

PD-AAS-304  
42564

Prepared for:

Office of Population  
Bureau for Science and Technology  
Agency for International Development  
Washington, D.C.  
Under Contract No. DPE-3024-C-00-4063-00

**THE PERFORMANCE OF THE ASSOCIATION  
FOR VOLUNTARY STERILIZATION IN  
DEVELOPING COUNTRIES, 1982-1985**

June 1985

by

Scott W. Edmonds, M.P.H.  
Donald H. Minkler, M.D.  
Barbara L.K. Pillsbury, Ph.D.  
Michael H. Bernhart, Ph.D.

Edited and Produced by:

Population Technical Assistance Project  
International Science and Technology Institute, Inc.  
2033 M Street, NW, Suite 300  
Washington, DC 20036  
Phone: (202) 466-7290  
Telex: 272785 ISTI UR

Report No. 85-49-019  
Published January 5, 1986

## TABLE OF CONTENTS

GLOSSARY.....	vi
LIST OF TABLES AND FIGURES.....	viii
EXECUTIVE SUMMARY.....	ix
I. INTRODUCTION AND BACKGROUND.....	1
I.1 Purposes of the Evaluation/Scope of Work.....	1
I.2 Evaluation Team.....	2
I.3 Evaluation Methodology.....	2
I.4 Evaluation Constraints.....	3
I.5 Description of AVS.....	3
I.6 AVS Organizational and Functional Components.....	3
I.6.1 Focus and Policy.....	4
I.6.2 Operational Guidelines.....	8
I.6.3 Relationship with AID and AID Inputs.....	8
II. OBSERVATIONS AND FINDINGS.....	10
II.1 Program Accomplishments (1979-1985).....	10
II.1.1 General Accomplishments.....	10
II.1.1.1 AVS-Supported Clinics.....	10
II.1.1.2 Training.....	10
II.1.1.3 AVS Dedicated Clinical Spaces Equipped.....	11
II.1.1.4 Repair and Maintenance.....	12
II.1.1.5 Leadership Groups.....	12
II.1.1.6 Professional Publications.....	13
II.1.1.7 Counseling.....	13
II.1.1.8 Conferences and Workshops.....	13
II.1.2 Program Accomplishments in Countries Visited by Team Members.....	14
II.1.2.1 Indonesia.....	14
II.1.2.2 Nepal.....	14
II.1.2.3 Tunisia.....	16
II.1.2.4 Bangladesh.....	16
II.1.2.5 Brazil.....	17
II.1.2.6 Colombia.....	18
II.2 Expansion of VSC Services.....	19

II.2.1	Pilot Projects.....	22
II.3	Demand for VSC Services.....	23
II.3.1	Tunisia: An Example of Relationship of Demand to Funding Levels.....	24
II.3.2	Nepal: Outreach Needed to Meet Rural Demand.....	25
II.3.3	Guatemala: Unmet Potential Demand.....	26
II.3.4	Dominican Republic.....	27
II.3.5	Nigeria.....	27
II.3.6	Bangladesh: Unexpected Vasectomy Demand.....	27
II.4	Voluntarism.....	28
II.4.1	AVS Policies on Voluntarism & Informed Consent.....	30
II.4.1.1	AVS Policy on Voluntarism.....	30
II.4.1.2	AVS Policy on Informed Consent.....	30
II.4.2	Counseling.....	31
II.4.3	Monitoring and Surveillance.....	34
II.4.3.1	Monitoring of Governmental Policies...34	
II.4.3.2	Monitoring of Service Delivery.....	35
II.4.3.3	Monitoring the Local Press.....	36
II.4.4	Cross-National Follow-up Surveys of Female VSC Acceptors.....	37
II.4.4.1	Specific Research Questions.....	37
II.4.4.2	Data Collection.....	37
II.4.4.3	Anticipated Use of Survey Results.....	38
II.4.5	Follow-up Survey Results.....	38
II.4.5.1	Tunisia.....	38
II.4.5.2	Bangladesh.....	40
II.4.5.3	El Salvador.....	46
II.4.6	Findings from Other Countries.....	49
II.4.6.1	Indonesia.....	50
II.4.6.2	Guatemala.....	50
II.4.6.3	Brazil.....	51
II.4.6.4	Colombia.....	52
II.4.6.5	Sri Lanka.....	52

II.5	Medical Services.....	54
II.5.1	Training.....	54
II.5.2	Supply, Dedicative Space, and RAMs.....	56
II.5.3	Medical Service Standards & Guidelines.....	57
II.5.4	Medical Supervision of Subprojects.....	58
II.5.4.1	Site Visits.....	58
II.5.4.2	Medical Records & Required Reports....	59
II.5.4.3	Investigation and Follow-up of Fatalities.....	60
II.5.5	Medical Services: Country Examples.....	61
II.5.5.1	Bangladesh.....	61
II.5.5.2	Tunisia.....	61
II.6	Strategic Planning.....	64
II.6.1	Resource Allocation.....	65
II.6.2	Services.....	65
II.6.3	Policy Promotion.....	66
II.6.4	Country Strategies.....	66
II.6.5	Factors in Strategic Planning.....	67
II.6.6	National Leadership Groups.....	67
II.6.6.1	Africa (Francophone).....	67
II.6.6.2	Middle East.....	67
II.6.6.3	Tunisia.....	68
II.6.6.4	Egypt.....	69
II.6.6.5	Sub-Saharan Africa.....	69
II.6.7	Summary Observations of Strategic Planning.....	69
II.7	World Federation of Health Agencies for the Advance- ment of Voluntary Surgical Contraception (World Federation). ....	70
II.7.1	Background and Current Status.....	70
II.7.2	Funding History.....	71
II.7.3	Professional Education, Policy, and Program Development.....	71
II.8	Subgrant Development, Approval and Implementation...74	
II.8.1	Subgrant Development.....	74
II.8.2	Subgrant Approval.....	74
II.8.3	Subgrant Implementation.....	76
II.9	Monitoring and Evaluation.....	76

II.9.1	An Evaluation System.....	76
II.9.2	Monitoring.....	79
II.9.3	Future External Evaluations of AVS.....	80
II.10	Administrative Capabilities of AVS.....	81
II.10.1	Central and Regional Administrative Systems.....	81
II.10.2	Financial Administration.....	81
II.11	Impact of AID Requirements on Program Implementation.....	84
II.12	AVS Interest in New Technologies.....	84
III.	Recommendations.....	86
III.1	Future Directions.....	86
III.2	Voluntarism and Monitoring.....	87
III.3	AVS's Medical Services.....	87
III.4	World Federation's Role.....	88
III.5	AVS's Relationship with Other Private Voluntary Organizations.....	89
III.6	Meeting Existing Demand for VSC.....	89
III.7	Strategic Planning.....	89
III.8	Evaluation and Monitoring.....	89
III.8.1	General.....	89
III.8.2	Evaluation.....	90
III.8.3	Monitoring.....	91
	BIBLIOGRAPHY.....	92

## APPENDICES

- A. List of Persons Contacted
- B. AVS Organization Chart
- C. World Federation Conference and Meetings (1981-1984)
- D. World Federation Publications and Reports, March 1985
- E. Publications Produced with AVS Support, by Category and Year of Publication 1982-1985
- F. Asian Counseling Efforts and Technical Assistance Needs

for 1985

- G. Medical Safety Events and Materials Production Supported by AVS (1982-1984)
- H. Scope of Work
- I. PD-3 (September 1983) AID Policy Guidelines on Voluntary Sterilization

**GLOSSARY**

<b>ABEPF</b>	<b>Associacao Brasileira de Entidades de Planejamento Familiar (Brazilian Family Planning Association)</b>
<b>AID</b>	<b>Agency for International Development (Washington, DC)</b>
<b>AID/W</b>	<b>AID/Washington</b>
<b>APHA</b>	<b>American Public Health Association</b>
<b>APROFAM</b>	<b>Asociacion Pro-Bienestar de la Familia de Guatemala (Family Planning Association of Guatemala)</b>
<b>ATVS</b>	<b>Association Tunisienne de Sterilisation Volontaire (Tunisian Association for Voluntary Sterilization)</b>
<b>AVS</b>	<b>Association for Voluntary Sterilization</b>
<b>BAVS</b>	<b>Bangladesh Association for Voluntary Sterilization</b>
<b>BENFAM</b>	<b>Sociedade Civil de Ben-Estar Familiar no Brazil (Brazilian Civil Society for Family Welfare)</b>
<b>BGD</b>	<b>Bangladesh Government</b>
<b>CONAPOFA</b>	<b>Consejo Nacional de Poblacion y Familia (National Council for Population and Family), (Dominican Republic)</b>
<b>CPAIMC</b>	<b>Maternal Child Research Center (Brazil)</b>
<b>EFCS</b>	<b>Egyptian Fertility Care Society</b>
<b>FAN</b>	<b>Fertility Association of Nigeria</b>
<b>FHI</b>	<b>Family Health International</b>
<b>FPAK</b>	<b>Family Planning Association of Kenya</b>
<b>FPAN</b>	<b>Family Planning Association of Nepal</b>
<b>FPIA</b>	<b>Family Planning International Assistance</b>
<b>FP/MCH</b>	<b>Family Planning/Maternal and Child Health (Nepal)</b>
<b>GOT/USAID</b>	<b>Government of Tunisia, USAID</b>
<b>ICARP</b>	<b>International Committee for Applied Research in Population</b>

ICHSDP	"The Integrated Project"
IEC	Information, Education, and Communication
INAMPS	Brazil's Social Security Administration
IPPF	International Planned Parenthood Federation
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MOH	Ministry of Health
ob/gyn	obstetrics/gynecology
ONPEP	Office National du Planning Familial et de la Population (National Family Planning and Population Office), (Tunisia)
PD3	Policy Determination No. 3 (see Appendix I for text)
PKMI	Indonesian Association for Secure Contraception
PROFAMILIA	Asociacion Pro-Bienestar de la Familia Colombiana (Colombian Family Planning Association)
PROPATER	Promocao de Paternidade Responsavel (Responsible Paternity Promotion Party), Brazil
PVO	Private Voluntary Organization
RAM	Repair and Maintenance Center
S&T/POP	Office of Population/Bureau of Science and Technology (AID)
SAMEAC	Sociedade de Assistencia a Maternidade Escola Assis Chateaubriand (Maternal Education Society), (Brazil)
SOGH	Society of Obstetricians and Gynecologists
SOMEFA	Society of Medical Faculties (Colombia)
UBTH	University of Benin Teaching Hospital (Nigeria)
UPSFD	Sao Paulo Family Planning Unit
USAID	AID Missions in developing countries
VSC	Voluntary Surgical Contraception

TABLES AND FIGURES

Table I.6-1	Information on Relative Emphasis of AVS Activities (1982-1984)
Table I.6-2	Percentage of AID Cooperative Agreement - Funded Budget Expended for Grants and Other Costs, (1982-1984)
Table I.6-3	Percentage of AID Cooperative Agreement Sub-agreement Dollars by Area of Primary Emphasis
Table II.3.6	Increase of Vasectomy vs. Tubectomy in Bangladesh
Table II.7.2	World Federation for Voluntary Surgical Contraception Budget

## EXECUTIVE SUMMARY

### 1. Project Background

The Association for Voluntary Sterilization (AVS), established in 1943, was founded by volunteers dedicated to the proposition that surgical contraception is a safe and acceptable method of family planning for high-risk, multiparous women. AVS operated solely in the United States until the early 1970s, when it expanded to developing countries. For the past decade, AVS has received Agency for International Development (AID) financial support. Currently, AID support is through a cooperative agreement, authorized in December 1981 and running through 1986, with a maximum authorized budget of \$78.5 million.

### 2. Evaluation

AID asked the International Science and Technology Institute, Inc., to arrange an evaluation of AVS. The evaluation covers 1982 to 1985, except in certain instances when activities dating back to 1979, the time of an earlier AVS evaluation, also were studied. This evaluation was conducted during June 1985 by Scott Edmonds (team leader), Barbara Pillsbury, Donald Minkler, and Michael Bernhart. The evaluators first spent several days at AVS headquarters interviewing top-level staff and reviewing program documentation. The team members then split up and visited AVS projects in seven countries over the next 20 days, finally reassembling at AVS headquarters in New York City to draft the report.

Evaluated were the management capability of AVS; the quality of medical services rendered; the clear-cut existence of voluntarism; and the scope of counseling offered to prospective acceptors--for example, Are family planning alternatives discussed? Are acceptors completely aware of sterilization's irreversibility?

### 3. Project Accomplishments

3.1 Management. The high quality of AVS staff was apparent at all levels. Program direction is consistent, well-understood, and accepted by the employees. The high staff morale, combined with sound financial and administrative practices, is the necessary foundation upon which an international assistance organization can rely when managing many overseas projects. AVS has proved its management mettle, although some fine-tuning remains. For

example, subgrantees need to be taught the division between financial control and project development so they can refer questions to the proper entity within AVS for prompt and correct responses.

3.2 Medical service. AID should encourage AVS's initiative to post a medical advisor in each region to support project staff with technical assistance, a step already approved by USAID/Dhaka. This would both promote local implementation of services and bridge the communication gap that has caused some medical incidents to go unreported.

3.3 Voluntarism. AVS takes great precautions to ensure strict voluntarism in all projects it supports. No evidence of coercion was found in any AVS-supported services of the countries visited, no reports of coercion were made surrounding AVS-supported activities in any other countries either.

3.4 Counseling. Counseling is crucial in voluntary sterilization contraception choices because the procedure is permanent. Programs must make prospective acceptors understand the nature and consequences of their informed, voluntary decisions to accept sterilization. To gather pertinent data, AVS has funded follow-up surveys in five countries to rate acceptor satisfaction. Early results are positive.

In a tangential area, the World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception has played a positive role in advancing professional education, medical quality assurance, leadership, and policy development as well as information dissemination. However, AID and the World Federation need to work more closely to coordinate AID-funded federation activities with other AID population objectives.

Clearly, the evaluation shows that AVS has used AID support effectively over the period evaluated. AVS has won worldwide recognition as a leader in assisting both private and public institutions in developing countries to provide safe and affordable voluntary sterilization contraceptive services. AID should continue funding AVS for the next five years.

#### 4. Recommendations

Specific recommendations are summarized below.

##### 4.1 Directions

1) AVS should focus on achieving its twin objective of expanding existing services and introducing VSC to new areas. In regards to planned expansion, AVS should encourage its sub-

grantees to be more cost-effective and to become financially self-sufficient. This will probably require more technical assistance to subgrantees. In regards to provision of new services, AVS should place increased emphasis on overcoming barriers to the rapid expansion of services in countries where VSC has already been demonstrated as politically viable. This could be accomplished by working with the World Federation to develop specific policies for each of these countries.

2) AVS should help private physicians establish centers for surgical contraception by providing dedicated space or institutional reimbursement until these practitioners develop a client base.

3) AVS should establish a regional office for sub-Saharan Africa as soon as possible.

4) If a new cooperative agreement is signed, bilateral funding to complement central funds should be provided to missions to fund AVS projects in their respective countries.

5) Regional offices of AVS should develop regional strategies to supplement the country strategies now in force.

6) AVS should continue to emphasize safe VSC expansion and not divert its energies and resources into research on new VSC techniques.

#### 4.2 Voluntarism

7) AVS should continue its monitoring and surveillance to ensure voluntarism. AVS and AID should continue to support local monitoring initiatives, follow-up studies, and experimentation with approaches that give quick and reliable results.

8) AVS should continue its efforts to improve counseling for informed consent so that all requestors are fully aware of the permanence of the operation. Activities to improve counseling should be undertaken chiefly on a country- or region-specific basis in order to develop approaches that are the most effective possible, given the constraints that exist in each country.

9) Results of the cross-national follow-up survey of female VSC acceptors should be published in a professional journal (for example, Contraception or The International Journal of Obstetrics and Gynecology).

10) AID should make AVS's high-quality counseling materials available to other cooperating agencies.

#### 4.3 AVS's Medical Services

11) AVS should encourage national coordination of VSC training, and should limit training levels to VSC caseloads to assure sufficient training cases to acquire proficiency.

12) The provision of dedicated space and equipment for safe ambulatory VSC service delivery is an appropriate AVS concept and should be encouraged in planning institutional service and training project.

13) AVS should complete the transfer of financial responsibility for RAMs to alternative sources of support as soon as possible.

14) Project directors should convey the details of reporting requirements of complications and fatalities in writing to each surgeon providing VSC services through an AVS subagreement.

15) If comprehension of English is in question, project directors should be required to translate AVS medical service standards and reporting requirements into the local language.

16) The medical division should promote conformity to the medical service guidelines, require compliance with the reporting of deviations from the standards, and support in-service training and retraining whenever necessary.

17) If further resources are to be given to Tunisia for training out-of-country physicians, Tunisian trainers must be skilled in minilaparotomy and oriented toward presenting its use positively and accurately.

#### 4.4 World Federation's Role

18) AID should continue supporting this component of AVS, including core costs for the secretariat. AID and AVS should agree on a set of specific written guidelines outlining the types of activities AID believes most important for the World Federation to undertake with AID funding. These guidelines should be reviewed and revised periodically as necessary.

19) The World Federation should take a more prominent role in increasing the number of countries in which VSC is an accepted method of family planning and a health measure for high-risk women of reproductive age. Country leaders, and their orientation and out-of-country training resources, should be identified in countries where successful VSC programs are operating.

Technical assistance should be given to leaders in countries where VSC is not yet institutionalized to develop plans of action. The World Federation should inform AVS international and regional offices of impending activities so follow-ups can be done quickly before interest subsides.

20) The World Federation's information dissemination system should be continued and a feedback system encouraged so that subjects included in the materials are pertinent to the situations in the various countries.

21) To ensure that AID/Washington is cognizant of supportive of AID-funded World Federation activities, the same approval process used in other AVS-supported proposals should be utilized (as stated in C.2, Approval Criteria, p. 7 of the current cooperative agreement).

#### 4.5 AVS's Relationship with Other Private Voluntary Organizations

22) AID should ensure no duplication of effort or wasted resources among AVS, JHPIEGO, and other private organizations, preferably through joint implementation meetings and subagreement reviews.

23) USAID missions should hold periodic meetings with all private voluntary organizations in their regions to review progress and attempt to eliminate duplication.

#### 4.6 Meeting Existing Demand for VSC

24) Service statistics from locations where acceptors can conveniently obtain the contraceptive method of their choice should be used as crude indicators of VSC demand. AVS should collaborate with USAID missions by providing service statistics from clinics that could serve as sample points to compute demand on a country-by-country basis.

25) In larger facilities, trials should be carried out where designated space and designated staff - with no other priority responsibilities - can be assigned to family planning.

#### 4.7 Strategic Planning

26) AVS should support the formation of national leadership groups, especially in countries where sterilization remains a culturally sensitive issue.

#### 4.8 Evaluation and Monitoring

27) AVS should continue its recent efforts to develop a comprehensive monitoring and evaluation system.

