10. IPAVS will expand its New York - based staff and will add an OB-GYN specialist.
11. IPAVS will open two to three small regional offices: the first in Asia, the second in Latin America, and a third possibly in Africa. Each will have an outstanding person as program director and the staff will also include an administrator and a secretary.
12. Stressed during this 3-year grant will be:

Provision on-site of a wide variety of F.P. modalities in all IPAVS-supported facilities to make full choice of all methods routinely available:

  - Other F.P. modalities available in all IPAVS supported clinics.
  - With health benefits of V.S. well known in the countries concerned.

13. Increased emphasis during this 3-year period will be placed on cooperative arrangements with other AID-funded F.P. organizations for:

- Delivery of services.
- Arranging of training.
- Supplying and repairing equipment.
- Providing information and education.

For purpose of understanding the matrices, the following definitions are applicable:

- Inputs: Inputs toward the achievement of the objectives as stated for the years 1978, 1979, and 1980.
- Outputs: Results obtained from the inputs. (These include, in some instances, mid-1980 figures.)
- Purpose Status: The extent to which the "End-of-project status" statement originally projected in the grant document is accurate as of mid-1980 for each objective stated.
- Assumptions: The degree of validity of the stated assumption from which each objective was derived. In some cases, "Assumptions" includes the basic IPAVS philosophy used in making the 1977 predictions, rather than the validity of those projections.

1. Refunding and enlarging existing successful projects and by awarding subgrants to promising new and innovative projects.

INPUTS	OUTPUTS	PURPOSE STATUS	ASSUMPTIONS
<p><b>1978</b></p> <ul style="list-style-type: none"> <li>80% of total IPAVS budget was for all program procedures.</li> <li>50 subgrants were awarded               <ul style="list-style-type: none"> <li>29 for service</li> <li>3 for training</li> <li>10 for MAVS's</li> <li>4 for RAM</li> <li>3 for equipment</li> <li>1 for other</li> </ul> </li> <li>Total subgrant awards equalled \$2,869,834.</li> </ul> <p><b>1979</b></p> <ul style="list-style-type: none"> <li>82% of total IPAVS budget was for programs.</li> <li>Total subgrant awards equalled \$6,438,509.</li> <li>81 subgrants were awarded               <ul style="list-style-type: none"> <li>42 for service</li> <li>12 for training</li> <li>11 for MAVS's</li> <li>6 for RAM</li> <li>2 for equipment</li> <li>6 for I &amp; E</li> <li>2 other</li> </ul> </li> </ul> <p><b>1980</b></p> <ul style="list-style-type: none"> <li>Projected for 1980 - \$3,412,950 for service and operational budget is projected for fiscal year 1980.</li> </ul>	<p><b>1978</b></p> <ul style="list-style-type: none"> <li>There were 127 grants active at one point or another for a total of \$6,804,826.</li> <li>Of newly awarded grants, 20 or 40% were new grants, 30 or 60% were continuation grants.</li> </ul> <p><b>1979</b></p> <ul style="list-style-type: none"> <li>There were 146 grants active at one point or another, for a total of \$10,356,388.</li> <li>Of new awarded grants, 29 or 36% were new grants, 51 or 64% were continuation grants.</li> </ul> <p><u>Mid-1980</u></p> <ul style="list-style-type: none"> <li>95 programs are being active in 35 countries.</li> </ul> <p>Additionally, 14 proposals are being reviewed for 8 more countries and 34 more proposals are being developed that will include 5 more countries.</p> <ul style="list-style-type: none"> <li>Of newly awarded grants, 14 or 37% are new grants, 24 or 63% are continuation grants.</li> </ul>	<p>The objective is expected to be met in 1980.</p>	<p>Over the years IPAVS has funded over 400 projects in 48 countries. Potentially IPAVS has been working toward self-sustaining sub-grants. Major inputs from IPAVS funding to encourage self-sufficiency include:</p> <ul style="list-style-type: none"> <li>Developing expertise in developing countries.</li> <li>Incorporating V.S. into curricula at universities and on-going training programs.</li> <li>Acceptance has led to the procedures being performed routinely as part of on-going programs.</li> <li>Assistance has included the development of resources, i.e. space, equipment and set-up for delivery services.</li> <li>All service programs in every phase have had organization and development components, guided by IPAVS staff.</li> <li>There has been an effort to develop management capability to generate further support including:           <ul style="list-style-type: none"> <li>client donations for services</li> <li>medical payments for services within national systems, etc.</li> </ul> </li> </ul> <p>IPAVS sub-grants for training necessarily include a service component. Thus both service training subgrants are service sub-grants.</p>

2. Major IPAVS initiated service programs in 25 countries which have led to national programs of support for V.S.

- High quality outpatient VS services known and available for a significant proportion (1 clinic/200,000 pop.) of the population of each LDC where IPAVS has over a 3-year period helped to provide such services: (See attached country list.)
- Providing such services as an integral part of the health and family planning program of IPC.
- At least 100 potentially self-sustaining IPAVS subgrants providing services in countries around the world.

INPUTS	OUTPUTS	PURPOSE STATUS	ASSUMPTIONS
<p><b>1978</b></p> <ul style="list-style-type: none"> <li>• 58.5% of total IPAVS budget spent for subgrants was awarded for 29 subgrants with service as the primary component.</li> <li>• 58% of total sub-grants awarded had service as primary emphasis.</li> <li>• \$1,678,527 was budgetted for service.</li> <li>• \$99,921 was budgetted for training which includes service.</li> </ul> <p><b>1979</b></p> <ul style="list-style-type: none"> <li>• 49.6% of total IPAVS budget spent for subgrants was awarded for 42 service sub-grants.</li> <li>• 51.9% of total sub-grants was for service.</li> <li>• \$3,196,402 was budgetted for service.</li> <li>• \$94,497 was budgetted for training which includes service.</li> </ul> <p><b>MID-1980</b></p> <ul style="list-style-type: none"> <li>• \$1,423,015 is projected for salaries and training for performing procedures.</li> <li>• \$1,412,950 is projected for services and operational portions of sub-grant programs.</li> </ul>	<p><b>1978</b></p> <ul style="list-style-type: none"> <li>• 8,498 male procedures</li> <li>• 53,644 female procedures</li> </ul> <p><b>1979</b></p> <p>In 1979 four programs became self-sufficient in Korea, two in the Philippines and two in Thailand. These programs are ongoing but no longer report to IPAVS.</p> <ul style="list-style-type: none"> <li>• 12,324 male procedures</li> <li>• 66,549 female procedures</li> </ul>		<ul style="list-style-type: none"> <li>• High quality outpatient VS services are being insured through implementation of the IPAVS Minimum Medical Service Standards (Appendix I).</li> <li>• All service subgrants have focused on high quality in that programs have not focused on technique only, but rather on comprehensive programming including:             <ul style="list-style-type: none"> <li>- information and education</li> <li>- strong counseling components that would lead to reasoned decision making by acceptors</li> <li>- pre- and post-operative care</li> <li>- high quality surgical procedures</li> <li>- patient follow-up.</li> </ul> </li> </ul> <p>IPAVS sub-grants for training necessarily include a service component. Thus both service and training sub-grants are service sub-grants.</p> <p>Wherever and whenever possible V.S. service sub-grants have all been part of the larger health program of a country when family planning and health care services have been available. In training, such intergration with the health program is taught as part of the university curriculum. This training leads back to further programming.</p>

3. IPAVS will continue to provide increasing amounts of major surgical equipment including

- Provision of over \$2 million worth of IPAVS equipment and commodities annually.

INPUTS	OUTPUTS	PURPOSE STATUS	ASSUMPTIONS
<p><b>1978</b></p> <ul style="list-style-type: none"> <li>• \$467,761 worth of equipment was furnished within sub-grants</li> <li>• \$86,797 worth of equipment was furnished via special equipment grants.</li> <li>• \$70,911 worth of equipment was furnished via small grant.</li> <li>• 79 small grant items were furnished to 37 countries.</li> </ul> <p><b>1979</b></p> <ul style="list-style-type: none"> <li>• \$862,505 was expended for equipment items as part of sub-grants.</li> <li>• \$89,175 was funded for special equipment grants.</li> <li>• \$163,241 worth of small grants were awarded for equipment items.</li> <li>• 81 small equipment grants were awarded to 34 countries.</li> </ul> <p><b>1980</b></p> <ul style="list-style-type: none"> <li>• Expenditure of \$1,850,130 is projected.</li> </ul>	<p><b>1978</b></p> <ul style="list-style-type: none"> <li>• 49 laparoscopes were furnished,</li> <li>• 614 minilaparotomy kits.</li> <li>• 180 vasectomy kits.</li> <li>• In addition, O.B. equipment was provided.</li> </ul> <p><b>1979</b></p> <ul style="list-style-type: none"> <li>• 60 laparoscopes were furnished.</li> <li>• 1,676 minilaparotomy kits.</li> <li>• 1,007 vasectomy kits.</li> <li>• In addition, IPAVS supplied major O.B. equipment, (i.e., anesthesia machines, operating room tables, autoclaves, operating room lights, etc.) for dedicated space.</li> <li>• Necessary emergency equipment was provided to assure high quality provision of services.</li> </ul>	<p>Equipment was provided in line with the original projection.</p> <p>An increasing amount of equipment has been issued each year as exemplified in the 13.8% increase in 1978 and double those figures in 1979 and 1980.</p>	<p>(PAVS philosophy has been that contributions of equipment items for dedicated space contributes to eventual self-sufficiency of sub-grantees</p> <p>As well, the provision of high quality services has also required supplying major emergency equipment. Vasectomy kits and minilap kits (less expensive equipment items) make up the majority of equipment furnished. In 1979 laparoscope systems were emphasized as equipment items for sub-grantees.</p> <p>IPAVS has continually reinforced its policy of providing a full range of equipment items for the full range of services that comprise comprehensive programming. Thus, not only surgical equipment is furnished, but also supportive equipment for operating rooms and films, books, tapes, etc. for training purposes and the I &amp; E components of its programs - in other words the full range of equipment items for the full range of services rendered.</p>

4. IPAVS will also arrange facilities and personnel for in-country maintenance and repair of such equipment in 35 countries by 1980:

- With 40 repair technicians in place
- And maintenance facilities established in 22 countries.

INPUTS	OUTPUTS	PURPOSE STATUS	ASSUMPTIONS
<p><b>1978</b></p> <ul style="list-style-type: none"> <li>• 3 new RAM Centers were funded in Indonesia, Mexico and Panama. In addition, 6 other RAM Centers were funded wholly or in part by IPAVS (including Egypt, Thailand, Tunisia, Nepal, Guatemala and Korea.)</li> <li>• Total RAM funding amounted to \$915,438.</li> </ul> <p><b>1979</b></p> <ul style="list-style-type: none"> <li>• Three new RAM Center sub-grants awarded in 1979 were: <ul style="list-style-type: none"> <li>Burkina Faso \$15,000</li> <li>Senegal 28,905</li> <li>Nigeria 44,183</li> </ul>                     for a total of: \$88,126                 </li> <li>• Total grants awarded for RAM centers funding was \$954,397.</li> <li>• All RAM Centers were maintaining approximately 1,000 endoscopic units.</li> </ul>	<p><u>Mid 1980 Status</u></p> <ul style="list-style-type: none"> <li>• 12 countries have established RAM Centers for a total of 18 RAM facilities.</li> <li>• 31 technicians are currently salaried by sub-grants in 12 countries.</li> <li>• However, nine technicians are currently anticipated for training in 1980 in 7 countries.</li> <li>• Additionally, repair capability, (i.e., repair technicians trained) exists in 7 other countries.</li> <li>• A RAM Manager was added to IPAVS Headquarters staff in February 1980. In addition to providing technical assistance and assisting with the establishment of additional repair facilities, the RAM Center Manager will monitor: <ul style="list-style-type: none"> <li>- The number of repairs done as a measure of the activity of RAM Centers &amp; technicians.</li> <li>- The number of repairs/unit.</li> <li>- The man time needed to accomplish repairs.</li> <li>- The mean time between failures in equipment.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Projected was 22 countries with maintenance facilities. <ul style="list-style-type: none"> <li>- 12 countries have Centers i.e., maintenance facilities. 7 additional countries have repair capability.</li> </ul> </li> <li>• Projected was 35 countries with repair capability. <ul style="list-style-type: none"> <li>- However, only 19 countries have repair capability.</li> </ul> </li> <li>• Projected was 40 trained technicians. <ul style="list-style-type: none"> <li>- If the nine anticipated RAM technicians are trained by end of year 1980, this goal of 40 technicians will have been met.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Assumption was that IPAVS would establish all RAM facilities. However, JIPICCO has assumed responsibility for RAM facilities in other countries.</li> <li>• IPAVS is encouraging self-sufficiency in RAM capability and looks forward to government contribution to the RAM Centers in Thailand &amp; Korea.</li> </ul>

3. Training for physicians and paramedicals (health support personnel) in V.S. to be extended to 50 countries in response to those country requests:

- Training programs initiated in approximately 40 countries.
- Training up to 1500 physicians and paramedicals (health support personnel).

INPUTS	OUTPUTS	PURPOSE STATUS	ASSUMPTIONS
<p><b>1978</b></p> <ul style="list-style-type: none"> <li>• 38 sub-grants or 30% of on-going sub-grants had physician training as a component. 16 sub-grants were for training.</li> <li>• \$99,921 of newly awarded sub-grant budgets was for training.</li> <li>• \$1,201,641 was budgetted for salaries and training fiscal year 1978.</li> </ul> <p><b>1979</b></p> <ul style="list-style-type: none"> <li>• 41 or 44% of all active programs had training components. There were national training programs in Morocco, Mexico, Colombia, El Salvador, Tunisia, Korea and Indonesia.</li> <li>• \$943,497 of newly awarded sub-grant budgets was for training.</li> <li>• for salaries and training, \$2,522,817 was budgetted during fiscal year 1979</li> </ul> <p><b>1980</b></p> <ul style="list-style-type: none"> <li>• 19 on-going or current sub-grants during 1980 supported physician or health support personnel training.</li> <li>• \$801,191 of sub-grants budget went to training; for salaries and training \$3,423,015.</li> </ul>	<p>'78 424 MD's Trained 51 Health support personnel</p> <p>'79 674 MD's Trained 249 Health support personnel</p> <p>'80 448 Projected MD's Trained 1,846 TOTAL</p> <p>The IPAVS field clinician is currently developing guidelines for physician training and for follow-up of trainees in IPAVS supported programs, which will tentatively be in effect during late 1980.</p>	<p>Projected were:</p> <ul style="list-style-type: none"> <li>• Training numbering 1500 MD's and health support personnel.</li> </ul> <p>1398 physicians and health support personnel were trained with IPAVS funds 1978-79.</p> <p>An additional 448 more physicians will be trained (approximately) during 1980 bringing the total to 1,846 at the end of the current IPAVS grant, well above the 1500 projected.</p> <ul style="list-style-type: none"> <li>• Training extended to 50 total countries.</li> </ul> <p>(Trainees in VSC have come from 29 countries.)</p> <p>Only 23 programs of training in countries are represented for training among the 58 sub-grants awarded 1978-80. Twenty-five other trainees were supported via the small grant mechanism in fifteen countries, six of which have neither RAM Centers nor sub-grant support for trainees.</p> <ul style="list-style-type: none"> <li>• Training programs in 40 countries.</li> </ul> <p>(Training programs have been established in 23 countries to date).</p> <p>Goals appear to have been on target for numbers of trainees. However, countries in which training took place were less numerous than projected.</p>	<p>It has been a philosophy of IPAVS that male techniques are simpler, and hence, IPAVS has encouraged inclusion of male components into programs even though the obstacles have been great.</p> <p>Training for physicians in female V.S. techniques has occurred in every region of the world, while training for physicians in vasectomy has occurred everywhere except Africa, the Caribbean and Oceania.</p> <p>As part of the comprehensive approach to programming, the numbers of health support personnel being trained have been increased.</p> <p>Training for health support personnel has also occurred in virtually every area of the world since 1972, and, in 1978, in every region except the Caribbean and South America. Notable in 1979 was 98 health support personnel for V.S. services trained for Africa physicians have been trained in female V.S. procedures.</p>

5. (Continued)

INPUTS	OUTPUTS	PURPOSE STATUS	ASSUMPTIONS
<p>27 subgrants for 1980-81 project training for at least 448 more physicians (six of these 1980-81 sub-grants awarded do not specify projections for numbers to be trained).</p>			

6. Further support for information and education.

IMPACTS	OUTPUTS	PURPOSE STATUS	ASSUMPTIONS																
<p>1978</p> <ul style="list-style-type: none"> <li>• 33 subgrants or 64% of new subgrants awarded had I&amp;E components.</li> <li>• 4% of subgrants were spent exclusively for I&amp;E for a total of \$107,334.</li> <li>• Informed consent guidelines were developed and sent to all subgrantees to assist them in arranging counseling services.</li> </ul> <p>A survey of sub-grantees showed them to be nearly 90% in compliance, 5% in partial compliance, 5% developing materials.</p> <ul style="list-style-type: none"> <li>• The IPAVS/NIJ Library collection increased by 42% serials by 26%, reprints by 12% and audio-visuals by 29%.</li> <li>• IPAVS Newsletter began bi-monthly publication.</li> </ul>	<p style="text-align: center;">Summary Tabulation</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">'78</td> <td style="width: 33%; text-align: center;">'79</td> <td style="width: 33%; text-align: center;">'80</td> </tr> <tr> <td>Subgrants with I&amp;E components:</td> <td style="text-align: center;">64%</td> <td style="text-align: center;">65%</td> <td style="text-align: center;">(7)</td> </tr> <tr> <td>Percent of Subgrantee budgets:</td> <td style="text-align: center;">4%</td> <td style="text-align: center;">(7)</td> <td style="text-align: center;">4.7%</td> </tr> <tr> <td>Total sub-grants for I&amp;E:</td> <td style="text-align: center;">0</td> <td style="text-align: center;">6</td> <td style="text-align: center;">(7)</td> </tr> </table> <p>Amount budgeted for I&amp;E components has increased only gradually. A good 65% of sub-grants have I&amp;E components, and that I&amp;E is integrated into this many programs is significant. Compliance with I&amp;E requirements stipulated by IPAVS is another area in which solid accomplishment is documented.</p>		'78	'79	'80	Subgrants with I&E components:	64%	65%	(7)	Percent of Subgrantee budgets:	4%	(7)	4.7%	Total sub-grants for I&E:	0	6	(7)	<p>This objective has been met.</p> <p>The addition of the I&amp;E Specialist to headquarters staff should significantly impact on policies, guidelines and technical assistance on IPAVS's capability in the future.</p>	<p>Because of the sensitive nature of VSC and the methods for carrying it out, education is a basic and required component. Hence, every VS service program must include counselling and informed consent as a basis of sound decision making. IPAVS does require I&amp;E components in subgrants. Some subgrants however, do not lend themselves to I&amp;E components, such as RAM Centers, Administrative grants, special surveys and special equipment grants.</p>
	'78	'79	'80																
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<p>1979</p> <ul style="list-style-type: none"> <li>• 53 subgrants or 65% of new subgrants awarded contained I&amp;E components.</li> <li>• Subgrants devoted entirely to I&amp;E accounted for 30% of all funds allocated for I&amp;E.</li> <li>• 51% subgrants or 7.4% of all subgrants had I&amp;E as the primary component, 53 or 65% of all subgrants had I&amp;E as a component.</li> </ul>																			

7. At least one international conference on V.S. will be held in 1979 and will emphasize vasectomy and the male role in F.P. programs and the importance of outpatient procedures.