28) All monitoring and evaluative activities presently under way and the purpose of each analyzed.

29) Determination should be made whether the present activities are adequate for meeting AVS's information needs at various levels.

30) AVS should follow through on the present intent to improve the guidelines that AVS/New York has developed for including evaluation plans in the cooperative agreements with its grantees.

31) Appropriate evaluation methodologies should be worked out.

32) AVS grantees should participate in the evaluation process.

33) Determination should be made whether training, IEC, and other similar activities are being evaluated adequately. This will be increasingly important in countries where sterilization services are well established and AVS is trying to move into new approaches.

34) Evaluation should not become just bureaucratic paperwork. It is crucial to seek that delicate balance between a good evaluation system that provides only needed information and one perceived in the field as paperwork foisted on the field by headquarters.

35) AVS must hire a professional experienced in evaluation to fill the empty evaluation position, ideally supplemented by an assistant. With regard to the organizational location of the evaluation function, it should be understood that the objective is for the New York office to provide technical assistance to field personnel in carrying out utilization-focused evaluation.

36) AVS should modify the quarterly reporting forms it uses for project monitoring. These should provide for built-in linkage from one quarter to the next to show current progress toward end-of-project objectives. Self-assessment by grantees should be required in subagreements and subgrant financial inputs should be related to outputs, perhaps by eliciting cost-per-procedure data.

37) Site visits should be used for reviewing implementation progress.

38) Acceptor satisfaction with VSC should be carefully monitored during post-operative clinic visits.

39) AVS should work with AID to build into the next AID-AVS cooperative agreement a good evaluation plan for AID's evaluation of AVS.

## I. INTRODUCTION AND BACKGROUND

The Association for Voluntary Sterilization (AVS) is a nonprofit organization dedicated to making surgical contraception available on demand. The goal of AVS is not to promote sterilization over other methods, but rather to promote the inclusion of quality sterilization services in family planning and health programs as one method among many. AVS operates both national and international projects and is funded by private sources in addition to the Agency for International Development (AID).

AID funds AVS activities in developing countries as an integral part of health and family planning programs. This support commenced in 1972 and in aggregate now totals approximately \$90 million. AVS programs in 60 countries account for over 1.1 million voluntary surgical contraception (VSC) procedures performed between 1976 and 1984 (all funding sources). 1/

The current AID support is through a cooperative agreement (AID/DPE-0968-A-00-2001-00), authorized on December 22, 1981, that supersedes an AID grant (AID/pha-G-1129), authorized on August 25, 1977. The last external evaluation of AVS was conducted by an American Public Health Association (APHA) team in December 1979. AID audited the cooperative agreement and grant in September 1984. The AID Project and Contracting Offices conducted a management review in May 1984.

### I.1 Purposes of the Evaluation/Scope of Work

The evaluation was designed to provide information for decisions concerning the proposed extension of the AID/AVS cooperative agreement from January 1, 1987 to December 31, 1992.

The scope of work called for an analysis of AVS's programmatic achievements as compared to established project objectives, taking into account funding levels; AVS strategies at central and country levels; voluntarism and medical quality; and the overall program management, with particular emphasis on subagreements (further details in Appendix H).

The project officer and other AID/W staff were interested in determining AVS's compliance with AID's strict guidelines on counseling and informed consent; presentation of other contra-

---

<sup>1</sup> 1984 AVS Annual Report of International Programs, Table 3.1, p. 3.3.

ceptive methods to clients; medical quality control; the time lapse between counseling and the operation; the running of repair and maintenance (RAM) centers for equipment and who would best administer them -- either governments or private enterprises; and the effectiveness and future role of the World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception <sup>2/</sup> in the expansion of VSC in developing countries.

## I.2 Evaluation Team

The four-member evaluation team was comprised of a team leader with background and experience in family planning service delivery in developing countries and the evaluation of these services; a physician with obstetrics/gynecology (ob/gyn) expertise and experience in providing family planning services in developing countries; a social scientist with interest in the user perspective and experience in assessing family planning acceptance through information, education, and communication (IEC), and indigenous demand for services; and a management analyst with experience in assessing private voluntary organizations' (PVO) family planning programs.

## I.3 Evaluation Methodology

Documentation and reports relating to AVS's activities under AID funding were reviewed and discussions were held with AVS personnel at central and regional levels, USAID mission population and health officers, selected subgrantees, and AID/Washington (AID/W) staff. Team members made site visits in Brazil, the Dominican Republic, Colombia, Nigeria, Nepal, Bangladesh, Tunisia, and Indonesia. These countries were selected because they either had regional AVS offices or major in-country VSC activities. These included the major elements of AVS's projects such as service delivery, training, leadership activities, IEC, and human resources/rapid response subgrants.

The team also met with AVS officials in New York prior to site visits; returned to AVS central offices in New York to consolidate findings; and then attended a debriefing session with AID/W officials in Rosslyn, Virginia.

The evaluation concentrated on the period from 1982 to the present but also included events occurring after December 1979 when a previous evaluation had been conducted. The 1979 evaluation team had concentrated on four general areas: management, national associations, World Federation policy, and institution-

---

<sup>2</sup> Hereafter referred to as World Federation

alization/integration. The team also conducted site visits to Indonesia, Thailand, Bangladesh, Honduras, Mexico, and Tunisia, the findings from which constitute the bulk of this report. Overall, AVS is meeting project objectives efficiently, based on in-country observations.

#### I.4 Evaluation Constraints

Everyone--the evaluation team, AID missions, AVS/New York, AVS regional offices, and host-country collaborating organizations--regretted that more time was not allotted to the evaluation to permit in-depth analysis of the subgrant achievements and to verify reports. Nevertheless, numerous interviews were conducted based on structured interview forms developed by the team (see Appendix A). Although the findings were largely descriptive, they did permit the team to come to general conclusions regarding the general effectiveness of the AVS project.

#### I.5 Description of AVS

AVS is a nonprofit organization, founded in 1943, that promotes safe, effective, and affordable VSC for men and women. As of May 30, 1985, the organization had 108 programs in 41 countries with a combined population of over 1 billion. The organization is governed by a volunteer board of directors, and its international programs, to which this evaluation is directed, come under the scrutiny of a board-appointed international committee that actively participate in AVS's international project development process. The organization has an executive director, appointed by the board, who oversees day-to-day operations. The organization has a central staff of 72, divided into both technical and office support persons, and regional staff numbering an additional 21. The organization's central headquarters is in New York City. Its three regional offices are in Tunisia, Colombia, and Bangladesh; they monitor AVS projects in Africa, South America, and Asia respectively.

#### I.6 AVS Organizational and Functional Components

AVS has grown tremendously since its founding, and particularly since the organization became active in developing countries. In January 1975 there were 41 active subgrants; by 1978 the number had increased to 94. This growth, coupled with needs for additional technical assistance, monitoring and follow-up, and the changing complexity of program development resulted in a corresponding increase of professional staff from 10 to 28. In 1984, the number of active subgrants reached 108, excluding 37 small grants (\$7,500 or less) awarded in 1984.

At AVS headquarters there is an executive director with six divisions under his jurisdiction (see AVS Organizational Chart, Appendix B). The divisions are: Development, World Federation, Finance and Administration, International Programs, National Programs, and Medical. (The director of the Finance and Administration Division acts as executive director in the director's absence.)

The three regional offices are staffed by a regional director and support staff. The number of staff depends in part on the size and number of subgrants being monitored by each region, and in part to technical assistance, changing complexity of program development, the changing needs for monitoring and follow-up, and changing geographic priorities. The regional offices are backstopped by program managers located in the International Programs Division. This division plans and directs AVS's international assistance, including proposal development, subgrant management, procedures -- medical equipment procurement and distribution -- and grant implementation with the help of the regional offices. This division coordinates donors and sister and counterpart agencies concerned with international programs. It also technically assists institutions in developing countries.

The Development Division raises funds while the Finance and Administration Division provides support services such as accounting and audit; facility management; personnel administration; travel; office equipment and supply procurement; and operative and administrative support to the regional offices. The Medical Division ensures medical quality, evaluates and documents AVS-supported subgrants, arranges for training of professionals in voluntary surgical contraception, and introduces appropriate technology to improve availability, effectiveness, and safety of services.

The World Federation Secretariat is autonomous but closely allied with AVS in its commitment to VSC. The main functional areas are professional education, leadership, policy development, and quality assurance, performed through 44 leadership groups in 36 countries.

#### I.6.1 Focus and Policy

In 1982 AVS had almost 10 years of experience with international programs. Before 1982 the main objective was to expand VSC, and this is still the case. The early programs were based in Asia and Central America where receptivity and expertise were higher than, for example, West Africa and South America.

The focus of procedures before 1982 was on females because vasectomy was seen as unacceptable to males. However, it was not

so much male reluctance that prevented growth of vasectomy as an acceptable method as bias of service providers toward female programs, because, with proper counseling vasectomy acceptance grew.

The need to institutionalize in order to conserve funds was recognized in the various countries where pilot projects had grown into larger projects. These larger projects required larger inputs, draining available resources, because VSC projects require a phase-out as well as a phase-in period, on the part of the grantor. However, during 1982 to 1985 the organization's focus extended beyond service provision to improved quality control, informed consent, and counseling in ongoing projects, a process reflected in the subjects of World Federation conferences and publications (see Appendices C and D). This shift in focus required considerable technical assistance in these subject areas. For example, as awareness grew that minilaparotomy is a safe and cost-effective noninstitutional procedure when performed under local anesthesia, AVS began to concentrate on safety and quality of services, informed decision-making of couples, cost-effective programs, and interagency coordination. The geographical coverage of AVS projects also was examined. One of the indicators of geographical emphasis is resource allocation, as measured by regional funding levels and AVS regional staff members, number of subgrants, number of participating countries, and travel from headquarters. These indicators are illustrated in Table I.6-1

The goal of AVS is not to promote sterilization over other methods, but rather to promote the inclusion of quality sterilization services in family planning and health programs as one method among many. AVS, in fact, urges couples just beginning families to choose a temporary method of contraception, but believes that high-quality sterilization services should be available as a safe, effective, and suitable method for older, higher-parity couples.

AVS's stated policy is to introduce VSC to new and underserved countries. The South American and African regions have funding priority for subgrants, and less is allocated for Asia and Central America. However, two factors affect the transfer of emphasis: the ability to locate support for projects in the regions being de-emphasized; and the receptivity and absorptive capacity of the Latin American and African countries to implement grants. Therefore a certain lag-time is anticipated between policy determination and implementation, and site visits to regional AVS offices verified this lag.

TABLE I.6-1.  
INFORMATION ON RELATIVE EMPHASIS OF AVS ACTIVITIES  
(1982 - 1984)

# Countries							
Program Year	East Asia	South Asia	Sub-Sah Africa	N.Afr./ Mid.East	South Amer.	Central America	Carib.
82	4	3	3	5	4	4	2
83	4	1	8	4	3	7	4
84	3	2	9	4	5	4	2
# Subgrants							
82	19	16	5	16	14	12	4
83	11	3	15	16	8	19	8
84	26	8	20	12	10	16	3
\$ Obligated (x1,000)							
82	1947	2235	164	1037	1319	1841	631
83	734	1717	720	1136	1457	2207	790
84	1559	2153	950	769	1298	1182	364
International Travel (\$)							
	<u>Asia</u>						
83	53,750		-0-	63,000	19,500		18,200
84	55,750		21,800	53,500	22,000		25,800
85	60,000		25,800	46,000	29,000		18,000
Regional Office Staff							
	<u>Dacca</u>		<u>Tunis</u>		<u>Colombia</u>		
82	17 (6)*		13 (6)*		--		
83	23 (8)*		16 (7)*		1 (1)*		
84	26 (10)*		16 (7)*		4 (2)*		

NOTE: \* Professional staff

Source: AVS Annual Reports

TABLE I.6-2

**PERCENTAGE OF AID COOPERATIVE AGREEMENT-FUNDED  
BUDGET EXPENDED FOR SUBGRANTS AND OTHER COSTS  
(1982 - 1984)**

	1982	1983	1984
Subgrants	71.2	65.8	65.8
Personnel-related costs	15.2	15.3	17.0
Travel	1.2	1.4	2.0
Administrative costs	<u>12.4</u>	<u>17.5</u>	<u>15.2</u>
	100.0	100.0	100.0

---

TABLE I.6-3

**PERCENTAGE OF AID COOPERATIVE AGREEMENT  
SUB-AGREEMENT DOLLARS BY AREA OF PRIMARY EMPHASIS**

	1982	1983	1984
Sterilization Services	63.8	73.1	72.5
Training and Professional Education	16.2	6.2	4.9
Leadership and Policy Development	8.7	14.5	16.4
Information	5.0	1.9	4.9
Other	6.3	4.3	1.2
	<u>100.0</u>	<u>100.0</u>	<u>100.0</u>

---

AVS is a service-oriented organization with a reputation for identifying and funding subgrants expeditiously. Tables I.6-2 and I.6-3 show the proportions of the total cooperative agreement budget expenditure for subgrants and for service delivery.

However, striking the balance between VSC expansion and ensuring safe services, well-informed clients, and institutionalization of maturing programs, to allow transfer of funding, will not be easy and will require constant and careful monitoring over the next funding period.

### I.6.2 Operational Guidelines

AVS, by the very nature of its operational style -- that is the subgrant mechanism -- must give strict and detailed guidelines to its grantees to ensure basic compliance. For AVS, compliance means that VSC must be completely voluntary; that patients be completely informed when they choose this permanent method over other, more temporary means; and that the procedure be performed safely by well-trained, skilled service providers using the proper equipment and in the proper settings. To this end AVS has developed and distributes, worldwide, written guidelines, policy documents, standards, and training materials in several languages for its grantees. (See Appendix E for list of publications.) Presentations at the various AVS-sponsored meetings and expert committee gatherings reinforce the guidelines as well as provide a forum for discussion of their applicability in field settings.

### I.6.3 Relationship with AID and AID Inputs

Several factors contributed to AID's interest in supporting AVS in the early 1970s. One was the realization that temporary methods, such as pills and condoms, had a limited impact on reducing population growth because of problems of acceptability, resupply, and low continuation rates. Specifically, IUDs require trained personnel, mostly doctors, to insert them; expulsion rates are significant; and removals or reinsertions are often necessary. Another factor was that recent international advances in female VSC techniques -- endoscopy and minilaparotomy -- had proved to be safe and effective means of limiting family size. Vasectomy also had been proved to be a simple VSC procedure. These findings, combined with AVS's extensive professional contacts with international medical institutions and its policy of voluntarism, made AVS an institution well-suited to lead the VSC field.

AID's support in the 1970s came mostly through the Central Population Office in Washington, D.C., and, in fact, central grants and agreements are still the major funding mechanisms, although more bilateral funds are being used. AID's position as the major donor to AVS has, of course, influenced AVS's international programs to some degree, as evidenced by AVS's emphasis on service delivery. The selection of countries also reflects

AID's need assessments based on population pressures and other considerations.

The restrictions imposed by U.S. governmental and foreign aid regulations apply to programs funded by AID (Appendix I), and, although there are sometimes constraints, they have not inhibited VSC expansion significantly because of 1) the heavy demand by couples to limit family size and 2) the availability of service providers to meet this demand. AVS and the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) have been the major trainers of and suppliers to doctors and other professional and paraprofessional personnel involved in service delivery. Whether AID regulations, which are growing in number and complexity, cause constraints in the future depends on AVS's ability effectively to program its activities within AID's imposed limitations. Currently the AID grant and subgrant approval process has not impeded AVS's international programs, thanks to the close and cordial working relationship of the two agencies. Relationships between the AVS regional offices and the USAID missions in the respective regions appear to be good. In Bangladesh, Nepal, and Tunisia, for example, USAID population staff were quick to praise the accomplishments and good working style and relationships of the AVS regional staff with whom they interact. In Indonesia and Bangladesh, mission funding complements the AVS central grant through a "buy in" arrangement which allows VSC activities to be tailored better to mission priorities.

## II. OBSERVATIONS AND FINDINGS

### II.1 Program Accomplishments (1979-1985)

#### II.1.1 General Accomplishments

AVS has surpassed AID's projections set forth in the Project Paper. In particular, AVS has achieved much in the areas of voluntarism, medical surveillance, and project management, elements which were omitted from the list of anticipated accomplishments. No serious problems in implementation have affected project programs either at the central level or locally. In general, AVS staff and resources provide effective VSC services according to the stated objectives in each specific grant.

II.1.1.1 AVS-Supported Clinics. As of 1985, AVS was supporting 685 clinics, mobile clinics, and temporary sites operating in 33 countries. Although VSC services were introduced in Asia well before any other region, the largest number of AVS-supported service facilities in any one region in the 1984 period were in the Central American and Caribbean region, followed closely by Asia and South America. VSC has only recently been made available in the African and Middle Eastern regions, and increases in these areas are dramatic. Some sub-Saharan African countries, however, showing one or two VSC facilities in 1982 - 1983, but fewer or no facilities in 1984, may merely be realizing the award of surgical equipment or assistance via small grants in earlier years.

Increases in the number of service facilities over the three-year study period were most noticeable in Egypt, Morocco, Nigeria, Zaire, Nepal, the Philippines, the Dominican Republic, and Brazil. In some instances, the increase is explained entirely by a one-time large shipment of equipment to existing health and family planning structures, (e.g., Egypt, Morocco, Zaire, and Mexico). In other cases, the increase represents program expansion to include government facilities (e.g., in Nepal) or adoption of the mobile team approach (e.g., in the Philippines).

Similarly, sharp falls in the number of service sites could result from discontinuation of a major subagreement (e.g., in Indonesia) or reduction in a major program, as in Colombia where service was temporarily curtailed in response to nationwide religious opposition to VSC.

II.1.1.2 Training. Training is another important AVS output. By the end of calendar year 1984, AVS had 986 training facilities in 19 countries.

II.1.1.2.1 Comprehensive Training. Almost two-thirds of all AVS training facilities are in Asia. Of the remaining one-third, most are in Africa and the Middle Eastern region, followed by Central America and the Caribbean, and South American regions.

The number of training facilities in Asia, however, is somewhat inflated because of the definition of training facilities used for data gathering. For example, 18 facilities in Thailand in 1983 and 25 in Sri Lanka are merely sites at which volunteers and fieldworkers were trained, not the formal, ongoing, comprehensive training institutions that might be expected. However, these figures also include facilities for ongoing physician or paraprofessional training. AVS supports major training programs in Egypt, Tunisia, Bangladesh, Nepal, Indonesia, the Philippines, Guatemala, the Dominican Republic, Brazil, and Colombia.

II.1.1.2.2 Physician Training. Overall, AVS funds trained 2,709 physicians and 5,377 paraprofessionals in 36 countries during the 1982 - 1984 period.

An increase in physicians trained in Asia and sub-Saharan Africa over the 1982-1984 period is set against a decrease in medical staff training in North Africa, the Middle East, and South America, although this latter could well be a temporary phenomenon. No changes in paraprofessional training are apparent except in Anglophone Africa, where it is on the rise.

Bangladesh accounts for the largest number of medical and paraprofessional staff trained in any country during the three-year period, primarily because of a large effort to train government physicians and field agents by the Bangladesh Association for Voluntary Sterilization (BAVS). Egypt, Indonesia, Colombia, and Brazil are the other countries training physicians in large numbers, particularly in 1982 and 1984.

II.1.1.3 AVS Dedicated Clinical Spaces - Equipped. A dedicated clinical space is a small room which has been specifically set aside in a hospital for sterilizations. It is considered equipped when a single piece of vital equipment (for example, laproscoper or a minilap kit) plus the necessary emergency equipment enables a clinic to begin VSC services.

Many clinical facilities have either AVS/New York-provided or locally purchased equipment, instruments, appliances, or furnishings and/or were renovated, with AVS support, in order to start up or expand VSC via a subagreement, small grant, or other means during the 1982 - 1984 period. The number of equipped

dedicated clinical spaces funded by AVS per year has declined rapidly in the three-year period from 196 in 1982 to 71 in 1984.

Asia accounts for the majority of the dedicated clinical spaces equipped during the three years studied. The largest number of spaces equipped, after Asia, were in sub-Saharan Africa, where equipped clinics numbered 26 in seven countries.

Mexico, Egypt, Bangladesh, Indonesia, and Thailand received the most assistance for dedicated space creation in 1982; Indonesia, Jamaica, and Zaire, in 1983; and Morocco, in 1984. In most of these instances, the country had received a single large award of surgical and/or clinical equipment for a nationwide VSC program.

II.1.1.4 Repair and Maintenance. AVS has been instrumental in establishing repair and maintenance centers (RAM) to ensure proper care of sterilization equipment, primarily laparoscopes and laproscators. Currently, 14 centers are functioning. (AVS's goal is to help a VSC equipment RAM become self-sufficient and institutionalized, or to find alternative funding sources after successive years of AVS support. Hence, included in this figure are those RAMs funded in the past by AVS but now operating under a different funding agreement.) AVS tries to institutionalize these centers as soon as possible. So far, the RAMs in Korea, Thailand, Nepal, Jamaica, Panama, Indonesia, Morocco, Tunisia, and Egypt have been institutionalized, or had funding responsibility transferred to another donor.

II.1.1.5 Leadership Groups. AVS forms regional and national leadership groups, which are the forerunner of country and regional subgrants and help to attract dedicated professionals interested in starting national VSC services in their home countries. The World Federation is one vehicle for organizing these groups. Currently, three regional groups and 39 national groups exist.

Most national leadership groups are in Asia, North Africa, and the Middle East, followed by Central America and the Caribbean, and the European region. The number of such groups affiliated with the World Federation is small in sub-Saharan Africa and South America, which generally corresponds to the state of VSC in these regions.

The majority of the national and regional leadership groups (excluding those in Europe) received support from AVS for VSC-related programs during the study period. However, membership in the World Federation is not a prerequisite for receiving AVS assistance.

II.1.1.6 Professional Publications. AVS also develops and distributes publications to increase the effectiveness of VSC in developing countries. Reports, monographs, brochures, journals, and other forms of publications meant for special or general audiences within and/or outside the AVS system, produced by either AVS or the World Federation during the period 1982 - 1985, are outlined below.

o Guidelines (10) <sup>3/</sup> include printed and photocopied materials targeted to improve the skills, knowledge, or performance of the staff, volunteers, or subrecipients to enhance the quality of program outputs (for example, AVS's policy statement and the World Federation's counseling guidelines).

o Study Reports (11) include reports of the working committees, seminars, workshops, and task forces.

o Conference Monographs (5) are proceedings of the regional or international meetings sponsored by AVS/World Federation and published during the study period.

o Promotional Materials (23) includes publications aimed at special or general audiences describing programs or activities of AVS or the World Federation, produced during the period of this report (for example, vasectomy announcement brochure and the grant application form). For a complete list of AVS publications, see Appendix E.

II.1.1.7 Counseling. In 1982, AVS gave major impetus to developing a counseling program to replace those of unacceptable quality in certain service programs. To develop this program, policy and guidelines were formed, counselors selected and trained, and informational materials disseminated. The program's relative success is discussed in II.4.1 and II.4.2. Counseling is defined as providing the necessary information to ensure that each client can make a reasoned, informed decision to accept the contraceptive method in an atmosphere free of deceit, constraint, coercion, or personal bias on the part of the service provider.

II.1.1.8 Conferences and Workshops. AVS and its subrecipients sponsor international and national/regional meetings on subjects related to VSC programs. During 1982 - 1984, four international and 29 national/regional meetings were held. Several of the national meetings were convened by national

---

<sup>3/</sup> This and the following numbers in parentheses indicate the number of publications.

leadership groups. The international and regional conferences were organized exclusively by the World Federation, largely through AVS support. A more detailed discussion is found in II.7.

#### II.1.2 Program Accomplishments in Countries Visited by Team Members

II.1.2.1 Indonesia. In Indonesia, VSC is not an official method of family planning because of religious leaders' opposition. However, the government of Indonesia permits nongovernmental sterilization and is allowing the AVS-supported grantee, Indonesian Association for Secure Contraception (PKMI), to lay the groundwork for a national program. PKMI, with AVS financial support and technical assistance, is the major VSC catalyst in Indonesia.

AVS, through PKMI, locates and trains VSC specialists in ob/gyn departments in major medical schools, encouraging the recruits to establish services in their respective areas to demonstrate to the government that VSC is safe and effective. Service has expanded from 241 VSC facilities in 1975 to 1,375 in 1984. The number of procedures performed annually has risen 10 times over the decade, from 10,000 in 1975 to 100,000 in 1984, thanks to AVS-supported training of 747 doctors and 806 paramedics. The PKMI works with the government of Indonesia, which, recognizing PKMI's professional competence, has contracted the organization to conduct a need assessment in 13 provinces. The assessment's results will be used by the mission to upgrade 173 hospitals and 346 health clinics and to institute reimbursement for VSC services. The Indonesian government and USAID/Indonesia funds the RAMs PKMI operates.

Despite the progress, constraints remain. The government of Indonesia charges an operation fee for all procedures performed in hospitals and health centers, including VSCs. The fee is deducted from the Rp 15,000 service fee for female procedures and the Rp. 10,000 for male, paid by the National Family Planning Co-ordinating Board (BKKBN) and PKMI. BKKBN, because VSC is not an officially recognized method, has to divest limited funds from other sources to pay service costs. According to members of BKKBN's staff, the inclusion of VSC costs as a budget line item may not be possible until 1989 when the current fourth five-year plan expires. Also, the number of male VSCs being performed is very low -- about one-ninth of the total procedures.

II.1.2.2 Nepal. Aided by AVS expertise, voluntary sterilization is the leading contraceptive method in this country,

where demand for temporary methods is scant and the health care system is not able to provide the follow-up required to maintain continuation levels for temporary methods. Most Nepali couples marry very early and promptly begin, and then continue to bear children without much understanding of or desire for child spacing. In addition, the distances and natural topographical obstacles (i.e., mountains and climate), and the shortage of trained manpower are so inhibiting that the infrastructure for reliably extending any sort of services beyond the capital is virtually nonexistent.

For these reasons, the government of Nepal, since 1982, has placed a high priority on extending sterilization services as a short-term strategy for halting the country's destructive population growth (a natural growth rate of 2.3 percent per year augmented by population overflow from India to about 2.7 percent). Both male and female sterilization have become popular among Nepali couples who have produced their desired number of surviving children. The number of persons requesting sterilization has recently grown at 50 to 60 percent per year. Nepal's contraceptive prevalence rate is still only about 7 percent of married couples of reproductive age, but about 76 percent of these couples are now protected by sterilization.

AVS support plays a principal role. Most voluntary sterilizations are provided by three organizations: the Family Planning Association of Nepal (FPAN), a nongovernmental organization that receives a major part of its support from AVS; and two governmental agencies, Family Planning/Maternal and Child Health (FP/MCH) and "the Integrated Project" (ICHSDP), semi-autonomous organizations located in the Ministry of Health (MOH) that receive a major portion of their support from AID bilaterally. FPAN, however, actually performs the majority of the operations carried out under ICHSDP auspices as well as those carried out under its own auspices. Among the three providers, FPAN was the first to establish a formal set of standards ("minimum standards") for maintaining quality in male and female VSC; these have now been provisionally adopted by the Nepal government for countrywide use.

The AVS program in Nepal has developed much as in other countries -- that is, leadership development followed by training of physicians, increased availability of services, and, currently, emphasis on quality control and counseling.

Most voluntary sterilization in Nepal is provided by mobile teams during an October-to-March period when people are not preoccupied with the agricultural season. The teams set up temporary operating rooms in district hospitals and other community facilities such as schools or local governments' meeting rooms; although temporary, these operating facilities are

said to offer higher-quality service than the poorly equipped and understaffed permanent facilities. For historical reasons, female voluntary sterilization provided by FPAN is by mini-laparotomy, while a small corps of FP/MCH physicians performs laparoscopy. With AVS encouragement, FPAN and others hope to establish an expanded program to train physicians in mini-laparotomy.

USAID/Nepal and other donors have some concern that there is not more use of temporary methods. A few pilot projects of temporary methods carried out by FPAN demonstrated good levels of continuing use but with a higher level of staff involvement and follow-up than is possible on a national scale.

II.1.2.3 Tunisia. AVS is largely responsible for the high level of medical safety and quality in VSC services in Tunisia, where female voluntary sterilization now accounts for 35 to 40 percent of all modern contraceptive use (1983 prevalence survey). With AVS support, VSC (female) became widely available after 1978 as a program method in Tunisia's national family planning program directed by the National Family Planning and Population Office (Office National du Planning Familial et de la Population or ONPFP). Since then, AVS has financially supported the Tunis Training Center and 17 of the 23 family planning clinics and centers of the ONPFP. In Tunisia, in contrast to other countries, distinctions between AVS-supported and non AVS-supported VSC are impossible to draw. Rather, AVS and the ONPFP have been partners in maintaining high medical standards.

Throughout the Middle East and the continent of Africa, the Tunisian program is known as the leader, or model, in delivering effective, high-quality family planning services and in training clinicians from all over the African continent. In the realm of VSC, AVS has helped Tunisia achieve this leadership. Over 100,000 tubectomies have been performed through the program, with only two deaths. Complication levels are also low. A thorough program evaluation in 1984 verified the high level of medical quality and concluded that no further evaluation of medical quality and safety is currently needed. 4/

II.1.2.4 Bangladesh. In Bangladesh, AVS has introduced and promoted high medical safety standards, mostly through the Bangladesh Association for Voluntary Sterilization (BAVS), which administers a nationwide program that is among the most successful of all AVS-supported activities as well as one of the

---

4 "GOT/USAID Evaluation of the Tunisian Family Planning Program," June 1984, pp. 26-28, 77-79.

most successful of all family planning service delivery programs in Bangladesh. BAVS was established in 1975 and subsequently expanded from a central clinic and headquarters in Dhaka to 34 BAVS clinics throughout Bangladesh. These clinics perform a significant portion of all tubectomies and vasectomies in the country (about 20 percent, for example, in 1984), offer temporary methods for "rejected clients" (persons judged through the BAVS counseling and screening process as not suitable for sterilization) and, since early 1985, to the general public as well. From its inception in 1975 through March 1985, BAVS has performed 400,309 VSC procedures (248,668 tubectomies and 151,641 vasectomies).

II.1.2.5 Brazil. Brazil, the largest and most populous Latin American nation, has embraced VSC on the popular level while refusing to embrace it officially. Eighteen percent of married women of reproductive age have adopted voluntary sterilization in Brazil, making VSC the most popular contraceptive method.

While population, demography, and family planning are frequently debated in all the major media, the subjects are usually favorably and objectively presented. Initiatives toward a national population policy (which would allow family planning services in public institutions) were taken during the last year of military rule. There are some signs suggesting that President Jose Sarney may be personally in favor of family planning, but, with the many pressing national needs demanding immediate attention, these questions are not expected to be addressed early by the new civilian government.

The Brazilian Federal Council of Medicine approved a new Code of Medical Deontology in March 1984, according to which physicians are held responsible for observing specific legislation related to, inter alia, sterilization procedures, equally, the physician is responsible for adequately informing his or her patients about the consequences of any intervention contemplated. It is, therefore, understood from the new code that surgical contraception, although not explicitly approved, is henceforth an accepted procedure. The state councils of medical ethics are obliged to adapt their local codes to conform with the federal one.

Unrelated to the legal and ethical maneuverings, however, is the demand for family planning and VSC services, which keeps growing. The latter is the most used method among women of fertile age in all the northeastern states except Bahia (1980), and in Sao Paulo the vasectomy program is increasing its services rapidly (curiously, this success has not been replicated in Rio de Janeiro). Demand is expected to continue to grow rapidly.

Services are increasingly available and the territorial distribution is more equitable--although there are still many underserved areas in this vast country.

AVS channels money through four private agencies -- the Maternal Education Society (Sociedade de Assistencia a Maternidade Escola Assis Chateaubriand or SAMEAC) and the Brazilian Civil Society for Family Welfare (Sociedade Civil de Bem-Estar Familiar no Brazil or BENFAM) for training, and the Brazilian Family Planning Association (Associacao Brasileira de Entidades de Planejamento Familiar or ABEPF) and the Responsible Paternity Promotion Program (Promocao de Paternidade Responsavel or PROPATER) for services; currently, BENFAM is reviewing its role in family planning and is expected to present a new proposal to AVS that emphasizes service delivery.

ABEPF is an umbrella organization for 150 service institutions in Brazil. Of them, 30 are receiving AVS funding (\$450,000) through ABEPF, and this number is expected to grow. Total procedures expected are 25,000 to 30,000 under the subgrant.

PROPATER is an interesting experiment in providing vasectomies. The clinic is oriented exclusively to men and offers only vasectomies. Its existence has been publicized through social workers in Sao Paulo factories, and the response has been gratifying. The \$225,000 subgrant subsidizes 3,000 procedures in the main clinic, and another 600 in three private clinics. Program extension to Rio has been unsuccessful, because the social workers' professional organization has refused to cooperate. Despite this, PROPATER is viewed as a model of a successful program for men; the disbelieving from other countries have been brought to Sao Paulo and this has spawned imitations elsewhere.

Despite AVS's strong presence in Brazil, it does not provide the bulk of VSC. Brazil's Social Security Administration (INAMPS), is the principal provider. As explained later, INAMPS doctors operate without formal sanctioning and the service is provided in a way and at a cost that speaks eloquently to the desperation Brazilian women must feel about obtaining permanent contraception.

II.1.2.6 Colombia. Family planning services in Colombia were first offered by the International Planned Parenthood Federation (IPPF) affiliate, the Colombian Family Planning Association (Asociacion Pro-Bienestar de la Familia Colombiana or PROFAMILIA), in 1965. In 1971, VSC was introduced, and by 1985 350,000 men and women adopted voluntary sterilization. VSC is the second most popular contraceptive method in the country.

protecting 31 percent of couples conceiving.

The government position, like that of so many in Latin America, has vacillated between benign neglect and passive acceptance. The Colombian MOH does offer the full range of family planning services, VSC among them, but the active participation in VSC fell off markedly at the end of 1983, when, partly motivated by concerns over the wording of the informed consent form and perceived lack of government commitment, U.S. intermediaries reduced support to the ministry.

AVS supports PROFAMILIA on a procedure-reimbursement basis. It is expected that 50,000 VSCs will be performed this year, each one reimbursed at US\$6.25. A separate, small grant to PROFAMILIA is to underwrite the follow-up study on voluntarism, which was underway at the time of the site visit. The Society of Medical Faculties (SOMEFA) received \$35,000 to train 30 physicians in minilaparotomy.

#### 1.2 Expansion of VSC Services

From the beginning, AVS makes every effort to assure high-quality medical services by identifying and enlisting recognized leaders among physicians in each country. These leaders are often university professors of international reputation; in many instances, prominent physicians, JHPIEGO trained and equipped, become the nucleus around which AVS projects are built. Others worked in earlier, pioneer efforts, as in the Dominican Republic, where a 1976 International Committee for Applied Research in Population (ICARP) project, sponsored by the Population Council, sent the first group of Dominican physicians for minilaparotomy training at Bogota. From this beginning grew the currently AVS-supported National Council for Population and Family in the Dominican Republic (Consejo Nacional de Poblacion y Familia or CONAPOFA) and Colombian PROFAMILIA programs, the combined government plus private service outlets which accounted for 21,653 VSC procedures in 1984.

In most countries with AVS-supported projects, the relationship of service site selection to existing demand can only be intuited, with the help of local experts, because formal needs assessments for VSC are seldom available and data from sources such as the World Fertility Survey or contraceptive prevalence surveys are only a rough sketch of true local readiness for services. However, sub-Saharan Africa, where fertility remains high and contraceptive prevalence low, offers an opportunity to examine AVS's overall strategy for either introduction or expansion of VSC services. In brief, the strategy involves:

- 1) Education of policymakers, health professionals, and opinion leaders via a regional conference with topics including population dynamics and development, family planning as a basic human right, the role of family planning in primary health care, and the place of VSC among family planning alternatives.  
Example: The World Federation-sponsored Conference on Reproductive Health Management in sub-Saharan Africa, held in Sierra Leone, November 1984.
- 2) Stimulation of in-country leadership groups to provide information and education to local leaders and to encourage government and private support of VSC services.  
Example: The formation of the Fertility Association of Nigeria, which has applied for membership in the World Federation.
- 3) Provision of pilot projects to demonstrate the acceptability and feasibility of VSC.  
Examples: a) Small grants to individuals and institutions in Botswana, Cameroon, Ethiopia, Rwanda, and Somalia; b) Subagreements in Burkina Faso, Madagascar, Uganda, and the Comoros Islands.
- 4) Provision of grants and technical assistance, in collaboration with the donor agencies, in the development of national programs.

Examples: Kenya, Zaire, and Nigeria.

This expansion strategy recognizes implicitly the cultural sensitivity toward family planning, including VSC, throughout sub-Saharan Africa. Accordingly, AVS has pursued a wisely cautious course, with the initial emphasis on high-risk pregnancy as a public health rationale for voluntary permanent contraception, and with careful attention to IEC as the demand for VSC gradually expands.

In Nigeria, where VSC is still in the earliest stages of political acceptability and the contraceptive prevalence rate is only 6 percent, an opportunity exists for a carefully planned, rational approach to concomitant demand stimulation and service expansion. The 1984 World Federation-sponsored conference in Sierra Leone heightened interest in VSC in countries where a political climate of readiness existed. The Nigerian government has publicly endorsed family planning (without reference to VSC in particular), and, aided by the stimulus of the Sierra Leone conference, a leadership group (Fertility Association of Nigeria or FAN) has been formed. With USAID coordinating the efforts of a number of AID-supported agencies - including AVS, JHPIEGO,

Family Planning International Assistance (FPIA), Pathfinder, Family Health International (FHI), and Columbia University -- a number of projects have emerged that together can provide for an orderly, simultaneous expansion of IEC and medical and surgical services.