• Up to 20 regional and national conferences in support of V.S. will have been held during the 3-year period.

INPUTS	OUTPUTS	PURPOSE STATUS	ASSUMPTIONS
<p>1979</p> <p>• International Conference</p>	<p>4th International Conference on V.S., Seoul, Korea.</p> <p>More than 400 participants from 73 countries, 57 of which were from developing nations. IPAVS supported the attendance of more than 50% of the delegates.</p> <p>81% of conference participants requested IPAVS assistance in response to a questionnaire. The largest percentage of requests for assistance were for I &amp; E programs. Of almost equal concern were requests for training of physicians and health support personnel.</p>	<p>The goal to hold an International Conference in 1979 was met.</p> <p>Emphasis however was changed.</p> <p>With guidelines from USAID it was decided that emphasis of the male procedures should be shared equally with time allotted for the female procedures with emphasis on outpatient procedures for both.</p> <p>The comprehensive approach to programing was emphasized including</p> <ul style="list-style-type: none"> <li>- socio-cultural, political, religious and economic factors that influence V.S.</li> <li>- information and education techniques.</li> <li>- legal and ethical aspects of VS programs.</li> <li>- as well as surgical techniques and their program implications.</li> </ul>	<p>After attendance at conferences, governments or health care facilities abroad apply for IPAVS assistance.</p> <p>Attendance provides a forum for leaders to discuss the problems of building and promoting VS programs.</p> <p>Attendance enhances international understanding and cooperation among countries for the promotion of VS.</p> <p>In this manner IPAVS activities go through the phases from the "seeding effect" of the ideas to actual service and training programs. In this manner as well, cooperation for the promotion of VS is established at the international level.</p>
<p>IPAVS - budget input for conferences:</p>			
<p>1978 - \$167,000 -----&gt;</p>	<p>supported or cofunded 12 conferences in 10 countries including the 4th World Federation General Assembly.</p>		
<p>1979 - 396,000 -----&gt;</p>	<p>supported 9 conferences (and 1 with incomplete information) including 4th International conference on V.S. in Seoul, Korea.</p>		
<p>1980 - 300,000 -----&gt;</p>	<p>Conference involvement increased 50% over 1978 and included involvement in 18 meetings in 14 countries. 4 conferences were IPAVS sponsored.</p>		

**B. NPLS - Further Development and Support of NPLS's (National Leadership Groups)\* Is Favored.**

\*As IPAVS grew more sophisticated in its approach to the development of indigenous private, non-governmental organizations to promote VSC, it became clear that the term "NPLS" did not accurately describe the national organizations working with IPAVS to promote VSC. Hence, the term "National Leadership Group" has replaced "NPLS" as a generic term. "NPLS" now refers to only those groups promoting only VSC. NLC refers to all national groups that have taken the national responsibility for promoting VSC in the private sector.

INPUTS	OUTPUTS	PURPOSE STATUS	ASSUMPTIONS						
<p>The following amounts were budgeted by IPAVS in 1978, 1979 and 1980 for National Leadership Group support:</p> <table border="1" data-bbox="113 462 585 562"> <thead> <tr> <th>1978</th> <th>1979</th> <th>1980</th> </tr> </thead> <tbody> <tr> <td>\$296,000</td> <td>\$522,000</td> <td>\$909,000</td> </tr> </tbody> </table> <p>In 1978, IPAVS spent \$368,572 for direct support to national leadership groups, while in 1979 \$558,728 was spent. 1978 inputs were 21.5% below the budgeted amount while 1979 inputs were 7% above the budgeted amount. The 1980 expenditures for the first six months of 1980 is \$496,115 which is 9.2% above the planned budget.</p>	1978	1979	1980	\$296,000	\$522,000	\$909,000	<p>The status as of mid-1980:</p> <ul style="list-style-type: none"> <li>• IPAVS is currently providing direct financial support to 12 national leadership groups through the subgrant mechanism in the following countries: Bangladesh, Egypt, France, Indonesia, Italy, Korea, Philippines, Sri Lanka, Sudan, Syria, Thailand, Turkey.</li> <li>IPAVS is also providing direct support to the Regional Arab Federation of Associations for Voluntary Fertility Control, which is made up of 8 national Arab health organizations.</li> <li>• IPAVS is also working indirectly with 21 additional established national leadership groups providing various forms of technical assistance and printed material as needed, in the following countries: Australia, Colombia, El Salvador, Great Britain, Guatemala, Honduras, India, Jordan, Hong Kong, Morocco, Nepal, Netherlands, Pakistan, Panama, Rep. of China, Singapore, South Africa, St. Lucia, Tunisia, U.S.A., Venezuela, and Yemen.</li> <li>• IPAVS is currently working with leaders in a number of countries in an effort to assist them to establish national leadership groups. These countries include: Jordan, Brazil, Portugal, Mauritius, Sierra Leone, Morocco, Tunisia, Jamaica, and Peru.</li> <li>• In addition to working to establish and strengthen national leadership groups, IPAVS has assisted these organizations in developing action programs such as provision of service, training of manpower, providing equipment, and repair and maintenance of</li> </ul>	<p>The goal to bring the number of indigenous established national leadership groups to 30 by 1980 was surpassed. Actually, 33 indigenous organizations are working with IPAVS to promote VSC on a national level. In addition, IPAVS has identified nine additional countries where a national organization to promote VSC is desired by the medical leaders and is deemed necessary and realistic.</p> <p>In addition, as expected, the national leadership groups have acted as an important catalyst in their country and have directly stimulated the development of a large number of productive and innovative service, training, and equipment projects. In some cases, IPAVS accomplishments in some countries has depended in a large part on the national leadership group in that country.</p>	<p>At the 1973 second AVS-sponsored International World Conference on VSC, the participants gave IPAVS a mandate to begin to support national leadership groups modeled on AVS-US throughout the world.</p> <p>For the next 3 years, IPAVS assisted in the development of strong national groups promoting voluntary surgical contraception. The process usually begins by the attendance of a national leader at an IPAVS conference, the delegate's returning to his/her native country to study the needs for the promotion of VSC and then a request to IPAVS for support to establish a separate national voluntary association for the promotion of VSC.</p> <p>However, since 1976, it became evident that it was not always appropriate in all countries to establish a separate national group to promote VSC, since an already established national organization, was willing to promote VSC on a national level as part of its activities or was already doing so.</p> <p>In these cases, such an organization was encouraged to set up a special Voluntary Surgical Contraception Committee within its structure to work with IPAVS to develop appropriate VSC projects in country.</p> <p>Therefore, if necessary, IPAVS has been working with leaders in developing countries to assist them in developing the essential elements of strong voluntary organizations, such as:</p> <ul style="list-style-type: none"> <li>• by-laws and constitutions;</li> <li>• committee structures;</li> <li>• organizational goals;</li> <li>• program objectives and activities;</li> <li>• membership recruitment campaigns.</li> </ul> <p>Otherwise, IPAVS has assisted already established</p>
1978	1979	1980							
\$296,000	\$522,000	\$909,000							

IMPACTS	CHITUS	PURPOSE STATUS	ASSUMPTIONS
	<p>endoscopic equipment. National leadership groups have stimulated supplemental programs amounting to \$512,246 in 1978 and \$1,104,841 in 1979. In this way, national leadership groups have initiated a significant amount of IPAVS service, training and equipment subgrants.</p>		<p>the VSC needs in their countries to develop appropriate VSC programs.</p> <p>Local indigenous leadership groups can identify appropriate country needs and develop specific strategies, making use of the local professional communities to promote VSC.</p> <p>IPAVS is convinced that its efforts to work with local leaders through indigenous organizations have been a major reason for its significant accomplishments</p>

9. Features of a Strong WFAS.

- Annual General Assembly
- Increased Members
- Specific Program Plan
- Improved Role Definition

INITIATIVES	ACTIVITIES	PURPOSE STATUS	ASSUMPTIONS												
<p>• <u>Annual General Assembly</u></p> <p>In the initial planning for the World Federation during this grant period, it was envisioned that a General Assembly would be held each year, bringing together all the members of the Federation. This input has been fully complied with, since the Fourth, Fifth and Sixth General Assemblies have been held as planned. In addition, member attendance has been excellent. The General Assemblies and the committee meetings that take place during the General Assembly meeting have been the backbone of World Federation programs to date, as shown in the <u>MEMBERS</u> column.</p> <p>• <u>Membership Recruitment</u></p> <p>It was evident from the initial inception of the Federation that if the Federation was to be strong and successful, good representation from around the world would be necessary. It was felt that a steady increase in membership would be essential for success. The following table shows the membership growth:</p> <table border="1" data-bbox="120 1276 556 1344"> <thead> <tr> <th>1975</th> <th>1976</th> <th>1977</th> <th>1978</th> <th>1979</th> <th>1980</th> </tr> </thead> <tbody> <tr> <td>8</td> <td>12</td> <td>16</td> <td>22</td> <td>27</td> <td>30</td> </tr> </tbody> </table> <p>Growth in numbers has been steady since 1975. However, there now seems to be a trend towards slow or no growth and membership recruitment will certainly be more difficult in the future.</p> <p>• <u>Program Plan</u></p> <p>A three year program plan was</p>	1975	1976	1977	1978	1979	1980	8	12	16	22	27	30	<p>1978</p> <ul style="list-style-type: none"> <li>• Membership Guidelines were refined.</li> <li>• Appropriate WF documents were translated into Arabic, French &amp; Spanish.</li> <li>• Committee Procedures Manual was prepared.</li> <li>• Official and collaborative relationships with 16 international and national organizations were established</li> <li>• A survey was completed of all WF members to elicit baseline data on training needs and existing training programs, as well as equipment needs.</li> <li>• An inventory of IIE approaches, activities and materials was carried out by the IIE Committee.</li> <li>• A questionnaire on nomenclature was distributed to all members by the Expert Group on Nomenclature, soliciting information on the use and understanding of the word "sterilization."</li> </ul> <p>1979</p> <ul style="list-style-type: none"> <li>• The committee membership was reviewed and restructured to strengthen committee expertise and output.</li> <li>• A legal committee established and members appointed.</li> <li>• "Provisions for a Model Law on Voluntary Sterilization," based on recommendations of the Second, Third and Fourth International Conferences on Voluntary Sterilization, was drafted.</li> <li>• WFAS was represented at the UNFPA-sponsored International Parliamentary Conference on Population and Development held in Sri Lanka, August 28 - September 1, 1979 and at</li> </ul>	<p>The goals set for the World Federation have been met in that the Federation has grown in scope, membership, and organizational sophistication.</p> <p>In addition, a major breakthrough was the result of the Select Study Group which defined the role of the Federation and, more importantly, clearly showed that an organization such as the World Federation is badly needed.</p> <p>With the recent change in name, the Federation is making it clear that it is responsive to world needs.</p>	<p>As the number of national leadership groups grow and these groups matured, it became evident that there was a need for a unifying forum for the international voluntary sterilization movement, to provide representation, focus, and coordination at the international level. This concept was developed at the June 1974 IPAVS-sponsored Developmental Workshop on V.S., and the World Federation formed. The Federation became a legal entity upon its incorporation on January 22, 1975.</p> <p>The World Federation has acted on an international level to promote the growth in acceptance and availability of voluntary sterilization as a basic component of health services and family planning programs around the world.</p> <p>The Federation serves through its member associations and affiliates, as a unifying forum for the exchange of information, knowledge and research concerning VSC.</p> <p>It is quite clear from the sensitivity and controversy surrounding surgical contraception, that these groups working to promote VSC, and therefore the Federation, should be considered high risk organizations. Their work requires innovation, diplomacy, and sometimes tremendous risks (politically) to achieve their goals.</p>
1975	1976	1977	1978	1979	1980										
8	12	16	22	27	30										

EVENTS	CRIPWIS	PURPOSE STATUS	ASSUMPTIONS
<p>developed in 1977, that outlined the planned activities of the Federation from 1977 to 1979. In 1980, a new five year program plan was developed and this plan is now being refined and implemented.</p> <p>• <u>Improved Role Definition</u></p> <p>It has always been a goal of the Federation to better define its role in the international family planning and public health community. In early 1980 a special Select Study Group was established by WFVS to study the current activities and needs in this international community and to determine how the Federation could best serve those needs. The Study Group identified four areas of need that the World Federation should work in:</p> <ul style="list-style-type: none"> <li>- Analysis and formulation of policy.</li> <li>- Development of international standards and guidelines for WIC.</li> <li>- Interagency coordination.</li> <li>- WIC clearing house.</li> </ul> <p>The Executive Committee and Program Planning and Evaluation Committee have both adopted these findings and the new five year program plan is based on the Select Study Group's recommendations.</p>	<p>the IDPTA-ICO Consultation meeting held in Geneva, April 4, 1980.</p> <ul style="list-style-type: none"> <li>• A WFVS application for ICO status was submitted to ECOSOC. The application will be considered by the ECOSOC Review Committee in the fall of 1980.</li> <li>• Formal membership applications for collaborative relationships were submitted to two organizations: The National Council for International Health and the International Council for Voluntary Agencies.</li> <li>• An informational exhibit on the Federation was prepared for use by member associations.</li> <li>• The IAE Committee conducted a formal survey of IAE activities of all member organizations and collected information regarding IAE policies and guidelines from other international organizations.</li> <li>• A revised draft of the Committee Procedures Manual was developed.</li> </ul> <p><u>1980</u></p> <ul style="list-style-type: none"> <li>• Special study papers on the international family planning/health community and the role of the Federation were developed.</li> <li>• The Select Study Group developed recommendations that defined the role of the Federation in terms of the needs in the international family planning/health community.</li> <li>• A separate World Federation office was established outside WFVS structure.</li> <li>• The name of the Federation was changed to the World Federation of</li> </ul>		

9. Existence of a Strong WAVS. Page 1

INPUTS	OUTPUTS	PURPOSE STATUS	ASSUMPTIONS
	<p>Health Agencies for the Advancement of Voluntary Surgical Contraception to better reflect the broad purpose and goals of the Federation.</p>		

10. IPAVS will expand its New York - based staff and will add an OB-GYN specialist.

INPUTS	OUTPUTS	PURPOSE STATUS	ASSUMPTIONS
<p><b>1978</b></p> <p>The number of IPAVS staff more than doubled during 1978; as of November 1978 there were 43 authorized personnel (including R.O. staff) which included 27 administrative/technical and 16 support staff members.</p> <p><b>1979</b></p> <p>1979 approved positions included 35 administrative/technical and 20 support staff, for a total of 55 staff.</p> <p>Mid 1980 staff includes 28 administrative/technical and 20 support staff, for a total of 48 approved positions, presently filled.</p> <p>There are 38 authorized administrative/technical and 23 support staff positions for a total of 61 authorized positions. Corresponding with this increase is 12 for the Dacca office and 9 staff for the Tunis office.</p> <p>In 1978, IPAVS added a field physician (obstetrician/gynecologist) to assist IPAVS sponsored clinics around the world in providing and maintaining quality medical services. The physician's role is to assess the facilities, equipment, delivery of services, and the quality of surgical procedures performed in order to ensure that all facilities and procedures meet IPAVS standards.</p> <p>He also assesses physician and health support personnel training programs, offering assistance and</p>	<p>Three medical site visit tours were completed during 1978. He represented IPAVS at 2 conferences during 1978. Six country programs were visited for MSV's during 1979. He again represented IPAVS at 5 conferences during 1979.</p> <p>Two country programs were visited thus far during 1980.</p> <p>IPAVS Medical Standards have been completed in 1980.</p> <p>IPAVS Training Guidelines will be completed by end-year 1980.</p>	<p>During 1980, since IPAVS has made substantial changes in its personnel policies, salary structure, and benefits. As a result, the organization should be in a more competitive situation for recruiting qualified personnel.</p>	<p>The IPAVS goal has not been to simply increase staff at N.Y. headquarters. The trend is to increase regional staff since it is a regional staff will be more responsive to local needs because they will be more knowledgeable, and that their assumptions will be more sensitive and relevant. It is thus projected that N.Y. based staff will provide the regional staff with sound backup, and its numbers will only correspond to field and regional support needs. The New York staff will have to move into more sophisticated planning and technical back stopping functions.</p>

10 IPAVS will expand its New York - based staff and will add an OB-GYN specialist.

INPUTS	OUTPUTS	PURPOSE STATUS	ASSUMPTIONS
<p>technical advice as needed.</p> <p>A key responsibility of the field physician's position is advising on and drafting standards for IPAVS medical services, training, and other areas where medical input is required, i.e. g 'delinea for future IPAVS involvement in infertility.</p>			

11. IPAVS will open two to three small regional offices: The first in Asia, the second in Latin America, and a third possibly in Africa. Each will have an outstanding person as program director and the staff will also include an administrator and a secretary.