Insofar as VSC remains a little known and culturally sensitive subject, AVS chooses to emphasize quality, comprehensiveness, and acceptability of VSC over rapid expansion per se. Accordingly, as its contribution to the USAID-assisted development, AVS will launch at least one pilot project in each of Nigeria's 19 states, to serve as models as VSC expands. AVS's three-year demonstration project in Oyo State, which provides VSC as part of a statewide high-risk pregnancy program, and its forthcoming workshop at Ibadan University's Training Hospital on IEC for VSC, are integral parts of this strategy. The AVS strategy for expanding services, and the organization's role in the coordinated USAID family planning assistance to Nigeria, should be looked at as a possible model for other sub-Saharan African countries to emulate as they evolve national family planning programs.

The two current subagreements and a small grant for IEC support in Benin City show how AVS coordinates its activities with those of other donor agencies in Nigeria. Both the state-administered Specialist Hospital, which has had a family planning clinic since 1983, and the University of Benin Teaching Hospital (UBTH) have large maternity units and JHPIEGO-trained ob/gyn specialists on staff. Since 1978, the UBTH has operated a family planning clinic, which has grown into the Fertility Counseling Research and Training Centre with support from The Pathfinder Fund. Its family planning clinic now has six outreach clinics staffed by nurse practitioners trained in family planning, and the Research and Training Centre uses fieldwork motivators to promote family planning. In addition, the Planned Parenthood Federation of Nigeria operates clinics throughout the state, and private and missionary hospitals also provide family planning services.

Against this background, and with the cooperation of JHPIEGO, AVS developed subgrants to expand VSC services at the Specialist Hospital that supplied necessary medical equipment, and funds for a service subsidy and IEC for both medical personnel and VSC patients. Likewise, AVS funds are enabling the UBTH to renovate and equip a dedicated space to serve as both a service facility and a training site for hospital residents and other physicians in VSC techniques. Concurrently, FHI is conducting an ongoing VSC counseling project at UBTH, providing a built-in evaluation of the IEC materials developed by the UBTH ob/gyn staff with the help of an AVS small grant.

The lines of communication among the various agencies involved in this cooperative effort appear to be effective, both at informal and formal levels, and the overall coordination by the USAID population officer in Lagos is highly valued by the participants. The AVS component of this constellation of efforts has heretofore been orchestrated from AVS/New York, but will soon be delegated to a sub-Saharan regional office, to be established by the end of 1985. Thereafter, Nigeria will have a full-time AVS staff member.

### II.2.1 Pilot Projects

AVS often uses short-term pilot projects on an experimental basis, in either new geographical or programmatic areas, as part of its long-term strategy. AVS's pilot projects in Nigeria exemplify the usefulness of short-term commitments in stimulating both professional and popular awareness of, and demand for, institutionalized VSC services.

The January 1984 change in government shifted the Nigerian government's attitude toward family planning promotion. Accordingly, USAID is coordinating the stepped-up efforts of the various donor agencies working with indigenous public and private institutions to develop a national family planning program. AVS, given the responsibility to assist with the VSC component, expanded its involvement in Nigeria from the few training programs in place before 1984 (with a total commitment of \$218,000) to six pilot service projects in addition to two training grants (with a total commitment of \$290,000) in 1984.

As mentioned, over the next five years AVS plans at least one pilot project for each of Nigeria's 19 states. Because the pilot projects are models, they will cover various ingredients in comprehensive VSC services including IEC; medical VSC services; and physician, nurse, midwife, and other health personnel training.

The effect of one such pilot project on indigenous awareness and demand for services is instructive. The project director, together with the nurse/midwife of the pilot project at the Specialist Hospital, Benin City, conducted a one-day workshop on population, family planning, and VSC for physicians, nurses, and health personnel from throughout Bendel State on 18 April 1985. Originally planned for 100 participants, the workshop drew 150, many of whom expressed interest in referring patients for VSC. Parts of the workshop program have been subsequently broadcast on the local television news, and the project director has been interviewed on both television and radio.

### II.3 Demand for VSC Services

It is impossible to project worldwide and country-by-country demand for VSC; no accurate figures exist beyond the rough estimates based on analyses of the World Fertility Survey and selected contraceptive prevalence surveys and on assumptions derived from census data.

AVS's assumptions about VSC demand are based on years of experience in many countries. These empirically derived hypotheses state that

- o Demand for VSC services is a function of several variables including age, marital status, culturally derived family size preferences, anti- or pro-natalist political policies, religion, socioeconomic status, education background, health status, and infant and child mortality rates;
- o Demand for VSC in countries in which there are no legal barriers increases as a function of IEC about family planning and maternal and child health;
- o Demand for VSC increases in proportion to the accessibility of VSC services;
- o Demand for VSC increases with high quality of services;
- o Demand for VSC will continue increasing for the foreseeable future, given the prevailing age structure of developing country populations and the prevailing age-specific fertility rates;
- o Demand in any given country is of two types: expressed or latent. Expressed demand is manifested in explicit service requests. In the late 1970s, waiting lists for VSC existed, for example, in Tunisia. Today, waiting lists continue to exist. For example, Kenya has waiting lists estimated up to two years in many locations. Waiting lists have been documented for other countries as diverse as Brazil-(II.4.6.3), the Philippines, and Nigeria. Long waiting lists are common in areas which are only served by mobile clinics. Latent or potential demand, based on studies of the high proportion of all contraceptors who have chosen sterilization in selected countries, is safely assumed to be greater than expressed demand. Kessel and Mumford, in a 1982 review of potential demand in the 1980s, concluded that, "Because of the fragile condition of health care delivery systems in the developing world and the rural residence of the population, it is unlikely that surgical

sterilization can meet the projected need." 5/

### II.3.1 Tunisia: An Example of Relationship of Demand to Funding Levels

Before 1978 there was a waiting list for female surgical contraception in Tunisia. Tubal ligation was available in hospitals but was typically given low priority because of heavy nonelective surgery demands with which tubectomy requestors had to compete. Tubectomy was performed only by laparotomy; women had to spend many days in the hospital; and, because of pressures on hospital staff and facilities, they did not always get quality care. After AVS's entry into the program, along with JHPIEGO, the ONPFP was able to take VSC out of the hospitals and offer higher-quality VSC services at dedicated family planning centers and clinics, service points closer to the homes of the requestors.

Since that time, the ONPFP, with AVS assistance, has been able to meet the demand for VSC, although a recent plateauing has become a matter of concern. According to a phase-down plan for AVS (and USAID) assistance established by USAID in 1978-79, AVS financial support of VSC decreased from 71 percent in 1982 to 50 percent in 1983 to 36 percent in 1984; assistance is expected to terminate in 1986. The ONPFP has been assuming responsibilities accordingly, per the plan. In 1984, however, a joint GOT/USAID evaluation team recommended that "if the phasedown of financial assistance were to prejudice the quality and number of voluntary sterilizations achieved," a readjustment should be made "to maintain existing levels of performance." 6/ Since that recommendation was made, a plateauing or fluctuation in use of all methods has developed, due, apparently, to the phase-out of foreign assistance during a time of unanticipated domestic economic recession. The number of new VSC acceptors (or operations performed) has held constant but, because of the age structure in Tunisia, new acceptors are decreasing in proportion to married women of reproductive age. Until recently, the program has met demand in urban and other more accessible areas. Now the program is having difficulty meeting demand in the less accessible rural areas that are more expensive to reach. At present, quality is being maintained, but a drop in quantity is likely.

---

<sup>5</sup> E. Kennel, and S. Mumford, "Potential demand for voluntary female sterilization in the 1980s: The compelling need for a nonsurgical method," Fertility and Sterility, Vol. 37, p. 725, June 1982.

<sup>6</sup> op.cit., p. 78

AVS has entered into a new program (and financial) relationship with ONPFP and will be funding three specific activities-- activities to strengthen VSC counseling; IEC for postpartum VSC; and standardization of anesthetic regimes. The ONPFP, however, has asked AVS to continue its past practice of financing on a per-case basis through 1986.

AID should monitor VSC demand through 1985, and then consider the 1984 evaluation team's recommendation and the request of ONPFP for 1986 funding. Furthermore, AID should consider providing central funding from the Office of Population Bureau of Science and Technology (S&T/POP) for AVS to launch a project to provide voluntary sterilization to postpartum women, which would be complementary to the new bilateral project presently under review, to assure that existing demand in Tunisia is fully met.

### II.3.2 Nepal: Outreach Needed To Meet Rural Demand

Nepal illustrates a situation in which the use of modern contraceptive methods began as a response to demand for permanent contraception to end child-bearing, rather than for temporary methods to space children.

The government of Nepal and the Family Planning Association of Nepal began, in 1982, a mobile-team voluntary sterilization outreach program during the slack agricultural season. Field-workers first visit villages, meet with couples interested in voluntary sterilization, and compile lists of those who decide to request the procedure. When a waiting list has built up, a visit by a mobile team is scheduled. That many couples are eager to end child-bearing is apparent in the demand for sterilization, which has grown at about 50 to 60 percent per year.

About 76 percent of the 7 percent of Nepali couples using a modern method of contraception are now protected by voluntary sterilization. The mobile-team approach is a short-term strategy, to be used so long as a backlog of demand exists and until static facilities can begin to provide services (temporary and permanent) year-round. This will take time. High levels of demand for sterilization are projected for several more years before the backlog of relatively older, higher-parity couples wanting to end child-bearing can be satisfied. This situation -- active demand plus mobile-team service delivery to rural areas with primitive sanitation -- led AVS's Asia regional office to conclude, in 1983, that, "More so than any other country in Asia, Nepal needs our technical assistance almost more than our

financial support". <sup>7/</sup> Since then, an increased need for financial support to keep pace with the demand has been recognized.

AVS has been FPAN's second major foreign donor, after IPPF. FPAN has essentially lost its IPPF funding (which was 43 percent of its total funding in 1984) because of the general U.S. defunding of IPPF. Consequently, FPAN has appealed to AVS for more funds to maintain the same quality and quantity of services. The AVS Asia regional office now wants short-term (for example, six months) technical assistance from an ex-patriot physician able to deal with the complex issues the program faces at this critical juncture. This seems highly prudent.

### II.3.3 Guatemala: Unmet Potential Demand

Voluntary sterilization is the leading contraceptive method in Guatemala. Nationwide, 25 percent of married women of reproductive age are using some means of contraception; 40 percent of these women report adopting VSC, and another 4 percent report their husbands (partners) have had a vasectomy.

The AVS-supported Programa Consolidado meets the current expressed demand for sterilization at service locations throughout the country. Men and women who request the operation usually are scheduled for the next operation date (within one to two weeks for fixed clinics, or a month for mobile units), provided the requestors meet the Family Planning Association of Guatemala's (Asociacion Pro-Bienestar de la Familia de Guatemala or APROFAM) requirements for sterilization. The doctors try to operate on the scheduled day, rather than turning clients away, even if overcrowding of recuperation facilities results.

Nonetheless, a substantial unmet demand for sterilization exists, as shown by the 1983 contraceptive prevalence survey: 61 percent of married, fecund women in Guatemala who have all the children they want expressed interest in having the operation. (There are no nationwide data available on the demand for male sterilization.) Some women apparently want the operation, but not enough to actually seek it out. However, a major part of the unmet demand comes from people without ready access to a facility.

To satisfy this unmet demand:

- o Mass media efforts to inform the public of VSC as an option and of specific service locations should be strengthened;

---

<sup>7</sup> "Nepal Country Strategy for 1984," IPAVS Regional Office, p. 4.

- o The interpersonal communication program (currently consisting of 14 female educators) should be expanded; and
- o The number of service facilities should be increased.

IEC and availability of VSC services, especially quality services, are the keys to translating latent or potential demand into expressed demand. 8/

#### II.3.4 Dominican Republic

VSC is the leading method of contraception in the Dominican Republic. The most recent contraceptive prevalence survey showed that 45 percent of married women of reproductive age were using family planning methods, with roughly one-third of them protected by VSC. Both CONOPOFA and PROFAMILIA report that demand exceeds supply, particularly in the rural areas.

#### II.3.5 Nigeria

Despite the recent declaration of governmental support for family planning, pronatalist traditions persist and knowledge of VSC is scant. Nevertheless, the several pilot projects visited in this evaluation reported growing interest, especially when availability of VSC in conjunction with maternity services is strengthened by IEC. That VSC has increased at an unanticipated rate in Kenya, a country with an equally pronatalist tradition, suggests that the potential exists in Nigeria and elsewhere in sub-Saharan Africa for rapid change in demand. Some analysts have gone so far as to predict that VSC will become the most common method of contraception in Africa within the next 10 years.

#### II.3.6 Bangladesh: Unexpected Vasectomy Demand

Demand for sterilization has been great in Bangladesh for several years, but chiefly for tubectomy. In 1980, for example, vasectomies accounted for only 9.8 percent of all sterilizations performed in the country. Bangladeshi men equated vasectomy with castration, and rejected it. Health and family planning

---

<sup>8</sup> Jane Bertrand and Mark McBride, "Evaluation of the APROFAM Program for Voluntary Sterilization in Guatemala," Tulane University and USAID/Guatemala, February 1985, pp. 3, 108-9.

personnel argued that persuading men otherwise was not worth the effort: Bangladesh was too Muslim and conservative a country for vasectomy ever to become popular. Most family planning personnel showed little optimism when external evaluators and others advised them to turn their attention to vasectomy. 9/

They said it could not be done, but, despite pessimistic predictions, in 1981 demand for vasectomies began to increase. It did so steadily and, in BAVS clinics since mid-1984, vasectomies actually have surpassed tubectomies in popularity. In the BAVS clinics in 1980, vasectomies accounted for only 8.2 percent of all VSC procedures; in 1984, vasectomies had increased to 59.4 percent. In the nation as a whole, vasectomies in 1984 had climbed to 47.7 percent of all VSC procedures, in contrast to only 9.8 percent in 1980. (See Table II.3.6)

The lesson should be apparent. Even in conservative countries, even in Muslim countries, it may be quite possible -- and not all that difficult -- to overcome the initial opposition to vasectomy as well as the equation of vasectomy with castration. The case of Bangladesh merits study by other countries in which similar opposition is heard.

#### II.4 Voluntarism

No evidence of coercion in any AVS-supported programs has been uncovered. There is no evidence or report of coercion in AVS-supported services in any of the countries visited, nor any evidence that people have undergone forced sterilization in any AVS-supported activities elsewhere. AVS works hard to ensure voluntarism -- that women and men who undergo sterilization are fully informed about the procedure and that it is done only after requestors have given carefully considered consent. In many countries, AVS-supported programs take the lead -- and are generally recognized as the leader -- in surveillance and supportive actions to ensure voluntarism. BAVS is a good example. AVS uses the same prevention approach as it takes with medical quality: close monitoring to detect any questionable occurrences or patterns, while at the same time initiating activities (such as training, workshops, guideline writing, and special personnel recruitment) to raise standards throughout the system and prevent infringements.

---

<sup>9</sup> Barbara Pillsbury, Lenni Kangas and Alan Margolis, "U.S. Assistance to the Family Planning and Population Program in Bangladesh, 1972-1980," April 1981, pp.13, 101.

TABLE II.3.6

INCREASE OF VASECTOMY VS. TUBECTOMY IN BANGLADESH

	BAVS Clinics		All Facilities	
	No. of Procedures	% age of Procedures	No. of Procedures	% age of Procedures
1980				
Vasectomy	2,821	8.2	20,104	9.8
Tubectomy	31,440	91.8	185,421	90.8
Total	34,261	100.0	205,525	100.0
1984				
Vasectomy	60,764	59.4	306,207	47.7
Tubectomy	41,552	40.6	336,108	52.3
Total	102,316	100.0	642,315	100.0

Specifically, AVS has upheld voluntarism through or because of the following factors:

- 1) Global policies and guidelines that AVS has developed and enforces;
- 2) Counseling to ensure informed consent and the requestor's understanding of the procedure's irreversibility;
- 3) Programmatic safeguards, or policies, established in each country to prevent later regret (for example, required waiting periods, spousal agreement, and minimum age and parity requirements);
- 4) Natural safeguards, factors existing outside the program that make coercion unlikely (for example, obstacles a person must overcome to get the procedure -- such as having to travel a great distance to reach a clinic, or religious opposition groups and a press that would quickly seize upon and publicize any transgression);
- 5) Good monitoring and surveillance to detect potential problems and permit AVS and its grantees to take preventive action; and
- 6) Systematic follow-up surveys of sterilization acceptors to ascertain their satisfaction with, or complaints about, the procedure.

Finally, in addition to the deep humanitarian concern AVS shares with AID, AVS realizes from a purely pragmatic point of view that the only way to run a successful program is to provide fully voluntary services. Because sterilization is the sole activity around which AVS exists, AVS focuses on ensuring voluntarism in sterilization with a single-mindedness that clearly exceeds the attention given to the issue by organizations and governmental bodies responsible for a broad range of family planning services.

#### II.4.1 AVS Policies on Voluntarism and Informed Consent

II.4.1.1 AVS Policy on Voluntarism. AVS has developed at least six policy statements on voluntarism and means to ensure voluntarism. Policy I.1, titled "Voluntarism," states:

Conscious of the profound effects that voluntary sterilization may have on the psychological, physical, and economic well-being of the clients, AVS considers respect for voluntarism of primary importance. Thus, in all AVS-funded programs which involve the delivery of voluntary sterilization services, AVS insists that utmost care be taken to ensure that each client receives all information necessary to make a reasoned, informed decision, and that this decision is made in an atmosphere free of deceit, constraint, coercion, or personal bias of provider personnel.

AVS has also formulated several related policy statements: on informed consent, counseling, availability of temporary family planning methods, nonmedical criteria for voluntary sterilization clients, compensation of personnel, and payments to requestors. Together, these are the policy base for VSC services that conform to AID regulations.

II.4.1.2 AVS Policy on Informed Consent. AVS policy statement I.3, titled "Informed Request and Consent," is:

Voluntary, informed request and consent, which is the logical consequence and practical application of AVS's policy on voluntarism, must be obtained and documented for every individual who undergoes a sterilization procedure supported by AVS.

Voluntary, informed request and consent are achieved when the client fully understands the nature and effects of the sterilization procedure and, of his/her own free will, chooses to undergo the procedure in preference to temporary family planning methods. To

achieve informed request and consent, programs must provide counseling services to the client in a non-coercive environment; no undue inducements may be brought to bear on his/her decision, and accurate information on alternative family planning methods must be discussed in an unbiased fashion.