INPUTS	OUTPUTS	PURPOSE STATUS	ASSUMPTIONS
<p>1978 \$58,000 for development</p> <p>1979 \$161,000 for one Regional office and development of a second.</p> <p>1980 \$300,000 for 2 Regional Offices; one in Asia, the other for Africa and the Middle East.</p>	<p>In April 1979, the IPAVS Regional Office for Asia was opened in Dacca, Bangladesh. The office assumed full responsibility for Bangladesh. Regional Representatives visited all 8 countries in the 2 regions for which the Asia office is responsible. Staffing included 10 personnel during 1979 and will include 12 during 1980. The additional staff will include a Field Clinician and an additional Program Officer.</p> <p>Mid 1980 - May 1, 1980 the IPAVS Regional Office for Africa and the Middle East was opened in Tunis, Tunisia with an Administrative Director. Total staffing is expected to reach 2 by end 1980, with staffing completed by a range of professionals and support personnel from Africa and the Middle East.</p> <p>The IPAVS strategy for a Latin America Regional Office was under development in 1979. By Mid-1980 it was decided that the interests of the region can best be served by a New York based Regional Office for the present time.</p>	<p>The goal of establishing 2 IPAVS regional offices by the end of 1980 has been met. However, their development region-wise was different from what was originally hypothesized. Staffing for the Regional Offices has surpassed the presumptions made in 1977.</p>	<p>IPAVS' purpose in establishing regional offices has included the following:</p> <ul style="list-style-type: none"> <li>• staff would be closer to the action or region.</li> <li>• such staff would be more knowledgeable, sensitive and responsive to the needs of the population in developing country programs.</li> <li>• More meaningful relations should be established with the sub-grantees and leadership so that a working relationship could develop and evolve.</li> <li>• In establishing better relations with a region's leaders, their contribution at the international level would be more responsible and effective</li> <li>• More effective technical assistance could be given by IPAVS at the national and regional levels.</li> <li>• These would hence develop a greater internal absorption and use of technical skills by developing nations.</li> <li>• A long range goal is that, thusly, the country and/or region is better equipped for self-help.</li> </ul>

12. Stressed during this 3-year grant will be Provision on-site of a wide variety of F.P. modalities in all IPAVS-supported facilities to make full choice of all methods routinely available;

- Other F.P. modalities available in all IPAVS supported clinics
- With health benefits of V.S. well known in the countries concerned.

INPUTS	OUTPUTS	PURPOSE STATUS	ASSUMPTIONS
<p>IPAVS Contractual Provisions for subgrantees explicitly states that: "The sub-grantee shall insure that any surgical sterilization procedures supported in whole or in part by funds from this sub-grant are performed only after the individual has given his/her voluntary consent to the sterilization procedure." Informed voluntary consent as one of its provisions states that the subgrantee must appraise the individual that "there are temporary methods of contraception that are available to him/her. These provisions are included in the Minimum Medical Standards and are strictly monitored.</p>	<p>All VS service projects funded by IPAVS have available temporary methods of contraception for those individuals who so chose instead of sterilization.</p>	<p>Although this objective has been met, IPAVS will continually emphasize surveillance of its programs to ensure that all family planning methods are available in all of its funded clinics.</p>	<p>Basic IPAVS philosophy is that</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization should be part of the comprehensive family planning and health programs in the countries where it is supported.</li> <li>• The full range of options for family planning should be explained to each acceptor so that he/she can make a reasoned, non-coerced decision to undergo V.S.</li> </ul> <p>IPAVS has been gratified by the response shown to its programming in many countries. One example is Colombia where word-of-mouth exchange ideas spread from prior acceptors to future acceptors. The demand for V.S. in Colombia is presently greater than that IPAVS funding can support.</p>

13. Increased emphasis during this 1 year grant period will be placed on cooperative arrangements with other AID-funded F.P. organizations for

- Delivery of services;
- Arranging of training;
- Supplying and repairing equipment; and
- Providing information and education.

INPUTS	OUTPUTS	PURPOSE STATUS	ASSUMPTIONS
<p><b>1968-69</b></p> <ul style="list-style-type: none"> <li>• At least 10 programs have been jointly funded by IPMS and by other USAID funded agencies. These programs are currently being developed for joint funding. (See Attached Table)</li> <li>• IPMS commands excellent for teaching with:               <ul style="list-style-type: none"> <li>- CRFA</li> <li>- PRKO</li> <li>- University of Chicago</li> <li>- Sargent Sargent</li> <li>- Rockefeller Hospital NY Teaching Program</li> <li>- Dominica Medical Center teaching program.</li> </ul> </li> <li>• IPMS has utilized consultant/technical assistance services from:               <ul style="list-style-type: none"> <li>- CRFA</li> <li>- PRKO</li> <li>- UNP</li> </ul> </li> <li>• Statistics/Information have been shared with organizations from:               <ul style="list-style-type: none"> <li>- Population Crisis Committee</li> <li>- Center for Population and Family Health</li> <li>- Family Index</li> <li>- Population Council</li> <li>- Population Information program</li> <li>- PAFSA</li> </ul> </li> <li>• IPMS regularly participates in donor agency coordination meetings</li> <li>• There is an interagency liaison</li> </ul>			<p>An assumption is that IPMS strives to coordinate with other agencies as appropriate. IPMS has made inroads in this area as the attached table shows and this will be an area of future commitment.</p>

11. Increased emphasis during this 1-year grant period will be placed on cooperative arrangements with other AID-funded F.P. organizations for

- Delivery of services;
- Arranging of training;
- Supplying and repairing and equipment; and
- Providing information and education

INPUTS	OUTPUTS	PURPOSE STATUS	ASSUMPTIONS
<ul style="list-style-type: none"><li>- APLIC</li><li>- SI/RI Regional Medical Library</li></ul>			

-23-  
Cooperative Arrangements With Other AID-Funded Organizations,  
1978-80

TABLE A.

<u>Subgrant No. &amp; Country</u>	<u>Subgrantee Agency</u>	<u>Other Donor Agencies Involved</u>	<u>BRIEF Program Description</u>
<u>Benin</u> 341-187-1 1980-81	Comite National de Benin pour la Promotion de la famille	International Planned Parenthood Federation	Information & Education Camps in Benin
<u>Brazil</u> 394-070-5 1980-81	CPAIME	IPAVS is funding services in conjun- tion with a JHPIEGO funded National training program	Female Services (laparos- copy & minilap) program - 1500 procedures
<u>Colombia</u> 337-171-1 1979-80	Profamilia	JHPIEGO (IPPF affiliate)	I & E Program (Colombia MOH, JHPIEGO & Profamilia are training M.D.'s & paramedics in la M/L, providing equipment establishing a RAM. Under IP307-155-1, we are pro- viding institutional reim- bursement for the practical training.) This s.g. pro- vides I & E about the pro- gram (service) program.
<u>Colombia</u> 307-155-2 1979-80	Profamilia	JHPIEGO (IPPF Affiliate)	See bracketed information under 337-171-1
<u>Ecuador</u> 342-170 1979-80	APROFE	IPPF	Training Program at APROF VS Center (Enrique Sotomayer Maternity Hospital.) Services in conjunction with training are supported jointly by IPPF & the hospital.
<u>Guatemala</u> 317-173-1 1980-81	APROFAM	IPPF	Ditto, Multisite service training + RAM Center
<u>Honduras</u> 350-173-1 1980	HFFA	IPPF	Consolidated program, IPPF provides temp. FP and one administrative support.

<u>Subgrant No. &amp; Country</u>	<u>Subgrantee Agency</u>	<u>Other Donor Agencies Involved</u>	<u>BRIEF Program Description</u>
<u>Korea</u> 145-055-4EM 1980	KAVS	Gov't of Korea UNFPA	UNFPA has provided 95 scopes and dollars to the gov't. for repairing scopes. This in turn was given to KAVS.
<u>Mexico</u> Prop. 363	FPA of Tijuana	FPIA	Service delivery program. F provide temp. FP and promot
<u>Mexico</u> Prop. 388	FPA of Monterrey	FPIA	" " "
<u>Morocco</u> 344-172-1 1979-80	MOH	USAID/Rabat PIEGO	National Training Center w/RAM capability
<u>Nigeria</u> 272-169-1 1979-80	Medicare Family Health Program	Luthern World Relief	Information & Education Program
<u>Pakistan</u> 052-043-4 1979-80	Lady Dufferin Hospital	UNICEF WHO	V.S. service program with other donors providing \$ for immunizations & nutrition activities
<u>Panama</u> 04-128-2 1980	Ministry of Health	KLI - Trained Technician	RAM Center
<u>Sri Lanka</u> 186-152-2 1979-80	FPA of SL	IPPF	Minilap program at Maternity Home
<u>St. Lucia</u> 164-106-3 1980-81	St. Lucia Family Planning Association	1) IPPF	Female VS; information & education
<u>Sudan</u> 155-123-3N 1979-80	Sudan Fertility Control Assoc.	International Fertility Research Program	Administration of SFCA
<u>Tunisia</u> 360-180-1 1980	ONPFP	JHPIEGO USAID/TUNIS (for training only)	Involves funding for the El Ariana and Baris Clinics (services), National Training Center, & RAM Center. In 19 it will include funding of a ONPFP projects (Thirteen res service centers)
<u>Indonesia</u> Prop. 367	Pathfinder	Previously funded by Pathfinder.	Training program
<u>Philippines</u> 101-086-(1-4)	FPOP	funded for 4 years IPPF	Itinerant team and training

**Part I-B. OBJECTIVELY VERIFIABLE INDICATORS FROM THE PROJECT DESIGN SUMMARY (Supporting Documentation to Matrices 1-14)**

This section takes parts 3 and 4 of the Project Design Summary sheet and compares data that was presented by AID/Washington with the most current IPAVS data. This information is presented in the following tables:

**Table 1: Comparison of AID Projections - Countries Served and Subgrants Awarded, With IPAVS Date, by Category, 1978, 1979, 1980. (Outputs)**

**Table 2: Comparison of IPAVS Actual Expenses and AID Supplied Budget Projections, 1978-80. (Inputs)**

1. Comparison of AID Projections, Countries served and subgrants awarded, with IPAVS data, by category, 1978, 1979, 1980. (Following outline recommended in Project Design Summary Logical Framework)

Variable	1978		1979		1980	
	AID Projected	1978-79	AID Projected	1979-80	AID Projected	Mid-1980 (or projected)
<b>V.S. service and/or I&amp;E project:</b>						
Countries	45	23	60	34	65	34
Subgrants Awarded	50	50	60	81	85	95
\$Total Awards		\$2,869,834		\$6,438,509		(?)
<b>Major service projects leading to National V.S. programs:</b>						
Countries	15	4	20	9	25	14
<b>V.S. training for N.D.'s and health support personnel:</b>						
Countries	20	16	30	25	40	30
Trainees	300	475	450	923	800	448 N.D.'s + (?) h.s.p.
<b>Provision of Major V.S. equipment including repair capability:</b>						
Countries via Subgrants	10	22	15	30	22	36
Countries via Small Grants		22		16		4
Technicians trained	15	(?)	25	(?)	40	31 + 9 projected

Variable	1978		1979		1980	
	AID Projected	1978-79	AID Projected	1979-80	AID Projected	Mid-1980 (or projected)
Dedicated Space for V.S.:	10		15		25	
Countries		7		12		15
Dedicated Space		9		23		31
Existence of National Associates for V.S. (countries)	22	22	26	28	31	33 +1 regional
International, Regional and National conferences for V.S. (Numbers annually during grant period)	6	11	7	12	6	8 complete 1 contem:
<p>In total, IPA VS has been involved in 50 countries since 1972.</p> <p>Best IPA VS estimates for National V.S. programs include:</p> <p>1978 Bangladesh; Guatemala, Korea and Thailand;</p> <p>1979 The above plus Barbados, Colombia, Mauritius, Mexico and Morocco;</p> <p>1980 All of the above plus Honduras, Nepal and Tunisia. Indonesia and Brazil have national training programs that will lead to comprehensive national programs.</p> <p>Two of these are national training programs leading to comprehensive national programs.</p>						

**1978-80 (AID Funding; Monitoring; Evaluation)**

	1978		1979		1980	
	AID Budget	Actual	AID Budget	Actual	AID Budget	Estimated
Personnel and Management Expenses N.O.	845,000(40)	576,000 +83,000 +58,000 <u>717,000</u> N.Y. (43)	916,000(50)	652,000 124,000 163,000* <u>939,000</u> N.Y. (55)	1,160,000(55)	1,035,000 228,000 <u>370,000**</u> 1,633,000 N (6)
Participants and Training	700,000	50 Grants 1,201,641	900,000	79 Grants 2,522,817	1,200,000	(?) Grants 37 already 3,423,015 awarded
National Association	600,000	394,000	850,000	522,000	1,070,000	909,000
Equipment and Maintenance	1,200,000	1,207,508	1,500,000	904,876	2,000,000	1,850,130
Services & Support of Institutions	1,300,000	866,787	1,500,000	2,666,710	2,200,000	3,412,950
Information & Education	248,000	156,317	394,000	306,597	592,000	459,330
Conference	350,000	147,000	500,000	594,000	400,000	300,000

Budget figures are from the AID Project Design Summary Logical Framework.

1. represents costs only, not carry-over obligations to sub-grantees. It is anticipated that there will be approximately 10,000 in carry-over obligations at the end of the IPAVS fiscal year 1980.

2. Estimated for 1980 derived from computer based data.

The following IPAVS budget categories are not included in these projections: Consultants, Rent and utilities, Equipment and Furniture, Supplies and Services, Communications, & Travel and subsistence. In 1978 these amounted to \$429,000. In 1979 they amounted to \$420,000. It is projected that in 1980 these will amount to \$655,000.

D. include budgeting for 10 Dacca Staff.

Part I-C. PROGRESS TOWARDS PURPOSE ACHIEVEMENT

**Purpose Statement:** To make high-quality voluntary sterilization services well known and readily available to couples in LDCs as an integral element of health and family planning programs wherever such services are desired. (Logical Framework)

**End of Project Status:** One high-quality integrated outpatient voluntary sterilization clinic readily available for approx. every 200,000 of population in each developing country where AVS has provided major program support for three years or longer. (Logical Framework)

Country	No. of Full-Service Clinics (i.e., VS Services Included)		Mid-1979 Popula- Population (est. millions)	Population per Clinic
	1975	12/31/79		
Bangladesh	33	255	87.1	341,569
Egypt	n/a	n/a	40.6	n/a
El Salvador	23	32	4.5	140,625
Guatemala	n/a	17	6.8	400,000
Honduras	2	16 (12/78)	3.1	193,750
Indonesia	n/a	200	140.9	704,500
Korea	843	2,267	37.6	16,586
Mexico	40	750	57.7	90,267
Philippines	184	854	46.2	54,289
Sri Lanka	50	70	14.5	207,143
Thailand	350	512	46.2	90,234
Tunisia	60	60	6.4	106,667

Population data are mid-1979 estimates from the "1979 World Population Data Sheet" of the Population Reference Bureau. Clinic data are from USAID's annual family planning statistical reports.

AID/W, OS/POP/FPSD

8/19/80

(Sri Lanka data updated 4/27/81)

Part I-D. PROGRESS TOWARDS GOAL ACHIEVEMENT

Goal Statement: To improve maternal health, reduce infant mortality, and decrease unwanted fertility by the integration of voluntary sterilization services into LDC health care systems. (Logical Framework)

Measures of Goal Achievement: Decreases in maternal and infant mortality rates, improvements in life expectancy, and decreases in birth rates and total fertility rates. (Logical Framework)

Countries selected for assessment of movement towards Goal achievement are those in which AVS has contributed major resources for three years or more.

Data were supplied by DS/POP/Research. Insufficient data are available for maternal mortality rates or other measures of maternal health.

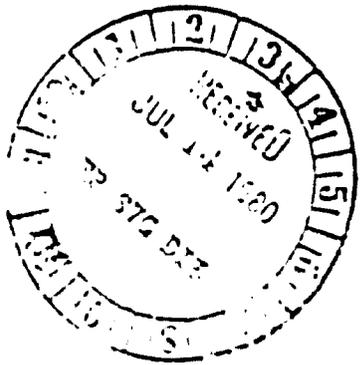
	<u>Infant Mortality</u>	<u>Life Expectancy at Birth</u>	<u>Crude Birth Rate</u>	<u>Total Fertility Rate</u>	<u>Prevalence of Contraceptive Use</u>	<u>Sterilization Prevalence</u>
<b>Bangladesh</b>						
1970	-	38.0	48.0	7.0	-	-
1975	-	42.0	47.0	6.8	7.8 (76)	1.0 (76)
1980	153.0	45.0	46.0	6.5	-	-
<b>Egypt</b>						
1970	117.0	52.0	34.8	-	-	-
1975	103.0	55.0	37.7	-	-	-
1980	85.0	57.0	41.0	5.3	-	-
<b>El Salvador</b>						
1970	-	58.0	40.0	-	-	-
1975	58.1	61.0	39.9	-	22.0	-
1980	51.0	63.0	39.7	5.9	34.0 (78)	18.0 (78)
<b>Guatemala</b>						
1970	89.0	53.0	41.6	-	-	-
1975	81.4	56.0	40.9	6.1	-	-
1980	76.0	59.0	42.9	5.7	17.0 (78)	7.0 (78)
<b>Honduras</b>						
1970	-	54.0	50.0	7.3	-	-
1975	115.0	57.0	49.0	7.2	-	-
1980	103.0	59.0	47.0	6.9	-	-
<b>Indonesia</b>						
1970	125.0	48.0	42.0	5.6	-	-
1975	-	50.0	38.0	5.1	-	-
1980	91.0	53.0	35.0	4.8	26.0	-
<b>Korea</b>						
1970	-	61.0	29.8	4.3	34.8 (74)	-
1975	60.0	63.0	23.0	3.1	44.2 (76)	-
1980	38.0	65.0	21.0	2.8	50.0 (79)	18.0 (79)
<b>Mexico</b>						
1970	74.0	63.0	43.0	6.5	-	-
1975	69.0	66.0	42.0	6.2	-	-
1980	60.2	67.0	37.0	5.2	40.0 (78)	7.0 (78)
<b>Philippines</b>						
1970	-	58.0	40.0	5.7	-	-
1975	-	61.0	37.0	5.4	-	-
1980	80.0	63.0	34.0	5.0	37.0 (78)	4.0 (78)
<b>Sri Lanka</b>						
1970	46.0	68.0	29.4	4.2	-	-
1975	45.0	69.0	27.7	3.5	32.0 (76)	10.0 (76)
1980	42.5	70.0	28.5	3.4	-	-
<b>Thailand</b>						
1970	90.0	58.0	39.0	5.5	14.8	7.6
1975	-	60.0	35.0	4.7	36.7	9.6
1980	68.0	63.0	29.0	3.8	51.3 (78)	17.0 (78)
<b>Tunisia</b>						
1970	-	54.0	37.0	6.2	-	-
1975	-	57.0	35.4	-	-	-
1980	-	59.0	33.0	5.7	19.0	6.0

END-OF-PROJECT EVALUATION

Program for Voluntary Sterilization (932-0968)  
Grant No. AID/pna-G-1125  
(Association for Voluntary Sterilization)

PART II

IPAVS AS AN AGENT OF SOCIAL CHANGE



## TABLE OF CONTENTS

Page

### IPAVS As An Agent of Social Change:

Impact on Legal Status .....	1
Impact on Policy Change .....	17
Impact on National Programs .....	21
Impact of Conferences on Voluntary Sterilization .....	24
Impact on the Knowledge and Understanding of the Health Community .....	29
Impact on the Knowledge and Attitudes of the General Public .....	31

**IMPACT ON LEGAL STATUS**

# DIGEST

(EXCERPT)

## Worldwide Laws and Policies on Contraception, Abortion and Sterilization Affect Service Provision

Two recent reviews of the worldwide status of laws and policies governing the practice of contraception, sterilization and abortion document striking changes that have taken place over the past decade:

- At least 30 countries now permit noncoercive provision of the pill and the IUD.
- The conditions for contraceptive sterilization have been relaxed in 17 countries, but the operation has been banned in two.
- In 42 countries, the grounds for legal abortion have been extended.

However, as the reviews by the International Planned Parenthood Federation (IPPF)<sup>1</sup> and the United Nations Fund for Population Activities (UNFPA)<sup>2</sup> make clear, "Laws and policies continue to frustrate efforts to spread family planning information and services."

### Sterilization Laws

Voluntary sterilization, according to the UNFPA survey, has created a "newly arising issue of medical law." Often, legislation pertaining to voluntary sterilization is inconsistent or nonspecific, and is frequently related to sections of national criminal codes dealing with infliction of bodily harm rather than with medical practice. In France, the survey points out, "there are no specific provisions on voluntary sterilization as a means of birth control . . . . However, until quite recently, French legal writing taught that

such an operation was unlawful and, despite consent of the patient, constituted a crime. . . ." In Belgium, where sterilization for family planning purposes was held to be unlawful despite the consent of the patient, "its practice was not prosecuted if operations were performed by physicians under regular medical conditions."

Many countries define the age and parity women must attain before they can obtain legal sterilization; some countries require spousal consent; and sterilization for the mentally incompetent is often restricted. In the United States, for example, regulations of the Department of Health and Human Services (formerly the Department of Health, Education and Welfare) prohibit the use of federal funds for the sterilization of minors, persons legally incompetent for reasons other than their age, and institutionalized persons.

The IPPF handbook notes that in 19 countries, the legal status of voluntary sterilization changed between 1970 and 1978. In all but two, access to sterilization was broadened. In Chile, however, where sterilization had previously been available for medical and socioeconomic reasons upon decision by committee, a 1975 Ministry of Health resolution stipulated that the procedure "ought not to be considered a method of fertility regulation" and that it could only be performed on medical grounds. And in Peru, under a 1976 Supreme Decree approving the guidelines of the country's new population policy, sterilization was prohibited as a means of fertility control.

In Romania, according to the UNFPA, sterilization is not practiced because it is incompatible with the country's strong commitment to population growth. Under a 1963 revision of the Spanish criminal code, sterilization is a criminal offense, and in Turkey, the procedure is subject to criminal prosecution unless performed for health or genetic reasons. In Venezuela, the code of medical ethics bars sterilization unless future pregnancies would pose a threat to the woman's health or there is substantial evidence that she would bear children with serious malformations.

In its section on sterilization, the IPPF handbook includes a proposal for a model voluntary sterilization statute which incorporates the concept of freedom from coercion and the right of couples to elect sterilization as a form of fertility control. The handbook also contains samples of the various types of consent forms recommended by the IPPF and the International Program of the Association for Voluntary Sterilization, including a model form recommended for use with illiterate acceptors.

<sup>1</sup>For a description of the investigative impact of the legislation, see "Romania Sterilization Abortion, Birth Control Issues, Domestic Birth," *International Family Planning Perspectives*, 6, 2 (1978).

BEST AVAILABLE DOCUMENT

## CITE SPECIFIC EXAMPLES OF COUNTRIES WHERE THERE HAS BEEN A CHANGE IN LEGAL STATUS OF VOLUNTARY STERILIZATION OVER THE PAST 10 YEARS.

Changes in the laws on sterilization can have widespread impact on the availability of voluntary sterilization services and programs. The World Plan of Action adopted at the United Nations World Population Conference in Bucharest in 1974 affirmed "the fundamental right of couples and individuals to decide freely and responsibly the number and spacing of their children" and "the obligation of States to provide guidance and means to allow the exercise of this right." IPAVS philosophy has been that this fundamental right covers all methods of family planning including voluntary surgical contraception for both males and females.

Since issues pertaining to the legality of voluntary sterilization are of basic importance to program implementation and acceptance, IPAVS naturally supports the notable liberalization in the legal status of voluntary sterilization in many countries in recent years. In many countries where there is no specific law prohibiting surgical contraception, the procedure is considered permissible. However, sterilizations, where otherwise illegal, can always be performed for medical reasons. Physicians in many areas of the world are increasingly performing sterilizations for socio-medical as well as strictly medical reasons, thus encouraging a more liberal interpretation of laws. Also, many countries have passed legislation either specifically authorizing voluntary sterilization or modifying past restrictive statutes.

The following tables summarize existing legal status and changes in laws governing voluntary surgical contraception. Table A does not include all countries of the world, however it is meant to be representative of prevailing attitudes on voluntary sterilization worldwide. Information included in Table A was drawn from the following sources:

- 1) Survey of Laws on Fertility Control, UNFPA, 1979.
- 2) Law & Planned Parenthood, IPPF, 1980, by John M. Paxman.
- 3) Jan Stepan & Edmund Kallogg, changes in the World's laws on Voluntary Sterilization in the 1970's. An update & review, 1979. Prepared for 4th International Conference on Voluntary Sterilization, Seoul, Korea, May, 1979.
- 4) Ira Lubell, M.D., International Status of VSC & its Implications for National Health Programs prepared for conference, Seoul, Korea, May, 1979.
- 5) Population Reports, Law & Policy, Series E, No. 4, March 1976.

Table B is drawn from Law and Planned Parenthood, an IPPF publication and summarizes changes which have occurred in the law in the past 10 years.

TABLE A

WORLDWIDE LEGAL STATUS OF VOLUNTARY SURGICAL CONTRACEPTION

Country	Legal (by specific statute or interpretation)	Restrictions (legal or medical profession authorized)	Illegal (by specific statute or interpretation)	No Specific or Unclear Legal Provision	Practice Info
Afghanistan	*(I)			*	Practice allowed.
Albania				*	
Algeria		Only for therapeutic and eugenic grounds. Spousal consent required	*		
Angola			*		
Argentina				*	Unclear provisions Not enforced but difficult to obtain.
Australia	*(I)	Over 25 required		*	
Austria	*	Over 25. Must be performed by physician			
Bahrain			* by interpretation	*	
Bangladesh	*				Promoted by state & widely practiced.
Barbados	*(I)			*	
Belgium	*(I)	Spousal consent required		*	
Benin				*	
Bolivia				*	
Botswana	*(I)	Spousal consent required		*	Only female sterilization is practiced.
Brazil	*	Only on medical grounds		*	Restriction not enforced - usually given on request.

TABLE A

WORLDWIDE LEGAL STATUS OF VOLUNTARY SURGICAL CONTRACEPTION (CONT'D.)

Country	Legal (by specific statute or interpretation)	Restrictions (legal or medical profession authorized)	Illegal (by specific statute or interpretation)	No Specific or Unclear Legal Provision	Practice Info
Bulgaria				*	Practice allowed.
Burma		*			
Burundi				*	
Canada	*(I)				
Central Af. Republic			*(I)	*	
Chad			*(I)	*	
Chile	*	Spousal consent required & only on med. grounds with women over 30 after 4th child & danger in future pregnancies			
China (Peo. Rep.)	*(I)			*	Gov't promoted & widely practiced.
Colombia	*(I)	Over 35, more than 2 children 1 of each sex. Spousal consent required		*	
Congo				*	
Cuba	*	Must be over 32			Mostly Female Sterilization.
Cyprus				*	
Czech.	*	Only for medical or genetic reasons or over 35 with 3 children or under 35 with 4 children			
N. Korea	*(I)				

TABLE A

WORLDWIDE LEGAL STATUS OF VOLUNTARY SURGICAL CONTRACEPTION (CONT'D)

Country	Legal (by specific statute or interpretation)	Restrictions (legal or medical profession authorized)	Illegal (by specific statute or interpretation)	No Specific or Unclear Legal Provision	Practice Info
Yemen Democratic				*	
Denmark	*	Must be over 25			
Dom. Republic	*(I)	Therapeutic or eugenic reasons or over 40 with 1 chil.; over 35-3 chil.; over 30-5 chil.; over 25-6 chil.			
Ecuador	*(I)	Over 25 with 3 chil. or med. or eugenic reasons		*	
Egypt	*(I)	Health & eugenic reasons or over 35 with 3 children, 1 a boy		*	
El Salvador	*(I)			*	Widespread, limited to females.
Ethiopia	*(I)	Spousal consent. Health reasons or 5 children & difficult socio-econ. conditions			Limited to females.
Fiji	*(I)	Spousal consent. Limited to married people		*	
Finland	*	For eugenic, Medical or over 18, socio-econ. reasons-Medical board approval required			
France	*(I)			*	

TABLE A

WORLDWIDE LEGAL STATUS OF VOLUNTARY SURGICAL CONTRACEPTION (CONT'D)

Country	Legal (by specific statute or interpretation)	Restrictions (legal or medical profession authorized)	Illegal (by specific statute or interpretation)	No Specific or Unclear Legal Provision	Practice Info
Gabon				*	
Gambia				*	
Ger. Dem. Republic	*				Ltd. to females.
Ger. Fed. Republic	*(I)	above 25 (or if under 25, mature)		*	
Ghana	*	Med. reasons		*	
Greece		Except for med. reasons	*(I)	*	
Guinea				*	
Guyana				*	
Haiti				*	
Honduras	*	If decided by 3 physicians			
Hong Kong	*(I)	Minors need parental consent		*	
Hungary		Med. reasons only			
Iceland	*	Over 25 or Med. or socio-eco. or eugenic reasons			
India	*(I)	Husband over 25 Wife over 20		*	Widely practiced, gov't. supported.
Indonesia				*	
Iran	*	Spousal consent with 2 children & parents over 25-unmarried			Uncertain legal status after Islamic revolution 1979.

TABLE A

## WORLDWIDE LEGAL STATUS OF VOLUNTARY SURGICAL CONTRACEPTION (CONT'D)

Country	Legal (by specific statute or interpretation)	Restrictions (legal or medical profession authorized)	Illegal (by specific statute or interpretation)	No Specific or Unclear Legal Provision	Practice Info
Iraq				*	
Ireland	*(I)	Spousal consent		*	Only male sterilization.
Israel	*(I)	Med. reasons or over 30		*	Mostly female sterilization.
Italy	*	Inspecific guidelines-only recently decriminalized			
Ivory Coast	*(I)			*	Not practiced.
Jamaica	*(I)			*	Widely practiced.
Japan	*	Eugenic or med. reasons, spousal consent			Widely practiced.
Jordan	*(I)	Over 30 except for med. reasons Spousal consent		*	Only female sterilization.
Kenya	*(I)			*	Not encouraged by gov't.
Kuwait	*(I)	Health & eugenic reasons only		*	Mostly female sterilization.
Lao People's Dem. Rep.				*	
Lebanon	*(I)	Over 30, spousal consent, 3 children		*	
Lesotho	*(I)	Several children or Med. grounds		*	Female only.
Liberia				*	
Libya			*(I)	No info.	

TABLE A

WORLDWIDE LEGAL STATUS OF VOLUNTARY SURGICAL CONTRACEPTION (CONT'D)

Country	Legal (by specific statute or interpretation)	Restrictions (legal or medical profession authorized)	Illegal (by specific statute or interpretation)	No Specific or Unclear Legal Provision	Practice Info
Luxembourg	*				
Madagascar			*(I)	*	
Malawi	*(I)			*	
Malaysia		Spousal consent		*	
Mali		Spousal consent, Med. reasons		*	Female only.
Malta			*(I)	*	
Mauritania				*	
Mauritius	*(I)			*	
Mexico	*(I)	Spousal consent		*	
Monaco	*(I)			*	
Mongolia				*	not practiced.
Morocco				*	Gov't. program in family planning.
Mozambique		Except Therapeutic VS	*		
Nepal	*(I)			*	
Netherlands	*(I)			*	
New Zealand	*	Only for adults			
Nicaragua			*		
Niger				*	
Nigeria	*(I)			*	
Norway	*	Over 25 or Med., eugenic, or socio-eco reasons			

TABLE A

WORLDWIDE LEGAL STATUS OF VOLUNTARY SURGICAL CONTRACEPTION (CONT.D)

Country	Legal (by specific statute or interpretation)	Restrictions (legal or medical profession authorized)	Illegal (by specific statute or interpretation)	No Specific or Unclear Legal Provision	Practice Info
Oman			*(I)	*	
Pakistan	*(I)	Spousal consent, 3 children (1 a boy)		*	
Panama	*	5 children & socio-econ reasons or Med. or eugenic reasons Spousal consent, over 26			Only females.
Papua New Guinea	*(I)			*	
Paraguay				*	Practice allowed.
Peru			*(I)	*	
Philippines	*(I)	Spousal consent		*	
Poland	*			*	
Portugal			*		
Puerto Rico	*(I)	Spousal consent		*	
Qatar			*(I)	*	
Rep. of Korea	*(I)			*	Gov't. support.
Romania			*(I)	*	
Rwanda			*(I)	*	
S. Arabia			*(I)	*	Occasional therapeutic Steril.
Senegal				*	
Sierra Leone				*	

TABLE A

WORLDWIDE LEGAL STATUS OF VOLUNTARY SURGICAL CONTRACEPTION (CONT'D)

Country	Legal (by specific statute or interpretation)	Restrictions (legal or medical profession authorized)	Illegal (by specific statute or interpretation)	No Specific or Unclear Legal Provision	Practice Info
Singapore	*	Parental consent for those under 21 & unmarried, none for over 21			Widespread .
Somalia			*		
S. Africa	*	Only adults			
Spain			*		
Sri Lanka	*(I)			*	Widespread .
Sudan				*	
Swaziland				*	
Sweden	*	Over 25 or between 18 & 25 for eugenic or Med. reasons			
Switzerland	*(I)	Spousal consent		*	Widespread .
Syrian-Arab Republic				*	
Thailand	*(I)	socio-eco & eugenic reasons - Spousal consent, at least 2 chil.		*	Widespread .
Togo				*	Not practiced .
Trinidad & Tobago	*(I)	Spousal consent		*	Only females .
Tunisia	*(I)	Spousal consent, children required		*	Only females .
Turkey			*		

TABLE A

WORLDWIDE LEGAL STATUS OF VOLUNTARY SURGICAL CONTRACEPTION (CONT'D)

Country	Legal (by specific statute or interpretation)	Restrictions (legal or medical profession authorized)	Illegal (by specific statute or interpretation)	No Specific or Unclear Legal Provision	Practice Info
Uganda	*(I)	Over 40, after multiple Caesarians or 9 or 10 children, or by spousal consent		*	Only females.
USSR		Except for Med. reasons	*(I)	*	
UK	*	Spousal consent			
United Rep. of Cameroon	*(I)			*	
United Rep. of Tanzania	*(I)	Spousal consent		*	
USA	*	State regulated-varying age req's			
Upper Volta				*	
Uruguay	*(I)			*	
Venezuela	*	Only for Med. reasons		*	
Vietnam	*(I)			*	Recent gov't. program.
Yemen			*(I)	*	Not practiced.
Yugoslavia	*	Over 35 or for Med. or eugenic reasons or therapeutic			
Zaire				*	
Zambia	*(I)			*	

EXPLANATION OF CHART:

- 1) An asterisk only in the column marked "Legal" denoted that the practice of voluntary sterilization is specifically approved by statute, although there may be restrictions governing its availability. e.g., is available only to persons over 35 for eugenic medical or therapeutic reasons.
- 2) An asterisk accompanied with an "(I)" in the column marked "Legal" indicates that no specific statute permits voluntary sterilization, but that legality can be reasonably inferred from official conduct allowing voluntary sterilization or from judicial or scholarly interpretation of existing laws.
- 3) The column marked "Restrictions" applies to known restrictions on the availability of voluntary sterilization. In many cases, guidelines are so vague or information is so scarce that no restrictions are listed. The fact that no restrictions are listed should not lead one to conclude that none exist. In the same way, the listed restrictions are not necessarily exhaustive. The restrictions may either be legal requirements or established procedures of the medical professions.
- 4) An asterisk only in the column marked "Illegal" denotes that the practice of voluntary sterilization is specifically prohibited by statute.
- 5) An asterisk accompanied by an "(I)" in the column marked "Illegal" indicates that no specific statute prohibits voluntary sterilization, but that illegality can be easily inferred from official conduct opposing voluntary sterilization, or from judicial or scholarly interpretations of the existing laws. Such an interpretation is often applied to Moslem countries which don't specifically treat the issue of voluntary sterilization, but where Islamic religious law would forbid voluntary sterilization except in extreme situations.
- 6) In the vast majority of cases, there are no specific statutes dealing with voluntary sterilization. Instead, the nearest applicable statutes deal with "the intentional infliction of grave corporal injury by causing amputation or loss of usage of limb, blindness, loss of an eye or other permanent afflictities." or other such imprecise statutory language. The above phrasing, taken from the Napoleonic Code of 1810 and widely adopted among countries of the world, is often qualified with language to the effect that medical or surgical treatment given in good faith is not criminal. By interpretation, these kinds of statutes are usually viewed as not forbidding voluntary sterilization.

The principle is common in virtually all criminal law systems in that unless an activity is specifically prohibited in the criminal code, it is deemed permissible. Therefore, in countries where no specific mention of voluntary sterilization is made and where official conduct has been such as to allow or promote voluntary sterilization, it is regarded as legal by interpretation in those countries.