Finally, before undergoing the procedure, the client must signify his/her understanding of the sterilization procedure, and voluntary choice of the same, by affixing his/her signature or thumbprint to a form delineating the elements of informed request and consent, which are as follows:

1. Temporary contraceptive methods are available to the individual and his/her partner.
2. Sterilization is a surgical procedure.
3. Certain discomforts and risks, which have been explained to the individual, attend the procedures; these include the fact that sterilization is not guaranteed, what complications may result, and what side effects may occur.
4. If successful, the operation will prevent the client from having any more children.
5. The operation must be considered irreversible.
6. The individual may decide against the procedure at any time, and no services or benefits will be withheld from him/her as a result.

Part of AVS's strategy for implementing its policies is to involve leaders in interpreting and further developing the policies on a regional or country-specific basis. A recent concrete example was the "Leaders Symposium on Voluntarism in Surgical Contraception Programs," convened by the World Federation and the Ministry of Plan Implementation of the Sri Lankan government in Sri Lanka in May 1985.

#### II.4.2 Counseling

Counseling has always been part of the process leading up to VSC requests in an AVS-supported facility. Since 1982, however, AVS has increased efforts to improve counseling to ensure voluntary acceptance with full cognizance of the procedure's permanency. Of all organizations working in family planning in developing countries, AVS is clearly a step ahead in the attention it devotes to improving counseling and in the

high-quality guidelines it implements in the programs it supports.

Good counseling always has been a part of all family planning programs, regardless of method, but a part more easily talked about than done -- especially in developing countries. AVS's new emphasis on counseling thus resulted in part from the observation that counseling in family planning projects and programs around the world is of uneven quality and sometimes even absent. Nor was there clear consensus on what comprised counseling or on how best to counsel. And, as governments around the world become increasingly involved in support to VSC, concern surfaced about the impact of government-sanctioned VSC on voluntarism.

To improve counseling, therefore, AVS, since 1982, has acted at several levels: policy and guidelines formulation, staff development, training of counselors, development of resource materials, and on-site technical assistance. Specific steps include:

1) Formulation of Policies and Guidelines. In April 1983, AVS developed and adopted a policy on counseling. The AVS policy statement I.2, titled "Counseling," reads:

AVS is unalterably committed to safeguarding the client's right to know and right to choose. Counseling is an indispensable component of any program which delivers voluntary sterilization services funded by AVS.

The client must be given every assistance and opportunity to decide whether voluntary sterilization is the most appropriate family planning method for him/her. Because this decision can only be made based on knowledge of both the temporary and permanent methods that are available, counseling must include the provision of this information. The various methods should be accurately and honestly discussed and the client's misconception regarding any of them corrected. The counselor must be sensitive to the client's mental state and emotional fitness to undergo the procedure, and to his/her feelings, fears, and expectations in order to document the client's understanding of the procedure and its results. The requestor must give his/her informed consent after the counseling process.

Finally, counseling services must be provided in a noncoercive manner and atmosphere.

The World Federation also developed and issued, in 1983, a document titled "Ensuring Informed Choice for Voluntary Surgical Contraception: Guidelines for Counseling and for Informed Consent." This document, developed with the assistance of professionals from 10 countries, is the World Federation's official policy on counseling. A "Manual on Counseling for Voluntary Surgical Contraception" will be published by the World Federation later in 1985. This manual incorporates the experiences of professionals involved in counseling programs who met in July 1983 in Dhaka to develop principles for counseling. It will draw additional guidelines for developing and implementing counseling programs.

2) Development of AVS Staff "Counseling Experts." Several AVS/New York and World Federation staff are designated "counseling experts" to serve as resources to other AVS staff and counterparts. The "experts" are actively engaged in all the counseling-improvement activities described here.

3) Provision of Training on Counseling. AVS financially supports counselor training in VSC programs throughout the world. An illustrative listing of AVS-supported training includes:

- o Bangladesh: Since 1980, the BAVS has conducted periodic training and refresher training for its counseling staff.
- o Brazil: ABEPI conducted two workshops in 1984 for counseling staff of its member clinics and plans to continue in the future.
- o Indonesia: PKMI is conducting a pilot program to train 144 VSC counselors.
- o Kenya: The Family Planning Association of Kenya (FPAK) will conduct a seven-day workshop in June 1985 to train 20 personnel from AVS-supported projects in Kenya.
- o Nigeria: The Family Research Unit of University College Hospital in Ibadan will conduct a five-day course in July 1985 for 20 nurse-midwives from AVS-supported projects in Nigeria.

4) Staff Training. AVS conducted training in counseling for its own International Programs Division staff in 1984 and 1985. In addition, selected international staff from AVS's regional offices will attend a five-day counseling and voluntarism workshop in New York in August 1985 to help them better to assess needs and to develop and evaluate counseling programs.

5) Development of Resource Materials on Counseling. AVS

and the World Federation have produced resource materials for developing countries to improve their counseling for sterilization. These include:

- o "Ensuring Informed Consent for Voluntary Surgical Contraception: Guidelines for Counseling and Informed Consent (see above);
  - o Manual on Counseling for Voluntary Surgical Contraception (see above);
  - o Flip charts for use by African health personnel who counsel requestors (currently being pretested in several African countries);
  - o Model training curricula for counselors (being developed by grantees with AVS staff assistance in Kenya and Nigeria); and
  - o Support in 1983 for reprinting "A Resourcebook on Guidance and Counseling for Voluntary Surgical Sterilization," a self-instructional manual developed by the Population Center Foundation of the Philippines.
- 6) On-Site Technical Assistance. Since 1984, AVS staff "counseling experts" have reviewed or assisted on-site counseling programs in Sri Lanka, Bangladesh, Nepal, Indonesia, the Philippines, Mexico, and Costa Rica.
- 7) Regional Initiatives in Counseling. In 1983, AVS conducted a counseling workshop in Manila. Since then, and with AVS support, activities to improve counseling have begun in almost all Asian countries served by AVS programs (See Appendix F)

#### II.4.3 Monitoring and Surveillance

AVS staff, both in New York and the three regional offices, carefully monitor activities in the field. The measures AVS takes to detect any questionable events or trends are comprehensive.

II.4.3.1 Monitoring of Governmental Policies. Nepal and Sri Lanka illustrate AVS's vigilance in monitoring sterilization-related policies of governments.

On a routine site visit in May 1983, AVS staff learned of compensation policies recently adopted by the government of Nepal as part of a stepped-up effort to curb population growth. The policies, however, would have provided compensation payments

to sterilization acceptors and providers that would have favored sterilization over other family planning methods. Thus, the new Nepalese policies conflicted with AVS-- and AID--policies on voluntarism.

The AVS staff visiting Nepal recognized immediately that if the government were to implement its newly adopted policies, AVS would be forced to terminate its support in Nepal -- as would USAID itself. Nepali officials were initially reluctant but eventually agreed to make policy changes proposed by AVS. AVS and USAID are thus still able to continue supporting family planning activities in Nepal.

In Sri Lanka, AVS went a step further and actually suspended its assistance, when it learned of a similar questionable situation, and called for a thorough review. Only after verifying that people were choosing sterilization on a strictly voluntary basis did AVS reinstate assistance (see paragraph II.4.6.5).

II.4.3.2 Monitoring of Service Delivery. AVS monitors voluntarism in actual service delivery by analyzing required service statistics and related reports submitted by grantees; by visiting service sites periodically; and by supporting grantee participation in surveys and special studies.

By analyzing service statistics to determine the numbers and characteristics of sterilization acceptors in a given locale in a given period of time, AVS is able to verify that they are the kind of people who are likely to be voluntarily requesting sterilization -- that is, that they are relatively older and higher parity married couples. For example, when service statistics in Bangladesh (where women marry and begin bearing children at about age 15) reveal that the median age of male sterilization acceptors is 41.4, that the median age of female acceptors is 29 with a husband aged 38.5, and that the mean number of living children for male acceptors is 4.2 and for female acceptors 4.1. This is a clear indication of people not likely to regret or to have been coerced into the procedure. <sup>1/</sup> In contrast, if service statistics place acceptors in their early

---

1 "BAVS Sterilization Acceptors Characteristics," Report No. 5, Evaluation Unit, Bangladesh Association for Voluntary Sterilization, May 1985, pp. 4-6. Another example of this type of survey is "Recent Changes in the Demographic Profile of Sterilization Acceptors in Nepal," by E. Noel McIntosh, Binny van Bergen, Dev Ratha Dhakhwa, Tika Man Vaidya, and Tara Bahadur Khatri, Kathmandu, (John Snow Public Health Group, Family Planning Association of Nepal, and Nepal FP and MCH Project), 1985.

20s with only one or two children, then the program would be investigated immediately. Surveys of acceptors can verify voluntarism too. In Bangladesh, for example, statistical samples of sterilization acceptors (along with service providers and fieldworkers) are interviewed every three months as part of a routine evaluation system to monitor voluntarism. <sup>2/</sup> Since January 1985, this system also monitors the AVS-supported BAVS program, as well as all other nongovernmental organizations performing sterilizations.

Clinic-based follow-up activities also are important for monitoring. The "Long-Term Follow-Up" being conducted by the AVS-supported FPAN uses a special FPAN mobile team. Dispatched from Kathmandu, the team is available to anyone who had a sterilization operation in the past (as distinct from the standard one-week postoperative follow-up). In one district, Naralparasi, FPAN held six such follow-up sessions this year. Although only 900 people have been sterilized in Naralparasi thus far in 1985, about 1,400 people have come for long-term follow-up, complaining of various problems. None, however, complained of not wanting the operation in the first place. Only two presented problems related to sterilization (and these, incisional hernias, were promptly treated at the local hospital). The remaining complaints are endemic among this malnourished, disease- and work-burdened peasant population: worms, backache, even sore toes.

Studying requests for sterilization reversal is another way of monitoring voluntarism. If people are being pushed or somehow improperly influenced into being sterilized, significant numbers of people seeking sterilization reversals would be a warning signal. This is not happening. AVS grantees in the developing countries do occasionally receive requests for reversals, but these have all been from couples who have lost their children through some unusual fatality or who have been divorced or widowed. When AVS grantees receive such requests, they have, at least in some countries (e.g., Bangladesh and Nepal), referred them to reversal experts and funded the reversal procedure.

II.4.3.3 Monitoring the Local Press. Finally, the local press is an important and automatic monitoring tool. In all countries where AVS has programs, the press is as quick as the

---

<sup>2</sup> M.A. Quasem & Co., "Report on the Evaluation of the Voluntary Sterilization Program for January-March Quarter 1985." M.A. Quasem & Co. is an external audit company contracted by USAID/Dhaka for monitoring voluntarism in the USAID-supported governmental program.

media in the United States to seize upon potential scandals and other newsworthy stories that sell papers. Charges of coerced sterilization certainly qualify, but such charges have been rare and even more rarely have concerned an AVS-supported facility. The few charges leveled against an AVS-supported program have been investigated promptly and proved to be unfounded.

#### II.4.4 Cross-National Follow-up Surveys of Female VSC Acceptors

As VSC programs have expanded, managers have learned how to design and extend services more cost effectively, and surgeons have learned how to make services safer. In 1984, AVS staff felt, however, that there was still relatively little systematic understanding of acceptors' motivations for, acceptance of, and satisfaction with VSC. AVS has thus funded follow-up surveys of women sterilized in AVS-sponsored services in five developing countries: El Salvador, Bangladesh, Indonesia, Colombia, and Tunisia. When complete, these will constitute the first internationally comparable set of surveys of VSC acceptors.

II.4.4.1 Specific Research Questions. The survey in each participating country has addressed, at a minimum, the research questions listed below (as well as additional questions directly relevant to the VSC program in each country).

- 1) What are the sociodemographic characteristics of VSC acceptors?
- 2) What are the acceptors' experiences with and knowledge of other contraceptive methods?
- 3) How did the acceptors learn about and come to the clinic for VSC?
- 4) Why did the acceptors decide to have VSC?
- 5) How well did acceptors understand the nature and consequences of the VSC procedure?
- 6) Are acceptors satisfied with the treatment they received at the clinic and with the operation itself?

II.4.4.2 Data Collection. Data collection is now complete; data came from interviews of a sample of acceptors soon after their operation (for example, at their one-week return visit to the clinic). A common format was followed in the surveys, including a core questionnaire that AVS developed after extensive literature reviews and consultation with investigators in each of

the four participating countries. The questionnaire was translated into local languages and pretested and adapted in each country. Interviewers were not clinic staff. Sample sizes ranged between about 500 and 1,500 female VSC acceptors per country. Sampling aimed for (1) sufficient cases from each clinic to enable meaningful analysis and (2) clinics representative of the country's VSC program.

II.4.4.3 Anticipated Use of Survey Results. Practical benefits expected from the surveys include:

- 1) Better understanding of the reasons women choose VSC, so that program managers can more effectively identify potential clientele;
- 2) Improvements, if needed, in client counseling procedures and content;
- 3) Improvements, if indicated, in informed consent procedures;
- 4) Modifications, if indicated, in the personal treatment of clients by clinic personnel; and
- 5) Development of better outreach programs and referral channels.

#### II.4.5 Follow-Up Survey Results

Preliminary results are available from Tunisia and Bangladesh. In both cases, the results are very positive (see II.4.5.1 and II.4.5.2). In addition, similar surveys have been undertaken in El Salvador and Guatemala after this series had been launched. The surveys are well designed and have, generally, been implemented well. When the final reports are available, the findings should be very reliable.

II.4.5.1 Tunisia. Sterilization is totally voluntary in Tunisia. No charges to the contrary have been made, and there is nothing in the Tunisian family planning program likely to lead to infringements. This is confirmed by results of the follow-up survey. A total of 605 sterilized women, aged 20 to 54 years, were interviewed from April to June 1984 at nine governorates of Tunisia. Most of these women were interviewed seven days after the operation (mainly laparoscopy under general anesthesia). Selected findings are summarized below.

- 1) Sociodemographic characteristics of women sterilized. The average age and parity of women sterilized are both

high. The majority of women had married at age 16 or 17, were 35 to 39 years old at the time of sterilization, and already had an average of 6.1 living children.

2) Prior use of other family planning methods. Nearly all sterilized women knew of other methods of family planning prior to sterilization. Nearly two-thirds had used a temporary method before becoming sterilized. The main reasons cited for choosing sterilization were (1) side effects of temporary methods, (2) recent contraceptive failure, and (3) decision not to have any more children.

3) The women's decision for sterilization. The main sources of information and influence on women deciding for sterilization were family members, friends, and neighbors. Sixty percent of the women cited these people as the main information source. In contrast, only about 30 percent of the women cited family planning workers. Ninety-five percent of the women discussed sterilization with their husbands; fewer than 3 percent of husbands opposed the decision.

4) Postoperative views on sterilization. The satisfaction level is very high. Ninety-eight percent of the women are satisfied with the operation; 75 percent said they experienced no postoperative problems, and 60 percent have advised friends to be sterilized. Many of the women who complained of postoperative problems already suffered from recurrent gynecological disorders and, according to the preliminary report, hoped that the operation would improve these disorders. This unmet hope may explain why 1.8 percent of women expressed some regret over the procedure; "lack of psychological preparedness" was also cited in the preliminary report. <sup>3/</sup> This figure, 1.8 percent, is nevertheless very low. Even in North America, regret levels of 10 percent have been considered normal and even low. <sup>13/</sup>

In addition to the survey findings and to the usual safe-

---

3 "Tunisian Female Sterilization Follow-Up Survey" preliminary results, May 1985. Note: A similar study by a Tunisian researcher supports the conclusions of the AVS-supported survey and provides additional information on why so many Tunisian women choose sterilization. Adly Ladjimi, M.D., "Etude sur la Conception Actuelle de la Planification Familiale dans un Pays Arabe et Musulman: La Tunisie" ("Study of Current Perceptions about Family Planning in an Arab Muslim Country: Tunisia"), Tunis: Center for Research on Human Reproduction, 1985.

13 Susan Philliber and William Philliber, "Social and Psychological Perspectives on Voluntary Sterilization: A Review." Studies in Family Planning, vol. 16, no. 1, January 1975, p. 14.

guards in all AVS-supported VSC services, these additional factors are evidence of a continuing atmosphere of voluntarism.

1) In Tunisia, as elsewhere in the Middle East, any indication of coercion would immediately be seized upon and exploited through the mass media by religious fundamentalists critical of Western influence and of the government's friendliness with the United States. For Americans familiar with the Middle East, it is useful to bear in mind the anti-Western and anti-American fundamentalist movement that overturned the government in Iran. The determination among family planning professionals in Tunisia ensuring voluntarism goes much further back, however, and definitely predates the growing concern among religious conservatives in the United States over U.S. international population assistance.

2) The reluctance of Tunisia's national family planning program (to which AVS provides support) to openly promote vasectomy, which the Tunisian public views with great suspicion, is evidence of the program managers' unwillingness to do anything that might provoke public criticism.

3) The Tunisian press is relatively open and would immediately publicize any transgressions.

4) The distances many women have to travel and the disruption of their lives by the procedure and postoperative recovery prove strong personal desire. (Postpartum sterilization is very uncommon in Tunisia; many women still give birth at home and those who give birth in a hospital are eager to return home promptly.)

II.4.5.2 Bangladesh. AVS's key effort in Asia is its support of BAVS. BAVS provides tubectomy and vasectomy services, based on high standards for counseling, voluntarism, informed consent, and medical quality. It also provides temporary methods and some maternal and child health care. BAVS operates 6 percent of the country's estimated 600 facilities in which VSC is available. In 1984, however, BAVS performed 16 percent (102,316) of the total procedures in the country. The remainder were through the government's approximately 400 rural health complexes. The generally higher quality of BAVS's services largely explains the greater demand for them.

Since 1984, charges have appeared in the U.S. and the Western press that people in Bangladesh were being coerced to become sterilized against their will. These were general charges against the government's program and AID support to it rather than against the AVS-supported BAVS program.

The basis for these charges is largely the policy adopted by the government of Bangladesh, and implemented beginning in February 1980, of compensating sterilization acceptors for the wage loss and the direct costs incurred in the process of and postoperative recovery from the procedure. The compensation payment given by the government of Bangladesh to both men and women is 175 takas, an amount equivalent to about US\$6. Although a very small sum, its purpose is to remove the financial obstacles that might prevent impoverished Bangladeshis from seeking sterilization or cause them to defer it until after additional (unwanted) pregnancies.

The government also provides a compensation payment of 45 takas (equivalent to about US\$1.50) to family planning field workers and other registered referral agents who refer and accompany an acceptor to a VSC facility. For most women, being accompanied by a female fieldworker or other woman or family member is essential because of the conservative cultural rules of purdah that prevent women from leaving their villages unescorted. The compensation provided to fieldworkers and referral agents is calculated to cover transportation and related travel expenses for accompanying the sterilization requestor.

No specific charges have been made against BAVS. Nor has coercion in the BAVS program ever been reported. BAVS, however, does follow the government's policy of compensating acceptors and family planning fieldworkers. The AVS Asia regional office in Dhaka monitors this arrangement closely -- a kind of "preventive monitoring" -- to verify that compensation is not misused. AVS and BAVS, therefore, decided in 1984 to include BAVS sterilization clients in the cross-national follow-up surveys. In total, 922 women were interviewed who had been sterilized in one of the BAVS clinics. Interviews were conducted by trained female interviewers at the time of follow-up visits to the BAVS clinic seven to 21 days after the operation. Preliminary (only manually tabulated, results are positive and indicate a high level of satisfaction with the procedure.