On the above cases and where an unclear statutory provision exists which awaits interpretation by official conduct or judicial decision, an asterisk has been placed in the column marked "No Specific or Unclear Legal Provision."

- 7) The "Practice Information" column is used primarily to denote the extent and types of voluntary sterilization practiced in a given country: In many cases, no information is available as to the extent voluntary sterilization is practiced. In others, voluntary sterilization may be practiced but there is not enough government involvement in the programs to regard the practice as legal by interpretation.

TABLE BSUMMARY OF CHANGES IN THE  
LAW OF VOLUNTARY STERILIZATION

Following the experiences of World War II, many countries took an understandably negative attitude toward the concept of sterilization. Other countries feared limiting their population growth. The trend in the last 10 years, with only a few exceptions, has been to liberalize the laws affecting voluntary sterilization. These liberalizations are effected by statutory changes as well as by new interpretations of existing laws. Non-legal changes, such as a government's decision to officially promote and regulate voluntary sterilization without an accompanying legal change, are not included here. Such non-legal changes should also be regarded as furthering the practice and availability of voluntary sterilization.

Country	Previous legal status	Eugenic	Medical	Social/socio-economic socio-medical	Request	Comments	Source
Austria	Illegal	x	x	x	After 25	Sterilization with consent before age 25 legal if "not contrary to good morals". <sup>1</sup>	Criminal Code of 23 January 1974, section 90(2).
Chile	Available, since 1974, for medical and socio-economic reasons, upon decision of a committee.		x			Sterilization "not to be considered a method of fertility regulation" hence can be "performed only on medical grounds". <sup>2</sup>	Ministry of Health Resolution No.003 of 8 September 1975.
Czechoslovakia	Voluntary sterilization permitted under indications laid down by Ministry of Health.	x	x	x		Indications essentially the same as under previous law, only slightly extended.	Czech and Slovak Ministries of Health Instructions of 1971 and 1972.
Denmark	Available for eugenic and medical reasons.	x	x	x	After 25	Under 25s may be sterilized if they meet conditions and Board approves. Sterilization of under 18s forbidden unless "very special reasons" exist.	Law No.318 of 13 June 1973, sections 2-4, implemented by Order No.98 of 12 March 1976.
Finland	Available for eugenic and medical reasons.	x	x	x		Medical Board approval necessary in most cases.	Law No.283 of 24 April 1970, section 1.
Germany, Federal Republic of	Since the (Supreme) Federal Court decision in <i>Dahn</i> case (1964) voluntary sterilization held legal.	x	x	x	If mature	In 1976 the (Supreme) Federal Court reaffirmed that sterilization of mature consenting person, even if done with no medical, eugenic, or social reasons, is legal.	Supreme Court (Bundesgerichtshof) decision of 29 June 1976.
Ireland	Available for eugenic or medical reasons.	x	x	x	After 25	If under 25 indications necessary: endangered by pregnancy, inability to physically or economically care for child, or eugenic reasons.	Law No.25 of 20 May 1973, section 18.
Iran	No specific legal provision. <sup>3</sup>	x	x	x	x	Up to age 25 two children required plus consent of spouse. If unmarried must be over 30.	Civil Penal Code, article 42, section 3 (1970).
Italy	Illegal				x	Penal Code section 552 forbidding sterilization repealed. <sup>4</sup>	Law No.104 of 22 May 1978, section 22.
Armenia, Republic of	No specific legal provision.	x				1973 law applies only to mandatory eugenic sterilizations. Available on request for family planning reasons.	Maternal Child Health Law (No.2514), section 9 (1973).

in good faith.

done "for lawful purpose" if consent given. No "person" can consent to sterilization of under-aged individuals (minors).

Crimes Act 1961 (1978); Contraception, Sterilization and Abortion Act (Act No.112), section 7 (1977).

Norway	Sterilization permitted under 1934 law if for "reputable motives". Unless for medical reasons, approval of Director-General of Health required.	x	x	x	After 25	If under 25 or incompetent to give consent, Board must authorize decision. If application denied, may be appealed to Sterilization Council.	Law No.57 of 3 June 1977, sections 2-3.
Peru	Section 165(2) of Penal Code prohibits mutilation which impairs function of organs. Question whether applies to sterilization.	?	?			Sterilization as a means of fertility control forbidden.	Supreme Decree No.00623-76-5A, approving the Guidelines of the Population Policy in Peru (1976).
Philippines	Question whether criminal law applied.				x	Criminal law on mutilation not applied to voluntary sterilization.	Secretary of Justice Opinion No.131 of 17 September 1973.
Singapore	On request if one or two children otherwise approval of Eugenic Board needed. Consent of spouse required.				x	Sterilization now available on request for all married persons. Those under 21 need consent of spouse, parent or guardian.	Voluntary Sterilization Act (Act No.25) 1974, section 3(2).
South Africa	Permitted if consent of person given.	x	x	x	x	Section of new law deals with circumstances under which incompetents can be sterilized. For others sterilization permitted if consent obtained.	Abortion and Sterilization Act (Act No.2) 1975, section 4.
Sweden	Available for eugenic, medical, socio-economic reasons. Approval of National Board of Health and Welfare required.	x	x		After 25	Persons aged 18-25 may be sterilized, after approval by National Board of Health and Welfare, for eugenic or medical reasons.	Law No.580 of 12 June 1975, sections 1-3.
Venezuela	Penal Code article 416 punished injuries causing loss of reproductive ability.	x	x			Sterilization to prevent conception authorized where pregnancy would pose threat to woman's health or where child would be born with serious malformations.	Code of Medical Ethics, 23 January 1971, section 31.
Yugoslavia Croatia		x	x		After 35	Applications screened by a commission.	Law No.1232 of 21 April 1978, sections 8, 13.
Slovenia			x		After 35	Prise to 35 sterilization may be performed for medical reasons if necessary. Applications screened by commission. Waiting period of 9 months after authorization.	Law of 20 April 1977, sections 19, 16.

**NOTES TO TABLE B**

\* This table only covers changes in law which could be properly documented. No doubt others have occurred. It was prepared by John M. Paxman, Consultant to the Law & Planned Parenthood Programme of IPPF, with the assistance of Dr Jan Stepan, Foreign Law Librarian, Harvard Law School.

- 1 Eugenic, medical, and socio-economic reasons fit within this category.
- 2 Previous regulations were much more liberal. Present regulations do permit sterilization of women over 30 following the birth of their fourth child where future pregnancies would involve an 'obstetric risk'. The regulations apply only to sterilization programmes within and subject to the National Health Service.
- 3 Present legal situation, due to 1979 revolution and the impact of Moslem law, cannot be assured.
- 4 When and if new legislation is developed the position may change. Presently there are no legal restrictions on sterilization save those which apply generally to the provision of surgical services.
- 5 Singapore first reformed its law on sterilization in 1969 then again in 1972 and 1974.
- 6 One of the specific innovations in this regard is to permit sterilization where the person has undergone a sex change operation.

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**Source:**

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**IMPACT ON POLICY CHANGE**

WHAT EFFECT ON POLICY HAVE IPA VS ACTIVITIES HAD IN VARIOUS COUNTRIES? HOW MANY COUNTRIES MAINTAIN ORGANIZED OPPOSITION TO VOLUNTARY STERILIZATION? WHAT COUNTRIES HAVE SHOWN A CHANGE IN THE RECEPTION ACCORDED IPA VS VISITORS TO THEIR COUNTRIES?

To answer these questions, levels of policy changes were defined as follows:

- 1) Direct influence that has lead to a change in policy and toward the acceptance of voluntary surgical contraception;
- 2) Tacit changes, or defacto, acceptance achieved without there being a change in policy;
- 3) Some movement toward a change in policy and/or attitude; and
- 4) No change or opposition to voluntary sterilization.

1) Direct changes in policy have occurred in at least 12 countries, including Australia, Bangladesh, Chile, El Salvador, Korea, Nepal, Philippines, Indonesia Thailand, Tunisia, South Africa, and Sri Lanka. While IPA VS cannot be considered the sole contributor to these policy changes, examples can be cited as to IPA VS influence on these changes:

- In Bangladesh, at present, the Government provides voluntary sterilization through more than 300 service stations, including 186 Thana hospitals, 93 Maternal Child Health centers, 8 medical college hospitals and some others. Approximately one-half the Thana health complexes do not yet provide sterilization services -- nor do many district or subdivisional hospitals. In addition, the Government has 19 mobile units, of which only 5 are currently functioning. If all the Government facilities provided voluntary surgical contraception services, it is estimated that the total capacity would be about 300,000 procedures per year.

IPA VS has had a direct impact on the quality of services provided at Government clinics. They have adopted the idea of the necessity for medical service standards for the government programs from IPA VS's attempt to insure high quality services in the IPA VS clinics. In addition, IPA VS is supporting SDG in providing emergency equipment to insure high quality services in their government clinics.

- In 1974, the Chief Justice of the Philippines ruled that sterilization was a legal procedure based on an article written in the Encyclopedia Britannica by the President of the Human Betterment Society and predecessor to AVS.

In addition, the Population Commissioner adopted almost verbatim the IPAVS Informed Consent Guidelines in late 1977 as part of their policy of accepting voluntary sterilization services. Nepal has followed suite in that these same IPAVS Informed Consent Guidelines are currently before the Ministry of Health for development into a policy for that country's voluntary sterilization program.

- In Tunisia, the country had a policy favoring voluntary sterilization before the IPAVS involvement. However, it was IPAVS's financial support for programs that helped establish the practice of voluntary sterilization in Tunisia. Without the financial assistance of IPAVS, Tunisia would not have been able to progress to the extent they have achieved at present.
- 2) In some countries, tacit changes in policy or defacto acceptance has been achieved without there being a specific change in policy. Such countries include Benin, Egypt, El Salvador, Guatemala, Honduras, Jamaica, Jordan, Morocco, Nigeria, Sierre Leone, Sudan, Syria, Yemen, and Zaire. Primarily changes of this nature have occurred where IPAVS has initiated programs that required acceptance by the government. Generally, IPAVS feels that tacit changes in policy can be considered in all countries where programs are funded without there being a policy in favor of sterilization.
- In Egypt, training programs will take place in 8 university hospitals. Although this program will be coordinated by the Egyptian Fertility Care Society (EFCS), the very fact that the training will take place in government educational institutions, shows tacit approval for voluntary sterilization. Additionally, the government of Egypt endorsed the statement by EFCS on the dangers of high parity.
  - In Morocco, at the initiative of the government, a joint project between the Moroccan Ministry of Health, IPAVS, AID, and PIEGO a national training and service center for Africa and the Middle East was established. Even though Morocco does not have a policy in favor of voluntary surgical contraception, the essence of policy shows in that the government accepts the national training program being implemented by the Ministry of Health. In order to arrive at this stage with voluntary surgical contraception programming, much work was done with individuals in Morocco (i.e., sending them to various conferences, on trips to other parts of the world and to other Arab countries, etc.).
  - In Brazil, the planned programs there will probably make that country the major recipient of IPAVS funds in South America.

Five major programs are already being funded and an additional four proposals are being developed that will bring IPAVS total commitment in funds to Brazil to over one million dollars. Implied in this level of commitment and acceptance by Brazil, is its tacit approval of voluntary surgical contraception for the country. Brazil is a country where official opposition to all types of family planning had been strong and where a definite pro-natalist attitude prevailed in the past. Because of the influence of Brazil in South America, it is expected that other Latin American countries will follow suite.

- 3) Where there has not been direct or tacit change in policy, some other countries have moved in the direction of acceptance of voluntary sterilization. These countries include Gambia, Haiti, Kenya, Peru, and Senegal. What is encouraging is that in these countries project coordinators are becoming receptive to prospects for programming and are engaging in initial dialogue. The prospects for future programming in these countries seems promising.
- 4) In some other countries there has been no change or continued opposition or resistance to voluntary surgical contraception. Voluntary sterilization remains illegal in many countries, including as examples Burma, Greece, Paraguay, Portugal, Somalia, Spain and Turkey. Basically, almost the entire continent of South America still shows official opposition where the Church is strong.

Most of South America remains officially opposed to voluntary sterilization. However, in Brazil for example, the new Ministry of Health is now permitting AID dollars, specifically having requested the American Ambassador to fund it to voluntary organizations and to universities to start programs.

Some of the Orthodox Islamic countries in the Middle East and sub-Saharan African regions continue to show official opposition. Notable are about 18 African nations that are officially opposed to voluntary sterilization; and 7 Middle Eastern countries. Some changes have occurred in Africa and the Middle East notably in Senegal and Yemen.

In Senegal, IPAVS could neither talk to AID/Senegal nor to any official of the government. In only the past 6 to 8 months, IPAVS has been receiving official invitations to discuss programming in the country with health officials. In North Yemen, (Yemen Arab Republic) since about 1 year ago the AID mission and the Family Planning Association invited IPAVS to discuss programs.

However, even where there have been policy changes in the positive direction, some of these positive policies have been reversed with changes in government within countries. Thus, in discussing changes in policy, especially in the developing countries where IPAVS has had an influence, it seems important to consider the fluidity of changes in policy with changes in the sometimes fragile government structure. For example, in Chile, IPAVS involvement for a time increased the

acceptance and availability of voluntary surgical contraception; however, with the change in governments in Chile, the movement in a favorable direction for voluntary surgical contraception was reversed.

One country is notable for the efforts that have been made to make family planning and voluntary sterilization as part of the family planning effort, separate from the government actions of that nation. In Sri Lanka, the Ministry of Plan Implementation developed a position paper "Family Planning Above Politics" that favored keeping family planning and voluntary surgical contraception separate from political changes. The paper was presented to the different political parties in Sri Lanka and approval was obtained that family planning efforts should continue regardless of the party in favor in the government. Without such a mandate from all the parties, Sri Lanka's family planning efforts would be on the upswing while one party favored it, and then wiped out when an opposition party assumed control, etc.

Changes in policy and acceptance towards ideas about voluntary sterilization have lead to an encouraging change in the receptions accorded IPAVS visitors to countries where voluntary surgical contraception had been opposed in the past. Actually IPAVS medical personnel have been accorded a fairly friendly reception in about any country they visited, because their technical expertise was seen as a welcome addition. However, IPAVS visitors representing voluntary sterilization in general have not been so well received in the past. Notable is the Philippines. In 1974, an IPAVS visitor was accorded a rather cool reception (i.e., "It was clearly understood that we were there as guests but not to talk about voluntary sterilization. The approach was quietly through the back door...we met with AID but nobody in the country was very keen on dealing with or talking about voluntary sterilization."). Over the years, however, as many as 29 subgrants have funded programs in the Philippines, showing the gradual change that is taking place.

A large part of the problem in discussing voluntary sterilization, from the viewpoint of IPAVS, has been that AID representatives themselves have not been receptive. For example, in Africa and Latin America, a large measure of the problem has been that AID personnel are not necessarily educated to the potential benefits that could be derived from IPAVS involvement.

**IMPACT ON NATIONAL PROGRAMS**

WHERE HAS IPAVS INVOLVEMENT LEAD TO THE INTRODUCTION OF VOLUNTARY STERILIZATION SERVICES IN A GOVERNMENT'S PROGRAM? WHICH COUNTRIES HAVE SHOWN A MORE PERMISSIVE GOVERNMENT POSTURE TOWARDS PRIVATE SECTOR PROGRAMS IN VOLUNTARY STERILIZATION OVER THE PAST 10 YEARS?

The truest indicator of progress in the acceptance of voluntary sterilization is the public support and advancement of voluntary sterilization by national governments. In 1972, when the International Project entered the family planning movement, there was only one country, India, where voluntary sterilization was part of the national government health services. By 1980, there were no less than 17 countries with national voluntary sterilization programs:

Barbados  
Bangladesh  
Colombia  
China (People's Republic)  
China (Republic of)  
India  
Korea  
Mauritius

Malaysia  
Mexico  
Morocco  
Nepal  
Pakistan  
Philippines  
Sri Lanka  
Thailand  
Tunisia

*Panama*  
*El Salvador*

The International Project points with pride to the pivotal role its projects have played in paving the way for national acceptance of surgical contraception. Examples of IPAVS contribution to these efforts include the following:

- In Thailand, the national training program conducted at Ramathibodi Hospital with IPAVS support which ended in 1977, succeeded in training hundreds of physicians from all provinces of the country and at all levels of health facilities, including the rural health centers which services the bulk of the Thai population. These same IPAVS trained physicians have gone on to train other physicians making the training in voluntary sterilization a generational effort and thereby assuring the progress, success and continuation of the Thai national program without IPAVS support.
- In Mexico, the speedy assistance of the International Project during 1977, allowed the health institutions of the Government of Mexico to take advantage of the "mood of the times" and to move boldly in gearing the national health services to provide sterilization to advance the availability of surgical contraception with the Mexican health service program. The present program of the Ministry of Health of Mexico sponsors more than 215 voluntary sterilization clinics and has reached all areas of the country except those with populations of less than 1500.

In other countries, national governments are supporting the provision of voluntary sterilization for their citizens, but due to local sensitivities, have delegated public responsibilities for conducting or coordinating the programs to non-governmental, national voluntary organizations. Included among these countries are:

Bangladesh  
Egypt  
Guatemala  
Honduras  
Indonesia

Examples of IPAVS involvement in the private sector include the following:

- In Bangladesh, the government was prompted to initiate a nationwide drive in early 1977 to train physicians and activate health centers to provide voluntary sterilization services because of the persistent and successful demonstration work of the Bangladesh Association for Voluntary Sterilization. In 1980, there is a network of 40 BAVS branch groups throughout the country.

BAVS has also made headway in development of I&E materials and counseling strategies that have had an impact on professional and public knowledge regarding voluntary surgical contraception. The innovative efforts of BAVS have demonstrated to the government the need for and feasibility of including voluntary surgical contraception in the national health program and the government has now accepted primary responsibility for provision of services in Bangladesh. However, the government still relies on BAVS for specialized professional training and the development of medical standards for voluntary sterilization. Largely owing to IPAVS requirements for medical services standards, BAVS worked in the past year to develop their own medical service standards and supervision system which will certainly have an impact on government clinics.

- In Egypt, the Egyptian Fertility Care Society (EFCS) has been working behind the scenes to encourage acceptance of voluntary sterilization in Egypt. The Society, with Government endorsement, adopted a resolution endorsing voluntary surgical contraception as one means to reduce high parity.

At the Society's Sixth Annual Meeting, a plan was adopted establishing an EFCS-coordinated national training and service program in twelve medical university facilities. The primary aim of the training program is to incorporate in all medical schools a special sterilization training component for inclusion in the Obstetrics/Gynecology curriculum. For physicians receiving special certification as a result of the sterilization training component, equipment will be provided to the institution where they

is posted and assistance provided by EFCS so that sterilization services can be established.

It is important, EFCS has been able to gain support and cooperation from all levels of the medical community, obtaining the assistance of Egyptian professionals to help design the national training program and other EFCS activities.

- In Indonesia, voluntary sterilization is a sensitive subject and is not an official part of the national family planning program. However, the government has designated the Indonesian Society for Voluntary Sterilization (PUSSI) as the national coordinator of surgical contraceptive activities in Indonesia. Because of its relationship with the national family planning government organization, the Indonesian Society has received cooperation from various government agencies in its efforts to popularize and integrate voluntary sterilization.

The Society has developed and organized a national manpower training program in conjunction with six major Indonesian medical teaching centers. The program includes standardized trainee selection and certification criteria, medical guidelines, informed consent materials and a standard curriculum. The Society is also responsible for the dissemination of voluntary sterilization information to the Indonesian medical profession. Once the manpower development project is completed, it is hoped that the government will assume a greater responsibility for its 11 branches throughout Indonesia and the recruitment of new members.

**IMPACT OF CONFERENCES ON VOLUNTARY STERILIZATION**

CITE SPECIFIC EXAMPLES WHEREIN ATTENDANCE AT AN INTERNATIONAL IPAUS CONFERENCE HAS DESENSITIZED THE SUBJECT OF VOLUNTARY STERILIZATION FOR A COUNTRY, OR FOR AN OFFICIAL OF A COUNTRY, WHICH HAS LEAD TO A WORLDWIDE CHANGE OF ATTITUDE ON VOLUNTARY STERILIZATION.

IPAUS considers its involvement with conferences, both funding the conferences themselves as well as the conferees, to be of primary importance. Conferences contribute to the dissemination of ideas and approaches about voluntary sterilization in a number of ways:

- 1) Conferences serve as an initial stepping stone for identifying key individuals in the voluntary sterilization movement who can take a leadership role in promoting voluntary surgical contraception in their country, thereby stimulating the development of new programs.

Example: At the 3rd International Conference on Voluntary Sterilization held in Seoul, Korea, 17 African countries were represented, 5 for the first time at a major conference on voluntary sterilization. As well, 9 South American countries were represented, 3 for the first time at a major conference on voluntary sterilization. Both of these world regions have been slow in developing voluntary surgical contraception programs. Immediately following the conference, seed projects became firmly established in 2 African countries which had not previously had programs: Benin and Sierre Leone.

- 2) Conferences serve as a stimulus for leadership persons and organizations to initiate broad programs with a wide spectrum of approaches.

Example: The success of the Korea Conference was borne out by an evaluation designed to assess conference preparations, planning and implementation. Of the respondents to a questionnaire, 98.5% rated the entire conference excellent or satisfactory.

Eighty-three percent of the conferees also requested IPAUS assistance in response to a questionnaire. The largest number of requests were for establishment or expansion of voluntary sterilization information and education programs. Of almost equal concern was the expressed need for training of physicians and health personnel in sterilization techniques. Additionally, 88 participants requested assistance in the form of equipment, 81 requested assistance in starting or expanding a voluntary sterilization service program, and 69 requested personal training in voluntary sterilization techniques. The responses are based on 213 participants who filled out questionnaires after the Korea Conference.

- 3) Conferences foster the incorporation of voluntary surgical contraception as an integral part of national health programs by stimulating the initiatives that increase availability, accessibility, and utilization of high-quality voluntary sterilization services.

Example: C.M. Wang from the Republic of China (Taiwan) attended an IPAVS conference in 1973 at a time when voluntary sterilization was not included in the health budget for that country. During that time period, small seed funds from IPAVS to the AVS-ROC were beginning the program in Taiwan. In the spring of 1975, Dr. Wang became Director General of the National Health Administration in Taiwan and today 40% of the national family budget is dedicated to voluntary surgical contraception services and programs. The national program continues in Taiwan, but is no longer funded by IPAVS.

- 4) Conferences provide a forum for the interaction of a multidisciplinary group through which specific issues relating to voluntary sterilization can be discussed.

Example: The plenary sessions - task force groups and round table discussions - at the major IPAVS conferences allow group interactions whereby ideas are shared and experiences are related. It is through such sharing of information that Egypt decided to replicate the highly successful Indonesian program for training.

- 5) Conferences foster and maximize information exchange so as to allow a cross fertilization of ideas, experience, and knowledge which will provide a sound foundation for discussion.

Example: The results of the French physicians survey, which impacted on legal change in France, was shared at the Korean Conference. As a result of the conference, Turkey and Syria now have plans to complete physician surveys in those countries to set the ground work for legal change.

- 6) Conferences generate recommendations and guidelines which will be used to pave the way for future programs, research and exchange of information.

Example: At the recommendation of the IFAVS Information and Education Committee, "Provisions for a Model Law on Voluntary Sterilization" was drafted, based on the recommendations generated from the 2nd, 3rd and 4th International Conferences on Voluntary Sterilization. IFAVS sponsored a IFAVS representative-observer to the International Parliamentary Conference in Sri Lanka, August 23 - September 1, 1979, in order to seek support for the Model Law. This Model Law is also featured in "Law and Planned Parenthood," a publication of the International Planned Parenthood Federation, which was published in 1980.

The focus of IPAVS conferences has changed over the years. In 1973, when surgical contraception was a relatively new phenomenon, the conference focused on techniques. In 1976, the conference emphasized broad programming that would encompass both male and female surgical contraception as part of national programs. And in 1979, the focus was again broadened to include the variety of components that make up comprehensive programming -- that is socio-cultural, religious, legal, political, and educational factors -- as well as reversibility of voluntary sterilizations.

As can be seen in the following table, conferees at IPAVS conferences come from all regions of the world. Consistently, conferees are funding themselves or finding alternative sources for funding themselves to attend IPAVS conferences. An increasing percentage of conferees are from developing countries; notable was the large delegation from Africa that attended the Korean Conference in 1979. Conferees also come from the full spectrum of professionals involved in policy making and health service delivery; conferees at the Korea Conference in 1979 included four Ministers of Health, one Secretary of State and Public Health, five Vice-Ministers or Under-Secretaries of Health and top-level family planning officials, program planners, administrators, physicians, lawyers, educators, researchers, and national policy makers.

TABLE A

COMPARATIVE ANALYSISOFIPAVS MAJOR CONFERENCES

Item	GENEVA 1973	TUNIS 1976	KOREA 1979
Registered Conferees (Percent from developing countries)	347 68%	361 68.5%	400 74%
Countries represented (Percent developing)	64 63.3%	66 69.4%	73 73.1%
AVS-funded conferees	141	143	241
Conferees funded by other agencies	91	65	74
Supporting agencies	5	9	14
Exhibitors	3	13	22
Staff	6	9	16
Cost (Approximate)	\$175,000	\$270,000	\$600,000

TABLE B

Countries Represented at Korea Conference, by Region

<u>AFRICA</u> (17)	<u>Central America</u> (7)	<u>Middle East</u> (6)
Benin	Costa Rica	Iran
*Cameroon	El Salvador	Jordan
Egypt	Guatemala	Lebanon
Ethiopia	Honduras	*Syria
Ghana	Mexico	Turkey
Kenya	Nicaragua	*Yemen Arab
*Mali	Panama	Republic (North)
Mauritius		
Morocco	<u>South America</u> (9)	<u>EUROPE</u> (9)
Nigeria	Bolivia	*Belgium
Senegal	Brazil	England
*Seychelles	Chile	France
*Sierra Leone	Colombia	Germany
Sudan	Ecuador	*Italy
*Swaziland	*Paraguay	Netherlands
Tanzania	Peru	*Portugal
Tunisia	*Uruguay	Switzerland
	*Venezuela	Yugoslavia
<u>AMERICAS</u> (25)		
<u>North America</u> (2)	<u>ASIA</u> (20)	<u>OCEANIA</u> (2)
Canada	<u>East Asia</u> (9)	Australia
U.S.A.	*Hong Kong	New Guinea
<u>Caribbean</u> (7)	Indonesia	
*Barbados	Japan	
*Dominica	Korea	
Dominican Republic	Malaysia	
*Grenada	Philippines	
Haiti	Republic of China	
Jamaica	Singapore	
*St. Lucia	Thailand	
	<u>South Asia</u> (5)	
	Bangladesh	
	India	
	Nepal	
	Pakistan	
	Sri Lanka	

\*Countries represented for the first time at a major IFAWS conference (13).

TABLE C

ANALYSIS BY REGION  
OF CONFEREES ATTENDING PRIOR  
MAJOR IPAVS CONFERENCES

(TOTALS)

<u>GENEVA (1973)</u>		<u>TUNIS (1976)</u>	
<u>REGION</u>	<u>TOTAL</u>	<u>REGION</u>	<u>TOTAL</u>
AFRICA	21	AFRICA	64
AMERICAS	111	AMERICAS	53
MIDDLE AMERICA	7	MIDDLE AMERICA	7
CENTRAL AMERICA	12	CENTRAL AMERICA	21
SOUTH AMERICA	30	SOUTH AMERICA	21
EUROPE	52	EUROPE	20
OCEANIA	10	OCEANIA	3
EAST ASIA	51	EAST ASIA	30
MID-EAST	17	MID-EAST	15
SOUTH ASIA	28	SOUTH ASIA	22

IMPACT ON THE KNOWLEDGE AND UNDERSTANDING OF THE HEALTH  
COMMUNITY

IFIC EXAMPLES OF THE CHANGE IN KNOWLEDGE AND UNDERSTANDING OF VOLUNTARY  
TION AMONG MEDICAL/PARAMEDICAL PROFESSIONALS. CERTAINLY THEY ARE MORE  
ABLE, BUT HOW? DO THEY SUPPORT VOLUNTARY STERILIZATION EFFORTS ONLY IN  
LLING TO GIVE PATIENT CARE? OR HAVE THEY SHOWN SIGNIFICANT SUPPORT FOR  
Y PLANNING MOVEMENT OR SPECIFICALLY THE VOLUNTARY STERILIZATION MOVEMENT  
EIR COUNTRIES?

t of the IPAVS programs and policies on the promotion of voluntary steri-  
in a large part of the world can hardly be measured in definite and  
ble terms alone. There are changes of the quantitative and conceptual  
no lesser significance that can easily be traced to IPAVS; such as:

- "Voluntary Sterilization" and Minilap" are now part of medical vocabulary used throughout the medical community and included in medical school curriculums.
- Use of local anesthesia and out-patient voluntary sterilization procedures are receiving wider acceptance, world-wide.
- Simplified and safer voluntary sterilization techniques are becoming more popular (e.g., minilap, yoon-ring, clips, etc.) than colpotomy and cautery. For example, in the IPAVS funded service programs, minilap procedures increased from 6% of all voluntary sterilization procedures in 1972-73 to 44% in 1979.
- Categories of medical and health support staff being trained for voluntary sterilization under IPAVS auspices are gradually broadening health support teams, which now include besides medical doctors, nurses, equipment technicians, social workers/counselors, motivators/promoters and even satisfied clients.

IPAVS, for example, funded training of only 9 health support staff in 1974, but this number increased to 249 by 1979 and is expected to grow further as emphasis on comprehensive programming is encouraged by IPAVS.

- The IPAVS scope and approach to training has broadened too. Not only specific courses are being developed and used for training, but also demonstration projects and rapid expansion of national training programs have also been conducted.

The example of the former are the training courses for counselors in Bangladesh, promoters training in Guatemala, nurses training in Thailand, and training of para professionals in Tunisia.

IMPACT ON THE KNOWLEDGE AND UNDERSTANDING OF  
THE GENERAL PUBLIC

**MISSING PAGE**  
**NO. 30**

CITE SPECIFIC EXAMPLES OF CHANGES IN THE KNOWLEDGE AND ATTITUDES OF THE GENERAL PUBLIC TOWARDS VOLUNTARY STERILIZATION. CITE SPECIFIC COUNTRIES WHERE A CHANGE OF PUBLIC OPINION HAS OCCURRED. HOW HAS IPAVS INVOLVEMENT ADDED TO THE CHANGE OF OPINION?

The complexity and the challenge that is posed for the diffusion of an innovative idea such as voluntary sterilization in societies that value high parity have myriad communication barriers, and almost no tradition of permanent termination of fertility, need hardly be elaborated. The very first step that needs to be taken for changing the need awareness of only the innovators and early adopters is a formidable task itself. It requires a careful and concerted approach and a strategy that takes into account existing demands and sensitivities of the society. Some of the highlights of the IPAVS approach that have been tested in the field and in most cases found to be satisfactory, are listed below:

- IPAVS, for obvious but very effective reasons, prefers to work with medical leadership of a country, at least initially. The advantages include not only the fact that they are the ultimate service deliverers for voluntary surgical contraception, but it is also true that the general public trusts and respects their opinion, particularly in matters of surgery. They are also easily identifiable, and invariably, influential in their communities.

The interest and participation of the medical community that sometimes begin at international conferences, is further boosted through site visits, training programs and the activities of NAVSs. In some cases, to elicit support of the entire medical profession in a country, KAP surveys are considered a good strategy. For example:

- The French NAVS conducted a KAP survey of physicians in France that also served to educate them on voluntary surgical contraception.
  - IPAVS has recently approved a request for a similar survey by the Turkish AVS, that is designed to educate the physicians and garner their support for changing the legal barriers against voluntary surgical contraception in that country.
- IPAVS insists on providing pre- and post-operative patient counseling at all service delivery sites by all subgrantees. Such counseling is aimed at providing all the relevant information to a requestor for him or her to make an informed decision. Obviously, about 100,000 acceptors who have been sterilized under IPAVS funded programs throughout the world, form a sizable pool of those who are knowledgeable about voluntary sterilization procedures.

- IPAVS demands that all its subgrantees include information and education programs as an essential component of their service program. Although not in all cases, most subgrantees seek funds from IPAVS for this purpose. The emphasis in I&E programs varies according to the situation of each country. Some countries, for example, have more problems in using mass media than others. However, all subgrantees are encouraged to use the group approach in reaching their intended audience. A typical I&E program consists of production of patient informational materials, monitoring personnel, use of audio-visuals, radio, t.v. and newspapers, where feasible, group meetings and home visits.

Although the reach and effectiveness of these programs is not scientifically evaluated for lack of trained staff and resources, the type of exposure the general public is given is evident from the progress reports sent by subgrantees. Examples:

- Guatemala: From March 1979 - March 1980 - 6,282 home visits -- 11,096 motivational interviews -- 1,525 group meetings attended by 17,711 persons -- 20,071 brochures distributed.
  - Honduras: From July - December 1977 - 2,381 home visits-- 9,854 interviews held -- 2,306 group meetings attended by 30,385 persons -- 6,413 brochures distributed.
  - Bangladesh: In 1979 - 4 seminars and 68 group meetings country-wide -- distributed 8,500 copies of materials -- mailed personally addressed letters to thousands of special interest professionals -- radio, newspapers and films were used extensively.
- The general impact of IPAVS's world-wide activities has been positive. For example:
    - In Thailand, when IPAVS started programs, the sterilization requestors had to have four living children before being considered for voluntary sterilization. But after a few years of successful work, this requirement by the government dropped to three and now to only two children. Moreover, as cited in the AID/APHA evaluation report, attitudes have changed in Thailand, where the national ratio of 9:1 female to male sterilizations has now changed to 3:1.
    - In Colombia and Bangladesh, IPAVS has demonstrated that when good comprehensive services are available, the demand grows faster than facilities.

- In Melbourne, Australia, when a newspaper inaccurately reported a 25% failure rate for sterilization, the AVS immediately corrected it by saying that it was closer to 1%. The story received international attention and recognition for AVS technical expertise. Thus, AVS also plays the role of an expert spokesperson on voluntary surgical contraception.

EVALUATION REPORT  
INTERNATIONAL PROJECT  
ASSOCIATION FOR VOLUNTARY STERILIZATION  
(AID/pha-G-1128)

A. Report Prepared By:

Pouru P. Bhiwandiwalla, M.D., M.S. P.H.  
Willard H. Beynnton, M.S., M.P.H.  
Philip D. Carney, M.D., M.Sc.  
Keekee Minor

During the Period:

September 17 THROUGH October 15, 1979

Under the Auspices of The:

AMERICAN PUBLIC HEALTH ASSOCIATION

Supported By The:

U. S. AGENCY FOR INTERNATIONAL DEVELOPMENT  
OFFICE OF POPULATION - AID/pha/C-1100

AUTHORIZATION:  
Ltr. POP/FPS: 12/20/79  
Assign. No. 1100-161

### III. CONCLUSION

It is the opinion of the evaluation team that IPAVS has successfully developed the objectives set by AID of expanding the acceptance of voluntary sterilization as a basic component of family planning and health service programs in the developing world. This achievement is measured through the evaluative criteria of relevance, management, institutionalization and policy development. IPAVS input of money, equipment and technical assistance is reflected in measurable program output, such as number of personnel trained, initiation of national programs, number of sterilization facilities provided and number of procedures performed.

IPAVS programs are relevant to AID goals and adhere to AID policies and guidelines, especially as regards abortion, voluntarism, informed consent, knowledge and availability of alternatives, quality of care and integration into general health services. The less-developed countries' sense of sovereignty and their variable levels of medical and administrative standards require the flexibility and sensitivity which IPAVS has demonstrated.

In spite of tremendous progress, the bulk of the work in providing generally available V.S. services lies ahead. Therefore, AID should continue to increase support to IPAVS. They are the best available organization for this work and should continue indefinitely until V.S. services are universally available.

The World Federation of Associations for Voluntary Sterilization is an important professional organization that deserves continued support. Its responsibilities should include formulation of guidelines for V.S. service, but standards should be determined nationally.

Although their pioneering role will be required in many new countries, their program emphasis must shift from demonstration type projects to provisions of V.S. services for all, especially the hard-to-reach rural poor. This objective will require (1) more emphasis on low technologies such as minilaparotomy and vasectomy as contrasted with high technology laparoscopic procedures; and (2) utilization of auxiliary and paramedical health workers in a team approach; and (3) increased integration into government health programs.