1) Length of time between the decision to have the operation and the operation itself. Most of the women (95.6 percent) said they had been seriously thinking about the operating for at least one month and many much longer. Only 4.1 percent mentioned an interval of less than one month.

2) Reason for having the operation. This was a multiple-response precoded question. Precoded reasons were: (a) own health, (b) spouse's health, (c) medical advice, (d) socio-economic reasons, (e) side effects of or dissatisfaction with other contraceptives, (f) contraceptive failure, (g) adverse impact of recent pregnancy or delivery, (h) wanted no more children, (i) cash or in-kind compensation, and (k) other

(specify). Not a single woman mentioned only the compensation as her reason for having the operation. The proportion of women mentioning the compensation as one of the reasons was negligible -- only 3.8 percent. A total of 96.2 percent of the women did not mention the compensation at all.

3) Postoperative satisfaction. Nearly all the women (98.4 percent) reported satisfaction with the operation. Only 1.6 percent said they were not satisfied.

4) Understanding of the permanence of the operation. Over 99 percent of the women knew they could not have any more children. Only 0.7 percent stated that they did not understand the permanence of the operation.

These results also indicate that the BAVS clinics are well-managed. 14/ Final results should be ready by autumn.

In preparing the questionnaire for this follow-up survey, AVS contracted for a focus-group survey of women who were sterilized at a BAVS clinic in Dhaka. The findings of this focus-group survey are firm evidence of voluntarism. They show clearly that concern for the well-being of the family's already-born children, pangs of recent delivery, poor economic conditions preventing the parents from providing a proper upbringing and education for the children, and crowding and congestion in the household were some of the critical factors that made the women and their husbands decide on sterilization. 15/ Specific findings include the following:

1) Sociodemographic characteristics. The respondents had been married at the age of 10 to 16, and ranged in age from 25 to 34 and had two to six living children at the time of the operation.

2) Experience with and use of other contraceptive methods. All but one woman knew of other methods before having the operation; most knew where they could obtain supplies. Only five had used another method in the past, however; all discontinued use or were dissatisfied because of side effects, lack of supply, or unintended pregnancies.

3) Sources of information and motivation for sterilization.

---

14 "Sterilization follow-up Survey: Key Observations" [Preliminary], by S. Alam, Mitra and Associates, May 1985.

15 Mohammed Alaudin and Nihar Ranjan Sorcar, "Focus Group Discussions with Sterilized Women in Bangladesh," Dhaka, November 8, 1984, p.14.

Close relatives were the most important source of both information and motivation. Dais (midwives) were also information sources, but most women indicated they did not make the final decision until reassured by relatives -- usually sisters-in-law or sisters -- who had already had the operation.

4) The decision-making process. The women said they had been seriously thinking about having the operation for periods ranging from two months to three years. The decision was usually triggered by a recent pregnancy. Most of the women thought they had enough children to maintain and were too poor to have more. This feeling intensified during the pregnancy and after delivery. Deterioration of health was another reason they cited. All the women had discussed the operation with their husbands and had their husbands' support.

5) Prior knowledge of sterilization. All the women knew, prior to sterilization, that it was a permanent method and involved abdominal surgery. All knew that it was not very painful or troublesome and that they could return to hard household work within a month.

6) Reason for preferring tubectomy over vasectomy. All the women expressed concern that their whole family would face economic hardship, even starvation, if a vasectomy were, by any chance, to incapacitate their husbands, the family bread-winners.

7) Pre- and postoperative counseling. All the women had received individual counseling at the BAVS clinic and said that the counseling was generally good. Only one woman said it was not effective (she had come to the clinic hoping that the operation would cure her gastric ulcer).

8) The influence of compensation. All the women had received from BAVS the standard taka compensation, a sterile garment (saree) to wear during and following the operation, and some medicine for postoperative recovery. In no case had a woman subjected herself to the operation for the purpose of receiving this compensation. (Bangladeshi women to whom this is suggested tend to find the question ridiculous or illogical and are either confused, incredulous, or insulted by such a suggestion.) Over half the women said they would not have been able to afford the procedure at that time had it not been for the compensation provided. One had borrowed money to pay for the travel expenses in anticipation of reimbursement at the clinic after the operation.

The surveyed women did not have any suggestions for improving the quality of services, but their comments did suggest ways in which the counseling can be improved. These have been incorporated in a new AVS project, "Strengthening of BGD [Bangla-

desh Government] Counseling Program" (AVS Proposal No. BGD-35-TR-1-B/A dated June 13, 1985).

Other surveys, evaluations, special studies, and analyses also confirm the voluntary nature of the BAVS program and of sterilization services in Bangladesh in general. These include the following:

1) "BAVS Sterilization Acceptors Characteristics," Evaluation Unit, Bangladesh Association for Voluntary Sterilization (reports no. 1 to 5). This is a periodic analysis of service statistics that BAVS carries out to help in program planning and monitoring. Data the analysis is based on come from admission forms that BAVS counselors fill in as they counsel each sterilization requestor. The forms contain a range of socioeconomic, parity, and family size information. Data from all the clinics are received at BAVS headquarters monthly and quarterly. This analysis of service statistics shows that the people receiving the operation in BAVS clinics are relatively older and higher-parity married couples -- not people likely to regret the procedure or to have been influenced somehow to undergo it against their will.

2) "Sterilization Campaign of 1977: A National Long-Term Follow-Up Survey," by M. Nawab Ali, Douglas H. Huber (now medical director of AVS in New York), Atiqur Rahman Khan, and Syed Waliullah, Bangladesh Fertility Research Programme Technical Report No. 25, 1979. This survey was conducted to find out whether any excesses had occurred during the 1977 campaign. Its findings were positive and revealed a satisfaction level of 95 to 98 percent among women who had the operation (p. 21).

3) "Report (s) on the Evaluation of the Voluntary Sterilization Program," by M.A. Quasem & Co. This is a series of six quarterly external audit-evaluations designed by USAID/Dhaka to monitor voluntarism in the government's program. Since January 1985, these external evaluations also monitor the AVS-supported BAVS program, as well as all other nongovernmental organizations performing sterilizations. Methodology for these audits consists of interviews with sterilized men and women and with service providers and fieldworkers, review of office records, and collection of sterilization performance data. Findings do not show any instances of involuntary sterilization.

4) AVS International Memorandum entitled: "AVS Regional Office's PD3 Recommendation Regarding the Increase in Provider and Acceptor Payments in Bangladesh," January 8, 1984. In September 1983, the Bangladesh government decided to increase the VSC compensation payments from the slightly lower level established in 1981. AVS's regional staff in Dhaka conducted this analysis to determine whether the increased compensation was

leading to violations of AID's Policy Determination 3 (PD3) on voluntarism (Appendix I). Staff made field visits, conducted interviews, and examined service statistics, project documentation, and the local press. The staff concluded that the increased compensation does conform to the requirements of PD3. The report concluded that the increase "has not resulted in any reports of alleged or documented cases of coercion in the BAVS program. Indeed, there has never been a report of such a case in the BAVS program" (p. 2). This continues to be true.

All evidence, direct and indirect, is that the compensation payments do not induce people to become sterilized who would otherwise prefer to have more children or to use a temporary method of contraception.

Where abuse does occasionally creep in is through people who try to take advantage of the system -- namely its compensation payments (in the same way that the existence of welfare payments in the United States occasionally results in welfare abuse). The most typical example of such "system abuse" involves men who request a vasectomy when they have already had one (or their wife has already been sterilized or is post-menopausal), their motivation being another 175-taka compensation.

Well aware of this phenomenon, BAVS has trained its counselors and physicians to screen out people not genuinely seeking the operation for its permanent contraceptive effects. Most such people are discovered by the counselors during the pre-operative interviews and are turned away. Some become nervous during the counseling interview and simply leave, fearful that they will be found out. All BAVS counselors screen carefully for such would-be abusers and, when they reject a requestor on this ground, enter his name in a record book. Statistics are collected by BAVS headquarters and analyzed in a quarterly report entitled "BAVS Clinic-Wide Vasectomy and Tubectomy Rejection Statistics." Some men manage to deceive the counselor but are found out by the physician in his preoperative screening that follows the counseling session. They, likewise, are rejected. The number of men who ultimately manage to slip through is very small. For example, one quarterly audit found that, in a sample of 624 vasectomy clients, only three men (less than one-half of 1 percent) had been sterilized twice. 16/

This kind of system abuse is clearly different from and much less serious than if the system were abusing an individual. Nevertheless, AVS and BAVS, and USAID/Dhaka, also closely monitor

---

16 M.A. Quasem & Co., "Report on the Evaluation of the Voluntary Sterilization Program for October-December Quarter 1984.", p. 64.

this situation and seek to eliminate deceivers. Ongoing efforts include improving counseling and screening, compiling and analyzing rejector statistics, and sponsoring special studies when questionable patterns emerge.

For example, in 1984 audits revealed that a large number of men and women had gone for VSC to a clinic outside of their home district (upazila). This raised the suspicion that they (or their spouses) had already had a procedure in the home district and that they were going to a second clinic to get a second compensation payment. USAID/Dhaka therefore commissioned a study of this phenomenon. Fears were allayed. Interviews showed that, in most cases, people went to an outside clinic simply because it was more accessible (closer or with better transportation), because its services were believed to be better, or because it had been recommended by someone. 17/

II.4.5.3 El Salvador. In January and February 1984 articles by a single journalist were published in the National Catholic Reporter and Christian Science Monitor, and subsequently picked up by the Washington Post and elsewhere. The journalist asserted that the Salvadoran family planning program was inducing and coercing women to become sterilized without their full knowledge or consent -- most specifically through food incentives and by forced postpartum sterilization. Alleged cases were cited from a displaced persons camp and a hospital maternity ward. AVS promptly launched several investigations of these charges.

1) Dr. Gonzalo Echeverry, an eminent Colombian obstetrician-gynecologist, conducted an overall program evaluation of the El Salvador family planning program in February 1984./18 After site visits, extensive interviewing, and careful review of project documents, he concluded that

- a) There is no evidence of pressure or coercive practices to adopt sterilization as a method of family planning;
- b) There are no material incentives, neither for sterilization requestors nor for the personnel involved in IEC activities;

---

17 "A Special Survey Report on the 'Outside Cases' of the Three Selected Upazilas for the 1984 April-June Quarter," Dhaka, April 25, 1985, pp. 21-33.

18/ Dr. Gonzalo Echeverry, "Evaluation of the Voluntary Sterilization Programs in the Republic of El Salvador," Report to the Association for Voluntary Sterilization, February 17 to March 3, 1984.

- c) No quotas have been established for IEC personnel for the recruitment of acceptors. (The programmatic objectives adopted for a determined working period for budgetary and administrative purposes have erroneously been interpreted as quotas.) Consequently, there are no disciplinary measures for unmet objectives;
- d) There is a time gap between the request for sterilization and the procedure. Also, more than one person is involved in the counseling sessions and informed consent procedures;
- e) Requestors receive respectful and humane treatment in all programs; and
- f) All VSC clinics offer [free] temporary contraceptive methods

2) AVS's Director of International Programs also visited El Salvador promptly after the appearance of the articles alleging abuse in the El Salvador program. He purposely went to the sites of the alleged abuses and interviewed clients and staff at those sites. He concluded in his trip report that

- a) The VSC programs in El Salvador are fundamentally and intrinsically noncoercive at all levels and in all sectors in both their implementation and policies. Furthermore, the national family planning program is well-managed and balanced and does not give disproportionate attention to VSC. And, the newspaper allegations regarding quotas, incentives, and other coercive practices were not substantiated. The program is being implemented on the whole in an entirely ethical manner. Indeed, it is in design organized to prevent abuses and inappropriate sterilizations.
- b) The family planning program in El Salvador is not designed or oriented to promote sterilization over other methods and, furthermore, there are safeguards present in the family planning program to ensure that all sterilization requests are well-informed and voluntary. There is complete availability and offering of other contraceptive methods. All methods can be obtained free of charge. All clients receive counseling by field and clinical staff prior to surgery to ensure they understand the consequences of their decision and are unlikely to regret it later. It is mandatory in all sectors that all clients provide their prior, informed consent and that this is documented and signed by the requesting client. Because facilities, staff, and resources are insufficient, most clients must wait for some period of time from when they choose

sterilization and when they are scheduled for surgery; they therefore have an opportunity to consider their request.

- c) The reason why the services are popular is that they are long-established in Salvadoran society. Voluntary sterilization services have been widely available in the country since the early 1970s...and...are of very high medical quality. The physicians in El Salvador are very well trained. Prior to the current civil strife, El Salvador was famous as a surgical sterilization training site for physicians from throughout Latin America. In addition, the program is well-managed and supervised....Staff in the program treat clients with dignity and respect. Finally, voluntary sterilization performance succeeds because in El Salvador family planning and voluntary sterilization are essentially nonpolitical. The two largest political parties support family planning services. Even the guerrillas allow the field staff of the AVS family planning program to conduct their work without problems in contested areas.

3) To investigate further the allegations, AVS contracted with the Center for Latin American Studies of Tulane University for a survey. A sample of 648 women, at different sites throughout El Salvador were interviewed according to a carefully planned methodology similar to that of AVS's four-country follow-up survey. The El Salvador survey concluded that:

- a) Women in El Salvador are voluntarily choosing sterilization because it is widely known, culturally acceptable, and a highly reliable means of terminating child bearing. It appears that the decision is made after considerable interpersonal communication with other sterilized women, (where applicable) the partner, and occasionally, health personnel. The length of time that women have known about sterilization and the interval they report between making the decision and having the operation further suggests that this is a well-contemplated action. In sum, there is no evidence from this study to suggest that these women were pressured or coerced into having the operation.
- b) Only one of the 648 women felt that she had been pressured into having the operation. This was not done by a health provider, but rather by the mother of the woman, who reportedly refused to take care of any more children.

- c) The majority of the 648 women interviewed:
- o had known about female sterilization for over three years,
  - o had been exposed to messages about sterilization on at least three mass media,
  - o had discussed the operation with a doctor, nurse, or social worker,
  - o had talked to an average of four other sterilized women about the operation, and
  - o had discussed the procedure with their partner.
- d) Overall, these women had positive impressions of the health personnel who served them: 95 percent or higher rated the care as "good" in all the facilities under study. 19/
- 4) USAID/El Salvador itself also extensively investigated the alleged abuses. Among other conclusions are the following:
- a) After conducting a random check of over 300 sterilization acceptor records in different locations in the country, USAID staff found that, in all cases, the informed consent form was properly executed and signed.
  - b) The specific case of alleged abuse at the San Francisco Gotero Hospital cannot be traced. 20/

These investigations support the overall conclusion that surgical contraception in El Salvador is conducted in an entirely voluntary manner in an atmosphere -- contrary to the early 1984 press allegations -- free of coercion, misinformation, or incentives.

#### II.4.6 Findings from Other Countries

Other findings testifying to the voluntary nature of VSC in other countries include the following:

---

19 J. Bertrand et al., "Female Sterilization in El Salvador: Factors Influencing the Decision," Tulane University, November 15, 1984, pp. 22-23.

20/ Terrance W. Jezowski, "Trip Report, El Salvador, 29 February - 3 March 1984," AVS, New York, pp. 4-6.

II.4.6.1 Indonesia. As VSC currently accounts for only about 3 percent of total contraceptive use in Indonesia, it would be hard to make a case that users are coerced. There certainly was no coercion observed and in none of the facilities visited were sterilizations performed without a correctly filled-out informed consent form. Service providers must submit this form to be reimbursed. Some facilities did not have full-time trained counselors present. This is being remedied, however, by PKMI, which is currently training counselors. The University of Indonesia has just finished data-gathering for the AVS-supported follow-up study of a sample of approximately 1,000 women.

II.4.6.2 Guatemala. APROFAM offers voluntary sterilization to men and women in Guatemala as part of its larger family planning program. Since 1977, over 55,000 male and female sterilizations have been performed as part of the voluntary sterilization program, known locally as the Programa Consolidado (Consolidated Program), which provides services in 35 locations throughout the country. This program began in 1973 in Guatemala City with financing from The Pathfinder Fund. Two years later, AVS began its support of APROFAM. Since 1975, AVS has been the sole funding source for this program.

Sterilization is the leading contraceptive method in Guatemala. According to the 1983 contraceptive prevalence survey, nationwide 25 percent of married women of reproductive age are using contraception; 40 percent of these women reported that they had been sterilized and an additional 4 percent reported that their husbands (partners) had had a vasectomy. Regarding potential demand, 61 percent of the women who wanted no more children claimed to be interested in sterilization.

USAID/Guatemala recently evaluated this program, among other purposes, to obtain qualitative attitudinal data from both recent acceptors (sterilized) and potential acceptors (not sterilized) on three key issues: (a) the cost of the operation and how this affects public perceptions of it; (b) sources of information about and motivation for sterilization; and (c) sources of influence in having the operation and whether the decision was truly voluntary. A total of 199 sterilized men and 399 sterilized women were interviewed about their experiences, impressions of the service facility, cost, and satisfaction with the operation.

The findings suggest an overall high level of satisfaction with the operation and a favorable impression of the quality of the services. Findings on the three main issues (a-c above) are outlined below.

a) Cost. Participants spontaneously expressed satis-

faction and gratitude for the low cost of the operation available through APROFAM. Low cost was not equated with inferior quality.

b) Communication. Many respondents first learned of the operation from the mass media (especially radio). However, interpersonal communication was important in the decision. Two barriers among those who are not sterilized include fear of physical/sexual changes and doubts about the reliability (permanence) of the operation.

c) Source of influence in the decision. None of the interviewees felt they had been forced to undergo sterilization. Their prime motive for sterilization was economic, followed by problems with previous pregnancies. 21/

II.4.6.3 Brazil. In Brazil, no evidence of lack of voluntarism was found. Requestors must pay for VSC, there are often considerable waiting periods, and many requestors are rejected. Four AVS-supported projects were visited.

1) PROPATER. This single-method organization performs only vasectomies. Male factory workers are recruited at work by social workers. A PROPATER social worker screens requestors, who must wait one week for the vasectomy and pay a price equivalent to US\$28.

2) UPFSD (Sao Paulo Family Planning Unit). This organization has active screening by a psychologist and a high rejection rate. The clinic uses minimum age and parity requirements (for example, age 24 and four children) and the Perkins risk scale to screen for high risk of regret. UPFSD states that 90 percent of men and women who come to the clinic ask for VSC, but that only 30 percent receive it. Requestors must wait two to five weeks for the procedure. The indigent pay nothing; others pay up to an equivalent of US\$30. Other contraceptive methods are free of charge.

3) CPAIRC (Maternal Child Research Center). CPAIRC centers serve the indigent favela population who pay on a sliding scale of zero to US\$10 per procedure. They must wait one week for VSC. A study by this organization revealed that the acceptors have a good understanding of the permanence of the procedure.

4) BEMFAM. This is a training program; it offers VSC only in the context of its training activities.

---

21 Bertrand and McBride, "Evaluation of the APROFAM Program for Voluntary Sterilization in Guatemala," Tulane University and USAID/Guatemala, February 1985, pp. 2-9.

II.4.6.4 Colombia. AVS supports VSC through Profamilia, an organization that was the center of public debate between the Catholic clergy and supporters of family planning in 1984. At that time, "hundreds" of Indians were alleged to have been castrated against their will. When the church was asked for evidence of these charges, three persons were brought forward. One was a severely retarded and schizophrenic woman who already had one child by an unknown man. The other two women were multiparous and in their early 40s who claimed they were unaware of the operation's irreversibility. But records showed appropriate procedures and documentation.

Still, doubt lingered that recruitment had been too aggressive. This concern may have been a holdover from an earlier program with the MOH, in which a per-procedure payment to medical practitioners was paid. The current program with PROFAMILIA does allow for some per-procedure payments, but these are fairly closely controlled. In larger clinics, the physician is paid a base salary and then receives a payment of US\$6 for every procedure if over four are performed in a single hour. The social worker screens the patients and is instructed by the director of social work to schedule no more than four clients per hour per physician. The existence of low-level antagonism between physicians and social workers probably testifies to the effectiveness of this arrangement. Only in very small clinics and in mobile units is the medical team reimbursed on a per-procedure basis. As a consequence of the debate with the Catholic church in 1984, the activities of both small clinics and mobile teams have been severely curtailed, leading to reduced numbers of sterilizations in the past 12 months. Evidence is, however, that the demand continues to be as strong as before the debate.

Minor discrepancies were turned up in one clinic: an old consent form -- more an authorization than an informed consent form -- was still in use and the signatures on some consent forms appeared forged. However, none of the acceptors has, on his or her own initiative, challenged the appropriateness of the counseling. Thus, there appears to be no conclusive evidence of involuntary sterilization of either men or women in Colombia.

II.4.6.5 Sri Lanka. Since the beginning of the family planning program in Sri Lanka, the government of Sri Lanka has offered, or provided, compensation to VSC acceptors, service providers, and "diffusers" in various amounts. In June 1983, the government increased the amount of compensation to acceptors from 300 rupees to 500 rupees. AVS immediately worried that this amount might exceed what reasonably could be equated with

compensation for wage loss and expenses and, therefore, might motivate Sri Lankans to request a sterilization for monetary gain rather than for health and fertility-limitation purposes.

AVS, therefore, suspended support to its Sri Lankan affiliate until it could ascertain that the increased compensation was not verging on involuntarism -- that it was still consistent with AID's PD3 guidelines on voluntarism. Following AVS's decision, AID also suspended its assistance to the Sri Lankan program. AVS then contracted for an independent external examination of the issue. Conclusions are excerpted below. 22/

- 1) The environment surrounding the decision to seek a tubectomy or a vasectomy in Sri Lanka is distinctly noncoercive. The level of education is high. The newspapers are still remarkably free, but no instance could be found of the press having uncovered a single instance of less-than-voluntary sterilization over the past few years. The atmosphere is not one of pressure.
- 2) The procedure for becoming eligible for sterilization is quite complex and allows for personal review and rethinking all along the way. The village head must first certify that the man or woman meets the government eligibility criteria: men must be under 50 and women under 45; they must be married and have at least two children; if they have only two, the youngest must be at least a year old. This certificate must then be taken to the hospital or clinic and reviewed by the medical officer or nurse in charge. The requestor is then asked to sign an informed consent statement (a strengthened form introduced by the AVS affiliate, the Sri Lankan Association for Voluntary Sterilization).
- 3) There are real; and feared, out-of-pocket costs associated with sterilization in Sri Lanka, and these costs have inhibited acceptance relative to other methods. There is no one figure for such out-of-pocket costs, which range widely depending on rural or urban residence, work status, and such considerations. The compensation provided by the government does meet most if not all of these costs for most acceptors.
- 4) In conclusion, the current sterilization acceptor payment does not constitute undue influence. The climate is informed and open. Clearly, government policy supports voluntary choice, but the government does not want any economic impediment to acceptance of VSC.

---

22 Nicholas Wright, M.D., "Report on the Sri Lankan Incentive Program for Voluntary Sterilization," 26 October 1983.

A study of post-sterilization acceptors (350 males and females) conducted by Sri Lanka's MARGA research institute reached similar conclusions on the high level of "voluntariness and motivation". 23/

After careful analysis, AVS did resume support to Sri Lanka. AVS continues surveillance by monitoring acceptor numbers and characteristics to detect any changes in patterns that might suggest questionable effects of the compensation policy. It has not identified any instance of coercion. FHI, together with two Sri Lankan PVOs, conducted two acceptor follow-up surveys, one male and one female, modeled after the AVS follow-up survey. Both reports are expected to be completed in summer 1985.

## II.5 Medical Services

### II.5.1 Training

AVS training policies and practices have evolved from an eclectic, informal approach to a mature, systematic program with clear training goals and standards and mechanisms for monitoring and evaluating trainees' performance. AVS encourages in-country training, with coordination at the national level by a voluntary coordinating body of representatives of governmental and non-governmental VSC training institutions.

AVS benefits from its close working relationship with JHPIEGO, particularly in regard to training. JHPIEGO-trained and -equipped physicians often subsequently train in their home countries. However, JHPIEGO-trained physicians generally represent teaching hospitals in large urban centers and understandably are biased in favor of laparoscopy. The result is a dramatic delineation of services, based on trainers' preferences: some institutions perform female VSC exclusively by laparoscopy, others by minilaparotomy only. As VSC acceptance diffuses to more rural and remote areas, AVS has attempted to balance its training for female VSC realistically between laparoscopy and both interval and postpartum minilaparotomy. The effort appears to be succeeding.

Currently accepted AVS training standards call for special selection criteria for different categories of personnel, including specialists (obstetricians/gynecologists and urologists), general surgeons, general practitioners, and, in some instances, paramedical personnel. For laparoscopy, eligible trainees are expected to be fully competent in abdominopelvic

---

23 Wright, "Report..." p.6.

surgery, with training limited to ob/gyn specialists, general surgeons, and physicians with a minimum of three years' experience in abdominosurgery. For minilaparotomy, at least minimum knowledge and experience in abdominal surgery and adequate surgical ability are required. General practitioners receive vasectomy training. Under certain conditions, paramedics may be trained in minilaparotomy or vasectomy procedures under the supervision of physicians.

That trainers' preferences prevail over training protocols, however, implies a lack of standardization. The World Federation, in an expert committee meeting on training held in Brazil in September 1984, addressed the issue of standardizing training goals and methodology. Participants included 22 experts representing 17 countries, with observers from USAID and other donor organizations. The report of the committee's three task forces recommends setting standard requirements for training institutions; defining objective qualifications of trainers; codifying selection criteria for trainees; standardizing training content; certifying trainees; following up trainees; and specific training for paramedics and the VSC delivery team.

The 1984 expert committee's report recognizes the need to balance training with existing VSC caseloads at the training institutions so trainees may observe and perform the requisite number of operations to assure proficiency. Moreover, as a matter of policy, AVS advocates concurrent physician training in laparoscopy and in minilaparotomy to accommodate the client's choice and the medical evaluation. Site visits, however, demonstrated the difficulty of achieving this goal before a critical mass of cases suitable for training purposes is reached. For example, in Nigeria, Benin City Specialist Hospital performed only 59 VSC procedures in the past year and Benin University Teaching Hospital, only 250. These levels hardly suffice to expose trainees to an appropriate mix of procedures. Often training is temporarily curtailed in favor of ob/gyn residents. In some instances, compromise in the number of cases required to certify proficiency, or substitution of cases of diagnostic laparoscopy for VSC experience, is tolerated.

Such compromises are inevitable as a viable national training and service program evolves. They highlight, however, the importance of a follow-up evaluation of each trainee, the details of which are carefully spelled out in the report of the 1984 expert committee on training. Implementation of this follow-up protocol -- which includes quarterly reports from trainees to the training institution, follow-up visits by the training staff, and eventual national trainee surveys -- has just begun in 1985, and cannot yet be evaluated.

Finally, the balance between initial training of ob/gyn or

general surgery residents and the in-service or refresher training of government and private physicians is gradually shifting. The surgical and anesthetic habits of older practitioners are more rigid than those of young resident physicians. Hence, AVS is increasing training support in teaching hospitals where young trainees can be exposed to all VSC modalities in conjunction with related family planning and maternal/child health practices.

#### II.5.2 Supply, Dedicated Space, and RAMs

In subprojects offering both laparoscopy and minilaparotomy, donor agencies often have to provide the equipment, supplies, and physical environment that make those procedures medically safe. AVS frequently shares this responsibility with JHPIEGO, with the latter supplying the surgical instruments, including laparoscopes, and attending to their repair and maintenance. AVS supplies emergency equipment, drugs, linens, surgical kits, and sterilizing equipment. In addition, in institutions with regular surgical operating theaters that are either overtaxed, unsuitably located, or poorly designed, or that create a psychological barrier, AVS renovates or constructs a dedicated space, usually contiguous with an outpatient family planning clinic or maternity service, in which ambulatory VSC with local anesthesia can be performed safely and expeditiously.

Several such dedicated VSC spaces in various stages of construction and operation were visited, particularly in Nigeria and the Dominican Republic. The site visits confirmed that these are important and often necessary adjuncts to VSC delivery, that they contribute to expansion of VSC caseloads, and that they enhance both the safety and utility of VSC subgrantee training sites. The host institution's contribution of building space, medical support personnel, building maintenance, and medical supplies is essential in these arrangements as part of the progressive assumption of recurring costs leading to self-sufficiency. To this end, partial payment for supplies by acceptors also has been instituted in some locations.

AVS, through its subgrantees, has supported RAMs in 14 countries. In 1984, three RAMs were in North Africa (Egypt, Tunisia, and Morocco); four were in Asia (Indonesia, Korea, Nepal, and Thailand); and the remaining seven were in Central America and the Caribbean (the Dominican Republic, El Salvador, Guatemala, Honduras, Jamaica, Mexico, and Panama).

In general, RAMs were well-staffed with trained technicians and had sufficient tools and spare parts. In Nepal, where there are 30 laparoscopes and 71 laproscators, three technicians maintain the instruments, which are tested at least twice

annually. The equipment is issued at time of use, and enough spares are kept to exchange laparoscopes and laprocaters quickly when necessary. The RAM technician may accompany the VSC team to ensure proper use and maintenance. The Nepal center is nominally part of the MOH infrastructure, but it is financed by USAID/Nepal, is located in the AVS grantee's compound, and comes under the grantee's supervision.

In Indonesia the same pattern of support is evidenced, with USAID/Indonesia support channeled through BKKBN, the Indonesia family planning government agency, which, in turn, asks PKMI, the AVS grantee, to operate the seven centers that maintain and repair the 500 instruments of both U.S. and German manufacture. (The German laparoscopes were provided by The World Bank.) This seems a rather convoluted manner to funnel finances and does little to relieve AVS's fiscal responsibility to the RAM, either directly or indirectly.

In Nigeria, repair and maintenance are contracted (no AVS funding involved) to a medical supplier in Lagos, who was trained in the United States. He visits all AVS-supported programs regularly and whenever problems arise. The subgrantees are completely satisfied with the arrangement.

AVS no longer supplies RAMs with laparoscopes and laprocaters. At some sites, both American- and foreign-manufactured equipment is in use, so spare parts must be purchased from non-U.S. sources, a procedure which requires waivers. For these reasons, and in keeping with the current emphasis on simpler and less costly technology (postpartum and interval minilaparotomy), AVS encourages RAMs to become self-sufficient, to align with an institution, or to find alternative funding sources. So far, the RAMs in Korea, Thailand, Nepal, Jamaica, Panama, Indonesia, Morocco, Tunisia, and Egypt have transferred funding responsibility to another donor.

### II.5.3 Medical Service Standards and Guidelines

The medical division was created in 1982, when AVS hired its first full-time medical director. The science committee, a multidisciplinary body, made up of experts in ob/gyn, urology, anesthesiology, and epidemiology, meets at least once a year to guide the medical division's policy. The committee's work is supplemented by ad hoc expert committees on specific topics, task forces, and conferences.

A set of medical service standards for both female and male VSC procedures was prepared and circulated as "Minimum Medical Service Standards." In January 1983, the AVS science committee and other experts declared the standards were no longer minimal,

charging AVS projects to make "every reasonable attempt to conduct service activities in accordance with the Medical Standards." Directors of AVS-funded programs were told to inform AVS of deviations from the practices described in the medical standards. The published report of the expert committee (see II.5.1), which met in Manila May 9 to 12, 1983 ("Safety of Voluntary Surgical Contraception"), is a set of supplemental guidelines, geared to specific surgical and anesthetic practices.

Strict compliance with published standards cannot always be achieved or enforced, particularly in areas in which some VSC activity (usually in the private sector) exists, patterns of surgical and anesthetic practice are established, or logistics hamper supply lines and communication. In such instances, the medical division encourages country "norms," flexible standards on service provision and training goals tailored to local circumstances by locally respected medical personnel. Country norms currently are being promulgated in the Dominican Republic, as an outcome of an April 1985 seminar on medical safety. The norms, jointly developed by PROFAMILIA and CONOPOFA, are heavily influenced by the AVS standards.

In sum, AVS's current medical supervision strategy is generally appropriate and in line with its current policy of enhancing service quality through professional education and supervision.

#### II.5.4 Medical Supervision of Subprojects

As AVS's VSC programs increase, the medical division in New York loses direct subproject supervision. Medical supervision becomes indirect, and tasks are delegated. AVS disseminates published medical service standards and guidelines; develops forms for required reports of program performance, complications, and untoward events; and recruits regional medical staff and regional medical consultants to visit in-country medical sites.

II.5.4.1 Site Visits. At the beginning of the current cooperative agreement medical site visits were sporadic and infrequent. A concerted effort has begun to visit sites regularly, with an attempt to visit the larger projects at least once each year. However, regularly scheduled visits to sites are difficult, given the number of projects, limited staff, and the visits requested by local project staffs to sort out special problems or untoward occurrences.

Although the medical division staff does, and intends to continue to, make site visits, these are increasingly focused on proposed new projects or special problem areas. Now site visits

are delegated to newly recruited medical personnel in the regional offices, and to regionally recognized consultants, enhancing AVS's medical supervision. The new recruits personnel in the Latin American and Asian regional offices are experienced and respected senior professionals; AVS plans to bring them to New York in 1985 for orientation.

**II.5.4.2 Medical Records and Required Reports.** AVS constantly refines its records and report requirements to standardize, simplify, and improve the process. The requirements for medical records, for reports of complications and deaths, and for site visitor compliance reports are clearly set forth in the published standards. In addition, improved versions of informed consent forms and "Physicians Training Reports" are currently being field-tested.

Despite concise and straightforward reporting forms and reasonable reporting expectations, the accuracy of field reports is questionable. The chronic problem of apparent underreporting of complications and late or insufficient reporting of fatalities arises both from a natural disinclination to acknowledge unsatisfactory outcomes and from a lack of clear understanding of AVS expectations and of the importance of the data by individual physicians.

Many physicians fail to report minor complications they considered inconsequential, despite AVS instructions. For example, purulent discharge from a small laparoscopy or minilaparotomy incision seems akin to a superficial surgical wound infection until probing questions are asked in a site visit. Likewise, some physicians do not feel required to report complications that responded to treatment (for example, successfully controlled bleeding). In general, subgrantees who report "no complications" in a large series of cases are probably underreporting. This, however, is difficult to prove, especially in projects that screen for the lowest risk candidates and use only conservative surgical and anesthetic techniques. Verbal and written reinforcement during supervisory and medical site visits is gradually improving the quality of reporting. A new model monitoring system (in Kenya, Indonesia, and the Dominican Republic), which reports complications in the simplified case record, will be field-tested shortly.

One source of confusion in reporting is worth mentioning. Anesthesia complications, or others arising before the tubal occlusion, are sometimes not considered sterilization-related, because the sterilization did not actually take place. As irrational as this may seem, such cases occur. Neither the standard nor the complications reporting forms specifically mention discontinuing a VSC procedure when complications arise

or when unsuspected pathology, such as dense adhesions, is encountered that would make the procedure dangerous. A reporting category of "Surgery discontinued without VSC completion" is called for to further physician education and fuller documentation of untoward events.

II.5.4.3 Investigation and Follow-up of Fatalities. Fatalities associated with VSC are rare, averaging an estimated one per 10,000 cases worldwide. Nevertheless, AVS investigates all suspicious deaths to ease fears that might affect the acceptability and diffusion of VSC as a public health measure. Although a surgical mortality rate lower than a country's expected pregnancy-related mortality may be rationalized, AVS does not do so. The organization's commitment to medical excellence shows in its handling of five apparently VSC-related fatalities in one country. In none of these five cases was the AVS 24-hour post-occurrence report requirement met. The attending surgeon was apparently unaware of the reporting requirement in one case. (A Ministry of Health investigation brought it to the attention of the government-sponsored AVS program director.) The second death (reportedly anesthesia related) was unreported because the patient was never sterilized. In both instances, the administrative level of the subgrantee (which is aware of the reporting requirement and supplied with the necessary forms) failed to communicate with the level of service delivery. Once AVS was notified, the project director dispatched a senior physician from the regional office for an on-site investigation and detailed report to the medical division. An in-country medical safety seminar was arranged as well.

In the course of the medical investigation and seminar preparation, the AVS representative learned of the three additional fatalities, in one case by word of mouth and in the others by alert probing into a newspaper account of two surgical fatalities. These, too, were probed. Each case was reviewed by the AVS medical director; the reports were analyzed by the associate director; and the relevant literature was searched by a special program officer.

In response, AVS

- 1) suspended VSC services pending completion of the investigation;
- 2) notified the attending physician as well as the program director of the findings of the investigation;
- 3) retrained the physicians in safety measures, for both anesthesia and surgery; and

- 4) held an in-country seminar on medical safety for AVS project physicians.

The measures taken by AVS to investigate VSC-related fatalities, to establish their cause and prevent reoccurrence, to institute corrective measures, and to use the lessons learned for educational purposes are both appropriate and laudable. In particular, the medical division recognized the exigencies of medical practice in developing countries that often make the strict application of the published "Medical Service Standards" impossible. And the medical division's emphasis on education -- learning from mistakes -- rather than punitive actions is commendable.

However, a serious communication gap, apparently between project administrators and the surgeons who actually perform VSC procedures, must be bridged. The subagreement's reporting requirements were well understood by the project director but not conveyed to each service site or participating surgeon. None of the cases involved a conscious attempt to hide the facts. Rather, the long reporting delay reflected either the operating surgeon's knowledge, or a project administrator misinterpretation of the need to report all fatalities in AVS-sponsored programs, regardless of the assumed cause of death. (AVS subagreements are written in English; therefore, both language and cultural barriers to full understanding of all of the details of subagreements may occur.)