IPAVS is a responsible organization with the technical and managerial capacity to expand. It should gradually assume new responsibilities, as new staff acquire experience. Effective expansion will require, in addition to new staff, increased delegation of authority as well as defined job responsibilities. The team's judgment is that with these changes in direction and management IPAVS could, in time, double its granting program with a modest increase in staff.

ANNEX D

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK
 Life of Project  
 From FY 62 to FY 66  
 Total U.S. Funding \$71,000,000  
 Date Prepared 5-21-66

ANNEX D

Project Title &amp; Number: Program for Voluntary Sterilization, 932-0768

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS																																																																																																																																				
<p><b>Program or Sector Goals:</b> The broader objective to which this project contributes:</p> <p>Improved maternal and child health and decreased fertility in less developed countries.</p>	<p><b>Measures of Goal Achievement:</b></p> <p>Decreases in maternal and infant mortality rates, improvements in life expectancy, and decreases in birth rates and total fertility rates.</p>	<p>Demographic statistical reports Vital statistics Fertility and other surveys</p>	<p>Assumption for collecting goal inputs</p> <p>Sufficient demand for contraceptive sterilization exists and can be generated to have measurable impact on health and fertility.</p>																																																																																																																																				
<p><b>Project Purpose:</b></p> <p>To increase the number of LDCs in which high-quality voluntary sterilization services are institutionalized and routinely accessible to the majority of the population.</p> <p><b>Intermediate Purpose:</b></p> <p>To increase the number of LDCs in which voluntary sterilization is acceptable as a family planning and health measure.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <p>a. One voluntary sterilization clinic in operation for every 200,000 population in 15 LDCs where AFS has provided major program support for three years or longer (up from seven LDCs at end-1977).</p> <p>b. Among countries which have received major AFS support for three years or more but have not achieved a 1:200,000 clinic/population ratio, the end-1980 ratio has doubled.</p> <p>1. All LDCs have made policy, legal or regulatory changes favorable to provision of contraceptive sterilization services.</p>	<p>AFS site visit reports USAID reports Population publications</p>	<p>Assumption for collecting purpose</p> <p>Sufficient understanding of contraceptive sterilization, population growth, and uncontrolled fertility can be transmitted to LDC national leaders to overcome cultural and political barriers and to gain policy and budgetary support for VS.</p>																																																																																																																																				
<p><b>Outputs:</b></p> <ol style="list-style-type: none"> <li>Service facilities in operation</li> <li>Training facilities in operation</li> <li>Persons trained:             <ol style="list-style-type: none"> <li>medical</li> <li>paraprofessional</li> </ol> </li> <li>Dedicated clinical spaces equipped</li> <li>Repair and maintenance (RAM) centers functioning</li> <li>National/regional leadership groups functioning</li> <li>Professional publications produced:             <ol style="list-style-type: none"> <li>guidelines, standards, policies</li> <li>study reports</li> <li>conference monographs</li> <li>promotional materials</li> </ol> </li> <li>Conferences conducted:             <ol style="list-style-type: none"> <li>international</li> <li>national, regional</li> </ol> </li> <li>VJ subjects included in int'l meeting programs</li> <li>Changes reported:             <ol style="list-style-type: none"> <li>National policy, laws, regulations, "climate"</li> <li>Program improvements (e.g., standards, staff competence, administration)</li> </ol> </li> </ol>	<p><b>Magnitude of Outputs:</b></p> <table border="1"> <thead> <tr> <th></th> <th>1982</th> <th>1983</th> <th>1984</th> <th>1985</th> <th>1986</th> </tr> </thead> <tbody> <tr> <td>1. Number</td> <td>218</td> <td>268</td> <td>287</td> <td>336</td> <td>397</td> </tr> <tr> <td>  Countries</td> <td>32</td> <td>36</td> <td>42</td> <td>49</td> <td>58</td> </tr> <tr> <td>2. Number</td> <td>115</td> <td>131</td> <td>152</td> <td>177</td> <td>210</td> </tr> <tr> <td>  Countries</td> <td>21</td> <td>24</td> <td>28</td> <td>33</td> <td>39</td> </tr> <tr> <td>3. a. Number</td> <td>514</td> <td>586</td> <td>649</td> <td>792</td> <td>962</td> </tr> <tr> <td>  Countries</td> <td>30</td> <td>34</td> <td>39</td> <td>45</td> <td>54</td> </tr> <tr> <td>  b. Number</td> <td>36</td> <td>67</td> <td>104</td> <td>156</td> <td>231</td> </tr> <tr> <td>  Countries</td> <td>12</td> <td>14</td> <td>16</td> <td>18</td> <td>21</td> </tr> <tr> <td>4. Number</td> <td>15</td> <td>17</td> <td>20</td> <td>23</td> <td>27</td> </tr> <tr> <td>  Countries</td> <td>9</td> <td>10</td> <td>11</td> <td>13</td> <td>15</td> </tr> <tr> <td>5. Countries</td> <td>14</td> <td>16</td> <td>18</td> <td>21</td> <td>25</td> </tr> <tr> <td>6. Numbers</td> <td>373</td> <td>357</td> <td>373</td> <td>406</td> <td>426</td> </tr> <tr> <td>7. a. Titles</td> <td>-</td> <td>6</td> <td>3</td> <td>4</td> <td>3</td> </tr> <tr> <td>  b. Titles</td> <td>3</td> <td>4</td> <td>5</td> <td>5</td> <td>5</td> </tr> <tr> <td>  c. Titles</td> <td>-</td> <td>-</td> <td>1</td> <td>-</td> <td>-</td> </tr> <tr> <td>  d. Titles</td> <td>5</td> <td>10</td> <td>9</td> <td>7</td> <td>7</td> </tr> <tr> <td>8. a. Number</td> <td>-</td> <td>1</td> <td>-</td> <td>-</td> <td>1</td> </tr> <tr> <td>  b. Number</td> <td>10</td> <td>12</td> <td>14</td> <td>16</td> <td>18</td> </tr> <tr> <td>9. No. of meetings</td> <td>10</td> <td>10</td> <td>12</td> <td>14</td> <td>15</td> </tr> <tr> <td>10. a. Countries</td> <td>-</td> <td>6</td> <td>8</td> <td>10</td> <td>12</td> </tr> <tr> <td>  b. Programs/projects</td> <td>-</td> <td>8</td> <td>10</td> <td>12</td> <td>14</td> </tr> </tbody> </table>		1982	1983	1984	1985	1986	1. Number	218	268	287	336	397	Countries	32	36	42	49	58	2. Number	115	131	152	177	210	Countries	21	24	28	33	39	3. a. Number	514	586	649	792	962	Countries	30	34	39	45	54	b. Number	36	67	104	156	231	Countries	12	14	16	18	21	4. Number	15	17	20	23	27	Countries	9	10	11	13	15	5. Countries	14	16	18	21	25	6. Numbers	373	357	373	406	426	7. a. Titles	-	6	3	4	3	b. Titles	3	4	5	5	5	c. Titles	-	-	1	-	-	d. Titles	5	10	9	7	7	8. a. Number	-	1	-	-	1	b. Number	10	12	14	16	18	9. No. of meetings	10	10	12	14	15	10. a. Countries	-	6	8	10	12	b. Programs/projects	-	8	10	12	14	<p>AFS and Subgrantee reports</p>	<p>Assumption for collecting outputs</p> <p>Past trends in the nature of LDC assistance requirements will continue. Host governments will continue to find U.S. international support acceptable. Political stability and favorable governmental policies.</p>
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ENVIRONMENTAL THRESHOLD DETERMINATION

TO : AA/DS (Acting), Mr. Bernard Chapnick

FROM : DS/POP, Joseph Speidel

SUBJECT: Environmental Threshold Determination

Project Title : Program for Voluntary Sterilization  
Project Number: 932-0968  
Specific Activity (if applicable) \_\_\_\_\_  
REFERENCE: Impact Identification & Evaluation (IIE) contained  
in attached paper Date May 21, 1961

I recommend that you make the following determination:

- X   1. The proposed agency action is a major Federal action which will not have a significant effect on the human environment.
- 2. The proposed agency action is a major Federal action which will have a significant effect on the human environment, and:
  - a. An Environmental Assessment is required; or
  - b. An Environmental Impact Statement is required.

The cost of and schedule for this requirement is fully described in the referenced document.

- 3. Our environmental examination is not complete. We will submit the analysis no later than \_\_\_\_\_ with our recommendation for an environmental threshold decision.

APPROVED: \_\_\_\_\_

DISAPPROVED: \_\_\_\_\_

DATE: \_\_\_\_\_

IMPACT IDENTIFICATION & EVALUATION FORM (Proj. No. 932-0968 )

<u>Impact Areas &amp; Sub-areas</u> <sup>1/</sup>	<u>Impact</u> <sup>2/</sup>	<u>Impact Areas &amp; Sub-areas</u> <sup>1/</sup>	<u>Impact</u> <sup>2/</sup>
<b>A. LAND USE</b>		<b>E. CULTURAL</b>	
1. Changing the character of the land thru:		1. Altering physical symbols.....	<u>N</u>
a. Increasing the population.....	<u>N</u>	2. Dilution of cultural traditions	<u>N</u>
b. Extracting natural resources...	<u>N</u>	<b>F. SOCIOECONOMIC</b>	
c. Land clearing.....	<u>N</u>	1. Changes in economic/employment patterns	<u>M</u>
d. Changing soil character.....	<u>N</u>	2. Changes in population.....	<u>M (decrease)</u>
2. Altering natural defenses.....	<u>N</u>	3. Changes in cultural patterns...	<u>N</u>
3. Foreclosing important uses.....	<u>N</u>	<b>G. HEALTH</b>	
4. Jeopardizing man or his works...	<u>N</u>	1. Changing a natural environment.	<u>N</u>
<b>B. WATER QUANTITY</b>		2. Eliminating an ecosystem element	<u>N</u>
1. Physical state of water.....	<u>N</u>	<b>H. GENERAL</b>	
2. Chemical and biological states	<u>N</u>	1. International impacts.....	<u>N</u>
3. Ecological balance.....	<u>N</u>	2. Controversial impacts.....	<u>N</u>
<b>C. ATMOSPHERE</b>		3. Larger program impacts.....	<u>N</u>
1. Air additives.....	<u>N</u>	<b>I. OTHER POSSIBLE IMPACTS(not listed above)</b>	
2. Air pollution.....	<u>N</u>	_____	_____
3. Noise pollution.....	<u>N</u>	_____	_____
<b>D. NATURAL RESOURCES</b>		_____	_____
1. Diversion, altered use of water	<u>N</u>	_____	_____
2. Irreversible, inefficient commitments	<u>N</u>		

FOOTNOTES: 1/ See Explanatory Notes for this form. 2/ Use the following for environmental impact: N - None; L - little; M - moderate; H - high; U - unknown.

.....  
 ADDITIONAL COMMENTS.

05/21/81

5C(2) - PROJECT CHECKLISTA. GENERAL CRITERIA FOR PROJECT.

1. App. Unnumbered; FAA Sec. 653(b); Sec. 671
  - (a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project; (a) Congressional Presentations
  - (b) Is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that figure) (b) Yes
2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? n.a.
3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance? n.a.
4. FAA Sec. 611(b); App. Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per *The Principles and Standards for Planning Water and Related Land Resources dated October 25, 1973*? n.a.
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified the country's capability effectively to maintain and utilize the project? n.a.
6. FAA Sec. 209, 619. Is project susceptible of execution as part of regional or multi-lateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. If assistance is for newly independent country, is it furnished through multi-lateral organizations or plans to the maximum extent appropriate? No

7. FAA Sec. 601(a); (and Sec. 201(f) for development loans). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

n.a.

8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

n.a.

9. FAA Sec. 612(b); Sec. 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.

Grantee will be committed under the Agreement to use all reasonable means to maximize in-country support. Use of U.S.-owned local currency will conform with A.I.D. and U.S.G. requirements.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency and, if so, what arrangements have been made for its release?

Under this worldwide grant, remittances to countries requiring use of U.S.-owned currency will be sent to USDC for exchange.

11. ISA 14. Are any FAA funds for FY 73 being used in this Project to construct, operate, maintain, or supply fuel for, any nuclear powerplant under an agreement for cooperation between the United States and any other country?

n.a.

### 3. FUNDING CRITERIA FOR PROJECT

#### 1. Development Assistance Project Criteria

a. FAA Sec. 102(c); Sec. 111; Sec. 291a. Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production, spreading investment out from cities to small towns and rural areas; and (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions?

n.a.

b. FAA Sec. 103, 103A, 104, 105, 106, 107. Is assistance being made available: [Include only applicable paragraph -- a, b, c, d, etc. -- which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.]

- (1) [103] for agriculture, rural development or nutrition; if so, extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, is full account taken of needs of small farmers;
- (2) [104] for population planning or health; if so, extent to which activity extends low-cost, integrated delivery systems to provide health and family planning services, especially to rural areas and poor;
- (3) [105] for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development;
- (4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:
  - (a) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;
  - (b) to help alleviate energy problem;
  - (c) research into, and evaluation of, economic development processes and techniques;
  - (d) reconstruction after natural or manmade disaster;
  - (e) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;
  - (f) for programs of urban development, especially small labor-intensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.

Project aims to increase availability of services to majority of population, including rural areas and poor, subject to host government policies.

(5) [107] by grants for coordinated private effort to develop and disseminate intermediate technologies appropriate for developing countries.

c. FAA Sec. 110(a); Sec. 203(e). Is the recipient country willing to contribute funds to the project, and in what manner has or will it provide assurances that it will provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)?

d. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"?

e. FAA Sec. 207; Sec. 113. Extent to which assistance reflects appropriate emphasis on: (1) encouraging development of democratic, economic, political, and social institutions; (2) self-help in meeting the country's food needs; (3) improving availability of trained worker-power in the country; (4) programs designed to meet the country's health needs; (5) other important areas of economic, political, and social development, including industry; free labor unions, cooperatives, and Voluntary Agencies; transportation and communication; planning and public administration; urban development, and modernization of existing laws; or (6) integrating women into the recipient country's national economy.

f. FAA Sec. 291(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

Varies greatly. Majority of subgrant assistance is to indigenous PVCs. Most of the assistance is complementary to national and bilaterally or multilaterally assisted programs.

n.a.

Project is entirely devoted to promotion of maternal and child health. In some countries, it facilitates and improves the quality of voluntary agency participation in delivery of social services. To some extent, it removes the obstacle of unwanted fertility to women's fuller participation in the national economy.

By their nature, activities supported under this project can be carried out only to the extent that they are consonant with the needs, desires, and capacities of the people of the country.

g. FAA Sec. 201(b)(2)-(4) and -(3); Sec. 201(e); Sec. 211(a)(1)-(3) and -(3). Does the activity give reasonable promise of contributing to the development: of economic resources, or to the increase of productive capacities and self-sustaining economic growth; or of educational or other institutions directed toward social progress? Is it related to and consistent with other development activities, and will it contribute to realizable long-range objectives? And does project paper provide information and conclusion on an activity's economic and technical soundness?

The activity gives reasonable promise of contributing to development through improved health and through reduction of the economic burden of excessive population growth. The activity's economic and technical soundness are discussed in the project paper.

h. FAA Sec. 201(b)(6); Sec. 211(a)(5), (6). Information and conclusion on possible effects of the assistance on U.S. economy, with special reference to areas of substantial labor surplus, and extent to which U.S. commodities and assistance are furnished in a manner consistent with improving or safeguarding the U.S. balance-of-payments position.

n.a.

The formal LETTER OF APPLICATION is under preparation and will be included in the set forwarded to the Administrator for approval.



**International Project**  
**ASSOCIATION FOR VOLUNTARY STERILIZATION, INC.**  
**708 THIRD AVENUE, NEW YORK, NEW YORK 10017, U.S.A.**  
**Telephone: 212-573-8350 Cable: IAFORVS NEW YORK**

May 29, 1981

Mr. Dallas Voran,  
Project Manager  
PHA/POP/FPSD  
Room 316, RPE  
U.S. Int'l Dev. Cooperation Agency  
Agency for International Development  
Department of State  
Washington, D.C. 20523

Dear Mr. Voran:

By this letter, the Association for Voluntary Sterilization would like to make application to the Agency for International Development for program funding for fiscal years 1982-86. AVS proposes to build on its previous nine years of successful experience in providing resources and support for development of operational Voluntary Surgical Contraception programs and an international leadership network. The latter would provide for the advancement of national capability for implementing VSC programs in developing countries. Specifically, in the 1982-86 period AVS proposes to:

- a) Foster accessibility and availability of voluntary surgical contraception in developing countries; and
- b) Integrate and incorporate comprehensive voluntary surgical contraception programs in developing countries where services and institutions have been started or initiated in the past; and
- c) Work with international leadership in the advance; and strengthening of national capability to formulate policies and to plan for implementing quality VSC programs.

As in the past, AVS will work through the International Project to obtain operational goals and the World Federation as the instrument for unified world leadership in the field of sterilization. These functions will be interdependent and mutually reinforcing, with the International Project and the World Federation working together closely as partners in growth. Operational activities will furnish the necessary experience

**04 JUN 1981**

# International Project

Mr. Dallas Voran  
May 29, 1981  
Page Two

on which to base recommendations for policies, standards, guidelines and technical publications. Policy, standards and guidelines, in turn, will influence the quality of the service, training, and information and education programs.

Projected budgetary allocations that have been determined as necessary to achieve project objectives follows:

1982	1983	1984	1985	1986
13.5 mil.	15.5 mil.	18 mil.	21 mil.	25 mil.

Thus, the total allocation requested for 1982-86 is \$93 million. Of course, the allocation requested from AID does not meet the entire costs of our program. AVS is very much dependent on various counterpart contributions from its projects in terms of in-kind and cash contributions (i.e., space, salaries, operational expenditures). The exact dollar value of these in-kind contributions are difficult to determine except as can be calculated on a project by project basis by national AID and host project officials. As well, over the past 3 years, AVS has contributed an average of \$70,000 in private funds for international programming.

AVS requests that the World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception (WFHA-AVSC) be funded directly by AVS and assume a greater role in meeting the project goals. The AVS Executive Committee has concluded that there are decidedly different roles for the International Project and the World Federation. The International Project has the experience to continue developing service proposals and programs (work on the operational level); the World Federation has a decisive role on the theoretical level. They recommend that the World Federation be given power and scope to deal with its decisive political and strategical roles in its work related to the development of standards, guidelines, an information clearinghouse, education, rural delivery, etc. The World Federation is a separate, legally incorporated organization, recognized by the U.N. Economic & Social Council, and cannot appropriately be treated as a subdivision of the International Project or of the Association for Voluntary Sterilization. It is proposed that AVS, for funding purposes, deal with the World Federation (WFHA-AVSC) as it deals with other agencies: i.e., the World Federation should present a formal request for a subgrant. This request would be processed through the International Committee of AVS.

AVS will be the sole grantee of USAID. The greater autonomy of the World Federation might actually allow it to obtain other donors from the international community. It is noted that AVS "controls" World Federation

# International Project

Mr. Dallas Voran  
May 29, 1981  
Page Three

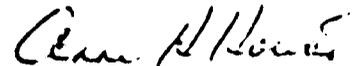
activities only insofar as those activities are funded through the sub-grant mechanism.

Essential to this plan is continuous evaluation of whether it is workable and working. As part of the cooperative agreement with USAID, AVS proposes to develop and appoint an evaluation committee to measure and to develop criteria for judging performance of WFHA-AVSC and the International Project.

It has been our experience in the past, the Association for Voluntary Sterilization looks forward to a productive working relationship with the Agency for International Development for the duration of the cooperative agreement for fiscal years 1982-86.

Sincerely,

Joseph E. Davis, M.D.  
Chairman of the Executive Committee, AVS



Mrs. Anne H. Howat  
Secretary, AVS

JD/AH/JG/DL/ps

Encl. 2

INTERNATIONAL PROJECT/AVS PROJECT OUTPUTS, 1982-86

OUTPUTS

<u>* International Project:</u>		<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>
1. Service facilities in operation	No.	218	248	287	334	397
	Countries	32	36	42	49	58
2. Training facilities in operation	No.	115	131	152	177	210
	Countries	21	24	28	33	39
3. Persons trained: Medical	No.	514	586	679	792	942
	Countries	30	34	39	45	54
Paraprofessional	No.	366	417	484	564	671
	Countries	12	14	16	18	21
4. Dedicated clinical space equipped	No.	15	17	20	23	27
	Countries	9	10	11	13	15
5. RAM centers functioning	Countries	14	16	18	21	25
<u>WFHA-AVSC:</u>						
6. National leadership groups functioning (WFHA-AVSC members)	Countries/ Regions	32/3	35/3	38/3	40/4	42/4
7. Professional publica- tions produced:						
a. guidelines, stan- dards, policies	Titles	----	6	3	4	3
b. study reports	Titles	3	4	5	5	5
c. conference mono- graphs	Titles	----	----	1	----	----
d. promotional materials	Titles	5	10	9	9	9
8. Conferences conducted:						
a. international	Number	----	1	----	----	1
b. nat'l, regional	Number	10	12	14	16	18
9. VS subjects included in international meeting programs	No. of meetings	10	10	12	14	15

OUTPUTS

<u>WFHA-AVSC (Cont'd):</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>
10. Changes reported:					
a. National policy laws, regulations, "climate" Countries	----	6	8	10	12
b. Program improvements: e.g., standards, staff competence, administration Programs/Projects	----	8	10	12	14

\* NOTE: Outputs for the International Project portion of this table are based on percent increments in total budget. Thus, 1983 outputs are 14% above those of 1982, 1984 outputs are 16% above those of 1983, 1985 outputs are 16.6% above those of 1984 and 1986 outputs are 19% above those of 1985.

JC/jav  
5/19/81

INTERNATIONAL PROJECT AVS  
PROJECTED BUDGET  
1982-1986  
(000 Omitted)

INTERNATIONAL PROJECT:

	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>
1. <u>Management:</u>					
Personnel	1,150	1,469	1,607	1,730	1,856
Fringes	275	353	386	415	445
Travel	103	280	298	317	337
Consultants	87	125	137	168	177
Rent & Utilities	170	222	238	253	274
Services & Supplies	94	135	145	155	165
Equipment	23	25	21	22	23
Communications	67	83	90	99	107
Subtotals	<u>2,083</u>	<u>2,692</u>	<u>2,922</u>	<u>3,159</u>	<u>3,384</u>
2. <u>Regional Offices</u>					
Asia	251	300	375	430	490
Africa/Near East	260	310	390	450	510
Latin America	70	100	150	170	200
3. <u>Projects:</u>					
a) Subgrants for services, training, I&E, other; and Small Grants	7,900	8,092	9,580	11,028	12,796
b) National Leadership Ass'ns.	1,100	1,360	1,870	2,620	3,250
c) Equipment and Repair and Maintenance Centers	1,200	1,440	1,825	2,200	2,600
4. <u>Communication Materials:</u>					
Publications (at Hqtrs. & A-V equipment)	20	31	16	16	18
Subtotals	<u>12,884</u>	<u>14,325</u>	<u>17,128</u>	<u>20,073</u>	<u>23,248</u>
WORLD FEDERATION:					
5. <u>Conferences:</u>					
International	0	600	0	0	860
Other	250	100	300	300	200
6. <u>Printed Materials:</u>					
a) Consultants	28	40	42	45	45
b) Production, printing & distribution	56	85	120	122	132
7. <u>Leadership Activities:</u> (i.e., Committee Activities, Special Study Group Activities, Participation in Int'l. Conferences & Special Projects)	110	175	205	230	260
8. <u>Technical Assistance:</u>	172	175	205	230	255
Subtotals	<u>616</u>	<u>1,175</u>	<u>872</u>	<u>927</u>	<u>1,175</u>
GRAND TOTALS	<u><u>311,500</u></u>	<u><u>315,500</u></u>	<u><u>318,000</u></u>	<u><u>321,000</u></u>	<u><u>325,000</u></u>

May 14, 1981

AID HANDBOOK 1, Sup A

TRANS. MEMO NO. 1:11

EFFECTIVE DATE  
June 14, 1977

PAGE NO.

PD-70

## A.I.D. POLICY GUIDELINES ON VOLUNTARY STERILIZATION

The attached Policy Determination 70 was approved by the Administrator on June 14, 1977.

Attachment

## A.I.D. POLICY GUIDELINES ON VOLUNTARY STERILIZATION

### I. Overview

The World Population Plan of Action of the World Population Conference of 1974 observed that: "All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children, and to have the information, education and means to do so. . ."

The Foreign Assistance Act (FAA) of 1961 (as amended) reflects additional considerations:

- (1) the process of economic and social development affects and is in turn affected by the pace, magnitude and direction of population growth; and,
- (2) in many LDCs high rates of population growth limit attainment of broader development goals, contribute to economic hardship and hazardous health conditions, and deny opportunities for improved quality of life for many parents and their children.

In carrying out a comprehensive population assistance program authorized by the FAA, A.I.D. has responded to the growing number of LDC requests for assistance and has helped to make the various methods of family planning permitted by our legislation available on a broader scale to the rural and urban population for use on a strictly voluntary basis.

More recently, LDC governments and non-government organizations have requested assistance to extend the availability of voluntary sterilization services.\* Such requests are partially in response to the preparatory work conducted by

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\*VS service programs include those activities which are primarily intended to provide voluntary male and female sterilizations to persons requesting this type of contraceptive procedure. For purposes of this discussion, however, VS training programs are included, since training generally requires that trainees conduct supervised procedures on patients who have voluntarily presented themselves at a service/training facility for sterilization.

page 2

various organizations which have received A.I.D. support, including the Association for Voluntary Sterilization (AVS), the Pathfinder Fund, the International Fertility Research Program (IFRP), and the Johns Hopkins University Program for International Education in Gynecology and Obstetrics (PIEGO) as part of its broad program of advance training in obstetrics and gynecology. These organizations have contributed to significant advances in the development of new surgical techniques which make sterilization safer, simpler and less expensive as an outpatient procedure. They have developed specialized equipment and given LDC medical personnel specialized training in the practice of obstetrics and gynecology, including endocrinology, identification of cancerous conditions, maternal care, and the management of infertility, and fertility, including sterilization procedures.

In providing support for sterilization services, A.I.D. must reaffirm its long-standing and complete commitment to the basic principle of voluntary acceptance of family planning methods and determine basic conditions and safeguards within which A.I.D. support for sterilization activities can be provided. These conditions and safeguards are needed because of the special nature of sterilization as a highly personal, permanent surgical procedure and to ensure that the needs and rights of individuals are scrupulously protected.

The official positions of national governments are mixed. While voluntary sterilization has become a basic part of comprehensive family planning services in many countries, in some there is only unofficial approval for action by non-government agencies while in other countries there is opposition to the method. A.I.D. staff and A.I.D.-funded grantees and contractors must be fully aware of national sensitivities and must receive AID/W and mission approval before making any commitments on commencing support for sterilization activities in any context.

## II. General Guidelines

A.I.D. acknowledges that each host country is free to determine its own policies and practices concerning the provision

page 3

of sterilization services. However, A.I.D. support for VS program activities can be provided only if they comply with these guidelines in every respect.

**A. Informed Consent:** A.I.D. assistance to VS service programs shall be contingent on satisfactory determination by the USAID (bilateral programs) and/or A.I.D.-funded grantees or contractors that surgical sterilization procedures, supported in whole or in part by A.I.D. funds, are performed only after the individual has voluntarily presented himself or herself at the treatment facility and given his or her informed consent to the sterilization procedure.

Informed consent means the voluntary, knowing assent from the individual after he or she has been advised of the surgical procedures to be followed, the attendant discomforts and possible risks, the benefits to be expected, the availability of alternative methods of family planning, the purpose of the operation and its irreversibility, and his or her option to withdraw consent anytime prior to the operation. An individual's consent is considered voluntary if it is based upon the exercise of free choice and is not obtained by any special inducement or any element of force, fraud, deceit, duress or other forms of coercion or misrepresentation.

Further, the recipient of A.I.D. funds used all or in part for performance of VS procedures must be required to document the patient's informed consent by (a) a written consent document in a language the patient understands and speaks, which explains the basic elements of informed consent, as set out above, and which is signed by the individual and by the attending physician or by the authorized assistant of the attending physician; or (b) when a patient is unable to read adequately a written certification by the attending physician or by the authorized assistant of the attending physician that the basic elements of informed consent above were orally presented to the patient, and that the patient thereafter consented to the performance of the operation. The receipt of the oral explanation shall be acknowledged by the patient's mark on the certification and by the signature or mark of a witness who shall be of the same sex and speak the same language as the patient.

page 4

Copies of these informed consent forms and certification documents for each VS procedure must be retained by the operating medical facility, or by the host government, for a period of three years after performance of the sterilization procedure.

USAID Missions should note their responsibility to monitor A.I.D.-assisted VS programs -- whether such programs are funded bilaterally or by A.I.D.-funded grantees or contractors -- to ensure continuing adherence to the principle of informed consent. In order to carry out this monitoring function effectively, all proposed programs -- either bilaterally funded or funded by A.I.D.-supported intermediaries -- shall be approved by the mission and AID/W prior to any commitment of funds or promise to commit funds for VS activities. In carrying out this responsibility, USAID staff should be thoroughly familiar with local circumstances and government administrative patterns and be able to communicate effectively with host country representatives.

**B. Ready Access to Other Methods:** Where VS services are made available, other means of family planning should also be readily available at a common location, thus enabling a choice on the part of the acceptor.

**C. Incentive Payments:** No A.I.D. funds can be used to pay potential acceptors of sterilization to induce their acceptance of VS. Further, the fee or patient cost structure applied to VS and other contraceptive services shall be established in such a way that no financial incentive is created for sterilization over another method.

**D. Quality of VS Services:** Medical personnel who operate on sterilization patients must be well-trained and qualified in accordance with local medical standards. Equipment provided will be the best available and suitable to the field situations in which it will be used.

**E. Sterilization and Health Services:** To the fullest possible extent, VS programs -- whether bilaterally funded or conducted by A.I.D.-funded private organizations -- shall be conducted as an integral part of the total health care services of the recipient country and shall be performed with respect to the overall health and well-being of prospective acceptors. In addition, opportunities for extending health care to participants in VS programs should be exploited to the fullest. Consideration must also be

page 5

given to the impact that expanded VS services might have on existing general health services of the recipient country with regard to the employment of physicians and related medical personnel and the use of buildings or facilities.

F. Country Policies: In the absence of a stated affirmative policy or explicit acceptance of A.I.D. support for VS activities, USAIDs should take appropriate precautions through consultation with host country officials in order to minimize the prospect of misunderstandings concerning potential VS activities. In monitoring the consistency of A.I.D.-supported VS programs with local policy and practice, USAIDs and A.I.D.-funded donor agencies shall also take particular note of program activities among cultural, ethnic, religious or political minorities to ensure that the principles of informed consent discussed under "A" above are being observed and that undue emphasis is not given to such minority groups.

Addendum:

*Additional A.I.D. Program Guidance for Voluntary Sterilization (VS) Activities, approved February 9, 1981*

**Additional A.I.D. Program Guidance for Voluntary Sterilization (VS) Activities**

1. **INTRODUCTION:** The previously provided Policy Determination No. 70 (PD-70), remains in effect. However, in light of several years experience, additional clarification of a number of points relating to the application of PD-70 and specific interpretation of its provisions appears to be needed.
2. **APPLICABILITY OF PD-70:** PD-70 states (page 3) "A.I.D. support for VS program activities can be provided only if they comply with these guidelines in every respect". This means that the provisions of PD-70 must be applied if A.I.D. funds are used for whole or partial direct support of the performance of VS activities. However, as also noted in PD-70 (page 2), "A.I.D. acknowledges that each host country is free to determine its own policies and practices concerning the provision of sterilization services". The provisions of PD-70 do not apply if A.I.D. provides support for population and family planning programs within a country and provision of VS services is not called for in the support agreement, i.e., VS activities may be a part of the host country's program, but A.I.D. funds are not used to support such services. For example, if A.I.D. support for VS program activities is geographically confined to particular parts of a country, PD-70 applies only to those areas with VS program activities supported by A.I.D. PD-70 does not apply if activities and projects are only peripherally related to provision of VS services, for example, A.I.D. support for construction of multipurpose buildings or broad-based training in reproductive health which includes VS techniques. Finally, in A.I.D.-supported population and family planning programs in host countries which use A.I.D. funds for activities other than VS and support VS activities with their own or other non-A.I.D. funds, PD-70 does not apply.
3. **INFORMED CONSENT:** The recipient of A.I.D. support used fully or in part for performance of VS procedures must obtain and document voluntary informed consent as part of the conduct of any VS procedure. A.I.D. does not require any specific format for this procedure. However, the elements of the procedure described in PD-70 (i.e., an explanation of the nature of the procedure, the attendant risks and benefits, availability of alternative methods of family planning, that the procedure is irreversible, and that the patient may withdraw consent) all must be part of the process of obtaining informed consent.
4. **METHODS OF PAYMENT:** All acceptor and/or provider payments in cash or kind beyond VS service costs as well as fees charged for VS and other contraceptive services shall be established in such a way that no financial incentive is created for sterilization over another contraceptive method.

(A) **Payment of Acceptors:** It should be noted that guidance differs for payments which may be made to acceptors of VS as contrasted to payments to providers of VS (guidance applicable to providers of VS services is described

in para 4.B. below). As stated in PD-70, para C, page 4, "no A.I.D. funds can be used to pay potential acceptors of sterilization to induce their acceptance of VS". Further, A.I.D. support generally cannot be provided to VS services which include incentive payments paid to potential acceptors. For example, a VS program supported by A.I.D. cannot be supplemented with acceptor incentives to induce acceptance of sterilization services. Determination of what constitutes an incentive must be made locally based on thorough knowledge of social and economic circumstances of potential acceptors. In general, recompense to acceptors for legitimate, extra expenses related to VS program services such as transportation, food during confinement, medicines, surgically related garments and dressings and the value of lost work are not considered incentive payments and are eligible for A.I.D. support. It should be emphasized that these payments must be of reasonable nature and aimed at making VS services equally available at the same cost as other contraceptive services. For example, payment for lost work must correspond to a reasonable estimate of the value of lost labor over a reasonable duration of convalescence.

(B) Payment of Providers of Services: In light of experience, it seems desirable to modify the previous A.I.D. program guidance relating to reimbursement for VS services as defined in AIDTO Circular 393 (10/27/77), page 6, section 3, "operating service costs", para. 4. The suggested prohibition of reimbursement to providers of VS services on a per-case basis has not proven practical in that payment per case or procedure is the time-honored method of paying for surgical procedures both in developed and less developed countries. Reimbursement of physicians, paramedical and other service personnel on a per-case basis can be an acceptable procedure. Compensation to providers for items such as anesthesia, personnel costs, pre and post-operative care, transportation, surgical and administrative supplies, etc., on a per-case basis is also generally acceptable. These payments to providers must be reasonable relative to other medical and contraceptive services provided so that no financial incentive is created for the providers to carry out VS procedures compared to provision of other methods of family planning. As in the case of payments to acceptors, this is a judgment which will have to be made on a country and program specific basis. However, in both cases, AID/Washington will provide assistance and guidance in making such determinations, and decisions relating to application of PD-70 should be submitted to AID/Washington for review. Even though payment on a per-case basis is often customary, A.I.D. Missions are advised to encourage patterns of service delivery and methods of payment which do not unduly emphasize VS procedures compared to other methods of fertility control. For example, if physicians who carry out the surgery are paid on a per-case basis and they have no role in the selection or counseling of patients, these service providers cannot induce additional patients to accept sterilizations over other contraceptive methods. Payments of physicians on a per-session rather than a per-case basis may also serve the same function. Since payments on a per-case basis do raise questions, often of a complex nature, beyond those raised by other types of compensation, where a mission can persuade a government to use such other frameworks for payment, whether immediately or phased-in, it should do so.

-3-

(C) Payment of Referral Agents: In some countries fieldworkers are employed to inform and refer potential acceptors of contraceptive methods including VS. When extra expenses are incurred in informing and referring VS acceptors, a per-case payment of these costs is acceptable. Again, as is the case with payments to providers and/or acceptors, a country or program specific determination that the payment is for legitimate extra expenses or activities associated with VS referral must be made. The aim is to make all available contraceptive methods available at the same cost to the acceptor.