#### II.5.5 Medical Services: Country Examples

II.5.5.1 Bangladesh. In Bangladesh, AVS has has a major impact in introducing and promoting high medical safety standards. This has been achieved through BAVS, one of the most successful of all AVS-supported activities, as well as one of the most successful of all family planning service delivery programs in Bangladesh. BAVS was established in 1975 in Dhaka and now runs 34 clinics throughout Bangladesh which perform 15 to 23 percent of all sterilizations (male and female) in the country and offer temporary methods to "rejected clients" and, since early 1985, to the general public. In its first decade, BAVS performed 400,309 VSC procedures (248,668 tubectomies and 151,641 vasectomies).

BAVS is a standardsetter in this appallingly poor country where the government lacks the manpower and administrative

capability to deliver high-quality services reliably. <sup>24/</sup> BAVS maintains medical standards of care considerably higher than those found in most government clinics. Within the BAVS program there was only one VSC-attributable death (female) in 1984, despite the performance of over 100,000 procedures. This is extraordinary.

The disparity between the high-quality services of BAVS and the poorer quality services of government clinics has provoked both resentment from the government and concern on the part of USAID (which supports both the government and BAVS programs through its present bilateral project). Recently, however, BAVS has helped government facilities improve VSC service quality by

- 1) Providing technical assistance for developing a government of Bangladesh Sterilization Manual, basically an adaptation of the BAVS Manual for Sterilization and VSC Service Delivery Guidelines developed in 1975;
- 2) Providing technical assistance on government VSC policy issues through BAVS' membership on the National VSC Technical Committee, the highest body for recommending VSC-related policy to the Ministry of Health and Population Control;
- 3) Organizing two training workshops, on January 2-3 and August 21, 1981, at BAVS training headquarters, to train top-level government physicians (including professors of ob/gyn and surgery of the medical college hospitals, the physician-administrators of the Ministry of Health and Population Control, and the district Civil Surgeons) in cardiopulmonary resuscitation and improved anesthesia techniques;
- 4) Developing training for government physicians on overcoming obstacles and dilemmas in maintaining medical standards in VSC service delivery (at the BAVS Third Annual Medical Workshop January 1, 1982);
- 5) Holding four regional medical workshops in May 1982 to train government rural health center physicians to implement minimal medical standards and manage emergencies in VSC operating theaters;
- 6) Providing technical assistance to the Directorate of Population Control and the Voluntary Health Services

---

24 M. Koblinsky, R. Simmons, J. Phillips, and Md. Yunus, "Barriers to Implementing an Effective National MCH-FP Program," ICDDR, B, 1984.

Society (a national-level nongovernmental organization) to organize a VSC conference on December 21-22, 1982, for all nongovernmental organizations providing VSC services in Bangladesh;

- 7) Training government physicians, program managers, and other staff members on the principles of client recruitment, counseling, and follow-up at the BAVS Fourth Annual Medical Workshop, March 1983;
- 8) Training government physicians in quality clinic management (medical and nonmedical issues), including preoperative client preparation and emergency preparedness (BAVS Regional Medical Workshops July-October 1983 and BAVS Fifth Annual Medical Workshop, January 1984);
- 9) Regularly offering both initial and refresher training for several hundred government physicians;
- 10) Technically assisting in the development of training curriculum for the initial (comprehensive) training of government physicians, which takes place at the government's eight model clinics; and
- 11) Supplying technical assistance to the government's Sterilization Surveillance Team to develop a mortality and morbidity investigation and reporting system for the country (as required by AID in a condition precedent of the present bilateral population project).

In addition, AVS has directly funded the government's VSC program through:

- 1) A consultancy by Dr. John Fishburne, Jr., in July 1980, for review of anesthesia-related sterilization deaths in the government program;
- 2) Twelve CPR training models (mannequins) for 12 government VSC training centers (eight model clinics, the Mohammadpur Fertility Research Model Clinic, district clinics in Khulna and Comilla, and the BAVS Dhaka clinic);
- 3) Emergency supplies, following a request from the government of Bangladesh and USAID's concurrence, to meet emergency situations -- sutures in 1980, ambubags in 1981, asepsis maintenance material (autoclave indicator tapes) in 1982, and local anesthesia medicine (Lidocaine) in 1983 -- for keeping the government's VSC services operating without interruption;
- 4) Occasional support for top-level government policy-makers

to participate in international seminars and conferences;

- 5) Support for the first phase of the Refresher Training Program for 600 government physicians (the second phase is being reviewed for approval); and
- 6) Plans to support Government physicians' initial (comprehensive) training program as well as government efforts to institutionalize counseling at all family planning service centers.

II.5.5.2 Tunisia. Since 1978, with AVS support, female sterilization has become widely available as a program method in Tunisia's ONPFP-directed national family planning program. It now accounts for 35 to 40 percent of all use of modern contraceptive methods (1983 prevalence survey). Since then, AVS has financially supported the Tunis training center and 17 of the 23 family planning clinics and centers of the ONPFP. Over 100,000 tubectomies have now been performed through the program; only two deaths have occurred. Complication levels are low. A thorough program evaluation in 1984 verified the high level of medical quality and concluded that there is no need for any further evaluation at this time of medical quality and safety. 25/

Counseling. VSC counseling, in the field and in the clinics, is part of general method counseling. A planned 1986 ONPFP counseling workshop will receive AVS funds.

IEC. AVS does not have a separate IEC program in Tunisia but contributes materials to the ONPFP and other donors in this area. VSC is not promoted apart from other methods. The AVS regional office is now translating materials on female VSC into Arabic and may soon do the same with materials on the male VSC.

## II.6 Strategic Planning

An organization's strategy is defined as its objectives and policies -- the objectives, of course, being the general direction in which the organization intends to move, the policy being the constraints it imposes on its own actions in pursuit of those objectives. In the current critical atmosphere both in the United States and Third World, considerable attention is being paid to policy development and enforcement, raising the danger that the policies (constraints) may become ends in themselves

---

25 "GOT/USAID Evaluation of the Tunisian Family Planning Program," June 1984, pp. 26-28, 77-79.

while the objectives of the organization are lost along the way.

The stated objectives of AVS are 1) to expand VSC in existing programs to serve larger populations, and 2) to introduce VSC in societies without programs. These general objectives could justify a broad range of activities. Perhaps the very generality of the objectives focuses attention on policies as guides to action.

#### II.6.1 Resource Allocation

How to spend money -- on VSC services or policy promotion, and in which regions -- is an AVS policy decision. There has been a marked shift of resources in sub-Saharan Africa and away from Asia and the Far East, a shift consistent with current AID policies (Table I.6-1). If this resource shift continues, additional money will have to be invested in project development in sub-Saharan Africa: specifically, creation of a regional office and allocation of more travel money to find promising funding opportunities.

#### II.6.2 Services

Whether to fund new or continuing services is a difficult issue. It brings into direct opposition the two stated objectives of the organization. AVS agonizes, appropriately, over the issue and attempts to encourage established programs to become self-sufficient in order to free resources for new subgrants. Technical assistance programs to promote improved cost effectiveness and financial self-sufficiency might make this a less painful choice.

At present, AVS fosters financial independence by gradually reducing the institutional reimbursement per procedure. But for organizations that bill on a variable cost basis, problems arise. If the AVS subsidy is less than the cost of the service, financial logic dictates that the recipient organization simply eliminate the service. Variable costs are most evident when practitioners are paid per procedure or contracted part-time; therefore AVS encourages recipients to hire practitioners or lease facilities long-term, making it difficult for the recipient agency to abandon sterilization when it is no longer a paying proposition. Although the strategy is Machiavellian -- it ties the hands of the recipient organization -- such maneuvering does increase the likelihood that surgical contraception will outlive AVS's subsidization.

A corollary to this issue is the choice of target population. High subsidy levels give poor people access to VSC,

obviously a desirable emphasis. If, however, a private sector organization is forced toward self-sufficiency by subvention reduction, then that organization has to find paying customers. Installment payments are an option but are not always workable because of additional administrative overhead. Instead AVS might help these organizations to develop additional sources of income in two ways: 1) contact with other intermediaries and 2) development of revenue-generating products and services, such as training courses. AVS should discourage recipient programs from blindly entering activities that operate at a net loss. Unfortunately, many of the most necessary family health programs -- nutrition, vaccination, and prenatal care -- fall into this category. Private sector recipients need to face the stark truth: if they are going to provide some services at a loss, they will need compensating revenue-generating services.

### II.6.3 Policy Promotion

Policy can be promoted two ways. The first is to plant a seed by providing services to unserved areas; the manifest objective of this tactic is to demonstrate the legitimacy of the service as well as the political viability of offering sterilization within a given political context. The second type of policy advocacy is directly to meet obstacles impeding the expansion of an existing service. Brazil is a case in point. The Social Security provides the bulk of the sterilizations in Brazil, a country in which 18 percent of the married women of reproductive age have been sterilized. Due to peculiarities of Social Security reimbursement policies, caesarean deliveries are paid for but tubal ligations are not. As a consequence, a Brazilian woman understands that, to get a tubal ligation, she must first get pregnant and then bribe the attending physician to deliver the child by caesarean and ligate her tubes in the process. Either AVS or the World Federation should question the Social Security reimbursement policies, but neither has. If AVS could successfully change the policies, then service expansion, paid for by Brazilian monies, would quickly reach areas that have no AVS subgrantees.

AVS has steadily increased monies going to leadership and policy development (Table I.6-3), a significant amount of which has been dedicated to developing medical and counseling guidelines. Now that guidelines have been articulated, the World Federation should turn attention away from the internal operating problems of sterilization programs and direct more energies to changing policy to permit expansion of VSC services into countries where AVS already has a small operation.

AVS has written country strategies for those countries in which it is or would like to be operating. These strategies are well done and represent a good start. Probably no more need to be committed to paper. However, the strategies, when they refer to operating avenues, usually focus on organizations, not on individuals. Many countries, however, still do not have a viable family planning organization. For those countries, the association needs to return to the 1970s modus operandi of identifying entrepreneurial individuals to support. This would be particularly useful in expanding services through private medical practitioners.

#### II.6.5 Factors in Strategic Planning

The role of policymaking normally falls to the board of directors. However, most of those policymaking options have been preempted by AID. A word of warning: the net result of multiple sources of policy is that an organization can easily lose sight of its objectives.

#### II.6.6 National Leadership Groups

As pilot projects are launched to establish the political viability of VSC, national leadership groups are formed to create an organized force for liberalization of relevant legislation and policies. The experiences in the following regions are instructive.

II.6.6.1 Africa (Francophone). Most countries in this region do not have national leadership groups. If groups could be formed, their specific functions might include, first, to influence policymakers and professional groups; second, to reinforce information and education for VSC; and, finally, to initiate technical activities (training and services).

II.6.6.2 Middle East. In this region, where cultural and religious conservatism continues to pose serious obstacles to VSC (in all countries but Tunisia), the Regional Arab Federation for Voluntary Fertility Care provides a unique forum for physicians of 10 Arab countries to share information and inspiration concerning possible new approaches. In 1982, this group's conference in Khartoum led to the publication, by the World Federation in 1984, of the first Arabic language medical textbook on family planning, including VSC. The World Federation, with the Regional Arab Federation and other organizations, plans to hold a workshop in 1986 for medical school deans and ob/gyn

professors on how to introduce sterilization into their training programs. The AVS regional director in North Africa and the Middle East believes this regional group will increasingly play a crucial lead role in establishing, legitimizing, and eventually popularizing VSC throughout the Arab world.

II.6.6.3 Tunisia. Tunisia's national VSC leadership group, the Tunisian Association for Voluntary Sterilization (Association Tunisienne de Sterilisation Volontaire or ATVS), differs from the norm. This group of about 200 physicians, led by some of Tunisia's most eminent gynecologists, formed several years after the national family planning VSC program had already started. (Tubal ligation became a standard program method in 1974. ATVS came into being only in the late 1970s and, legally, only in 1981 when it also became an affiliate of the World Federation.) Thus, there was no role for the ATVS influencing policymakers to support introduction of VSC as a family planning method. Rather, in searching for a niche in the ongoing program, without duplicating existing efforts, it was decided the ATVS should have as its mission the promotion of vasectomy. Vasectomy, because of traditional Arab-Muslim cultural beliefs that still prevail in Tunisia, is commonly equated with castration, has remained virtually a taboo subject, and is not a national program method, although some men discretely seek vasectomies from some private physicians. The ONPFP, which directs the national family planning program, supports vasectomy in principle, but thinks ONPFP promotion of vasectomy at this time would be too risky and potentially damaging.

For this reason, AVS made a \$21,000 grant to ATVS in 1983 for IEC to demystify vasectomy. To the extent possible, ATVS was also to stimulate or develop interest in minilaparotomy and local anesthesia. Under this grant (first-year subagreement), ATVS carried out six well-received vasectomy "information days" in key cities throughout the country and successfully introduced vasectomy into the curricula of medical, nursing, and midwifery students. Other activities identified in the first-year subagreement were not carried out because ATVS members were all busy in private practice, teaching, and hospital work and a salaried program coordinator was not included in the first year budget. A second year project has not yet been approved for submission to AID.

The AVS regional office in Tunisia remains optimistic, however, and has developed a \$65,000 follow-on grant for ATVS. Its objectives are 1) to conduct an IEC program directed toward political leaders, medical and other professionals, and the general public; 2) to establish an information and service center in Tunis; and 3) to provide vasectomy counseling and

services on a demonstration basis in one provincial clinic. Key to the success of this project will be finding the program coordinator (which may be possible by secondment of an experienced ONPFP staff member) and getting technical assistance in program matters from the ONPFP so no mistakes that provoke public outcry are made. The AVS regional office believes that, through slow but carefully planned steps with this national leadership group, public opinion can be turned around.

II.6.6.4 Egypt. The Egyptian Fertility Care Society (EFCS) has been criticized by some AID and AID-affiliated personnel for not having mobilized forces in the Egyptian government to adopt a law supporting sterilization. The training work done by the EFCS in the early 1980s, however, is beginning to show results. Evidence strongly suggests that the earlier negative judgment may have been premature and should be re-considered.

II.6.6.5 Sub-Saharan Africa. In Nigeria, the emergence of a leadership group, FAN, was greatly energized by the 1984 World Federation-sponsored Sierra Leone Conference, and is currently in the process of applying for World Federation membership. FAN, with support and technical assistance from AVS, draws upon nationally recognized and experienced leaders in the family planning field to provide information to policymakers and to encourage implementation of government policy to reduce the rate of population growth. FAN's first president explained that the association, in collaboration with the Population Association of Nigeria and the scientific committee of the Society of Obstetricians and Gynecologists (SOGH), plans to function as a "pressure group" to encourage the government to transform its current recognition of the impact of rapid population growth on Nigeria's development into tangible action. Its modus operandi is to provide essential data for policy formation, and to educate and disseminate information on family planning. FAN aims to become self-sufficient by attracting Nigerian philanthropic support. In the meantime, AVS supports FAN's attempts to get VSC accepted as a part of all family planning programs.

#### II.6.7 Summary Observations of Strategic Planning

To summarize, the following observations can be made as to how AVS charts its course.

- 1) AVS has clear, albeit general, objectives and the main thrust of the association's activities contribute to those objectives.

2) The policies that have been developed have been well suited to perceived changes in the environment as well as to the long-term interests of the organization. Notably, voluntarism has been the hallmark of AVS from its inception. As a consequence of recent closer official and public scrutiny of family planning efforts, AVS has taken pains to document extensively the patent voluntary nature of its program. AVS has provided conclusive evidence that it has enforced the policy zealously and effectively.

3) Systems have been put into place that preserve the basic AVS policies on voluntarism and quality. Attention that had been diverted from other strategic activities to attend to the external threat to voluntary sterilization may now, in large measure, be redirected to more energetic planning. That is not to say that AVS can now ignore its policies -- the systems in place will have to be monitored and maintained -- but rather that relatively increased emphasis can be placed on planning to meet the basic service objectives of the organization.

## II.7 World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception (World Federation)

### II.7.1 Background and Current Status

This international voluntary health and family planning organization was formed in 1975 and now has a membership of 44 health and planning organizations from 37 countries and three regions. The organization has an executive board and standing and program committees of volunteer international experts, and a small secretariat (of paid staff) in AVS headquarters in New York.

The World Federation's mandate is to develop a network of national leaders to promote VSC services, to establish appropriate VSC standards, to provide a forum for developing service policies and guidelines, and to share current information on surgical contraception techniques and programmatic issues (legal, IEC, informed consent, training, and safety).

To fulfill its information dissemination goals, the organization publishes a newsletter (Communique) three times a year (distribution of 2,000) and Update, a periodic report of members' activities and committee projects related to service delivery. The secretariat serves as an international clearinghouse for information on all aspects of VSC. The World Federation also has published eight comprehensive documents on various aspects of VSC in several languages, including Arabic, French, and Spanish; a series of reports; a number of policy statements and guidelines; and in addition resolutions, declarations, and plans

of action emanating from regional, national, and international meetings (see Appendix C). During 1982 to 1984, meetings arranged and funded by the World Federation included two international meetings, five international expert groups, and three regional programmatic meetings. The secretariat staff is currently comprised of four professionals and two secretaries. (A reduction in staff occurred in 1984 due to an AID funding ceiling. One program and one secretary position remain vacant.) Currently, the international membership network consists of 44 national organizations in 36 countries representing thousands of service delivery providers and family planning policymakers.

### II.7.2 Funding History

The organization's main source of funding is a subgrant from AVS which, in turn, submits the proposal to AID/W for approval under the cooperative agreement. The total expenditures for 1982 were \$545,726; for 1983, \$805,068; and for 1984, \$763,602. Funds allocated for fiscal year 1985 are \$580,100. (A financial summary by year and project activity is in Table II.7.2.)

### II.7.3 Professional Education, Policy, and Program Development

The World Federation disseminates VSC information worldwide and provides a forum for discussion and development of international guidelines, VSC service policies, and plans of action developed by world authorities in surgical contraception. This has stimulated many AVS service projects and has encouraged several governments to initiate and strengthen VSC. VSC initiatives, policy statements, and standards are more acceptable to developing countries when designed by multinational leadership (the actual VSC service managers) in the family planning field (as opposed to the United States or other developed countries).

The World Federation has a unique claim to being the authoritative international body on VSC because of the service delivery program experts in its volunteer network. In Indonesia, the World Federation policy statements helped the local non-governmental organization -- PKMI -- to influence the government to provide VSC services.

The dynamics of VSC acceptance and situational focus must be considered in viewing the World Federation's impact. Perhaps the focus of the World Federation's activities under the AID funding umbrella should be narrowed to those more directly relating to AID's own objectives of expanding safe VSC services. AID should not dictate the World Federation's course, but selectively fund priority activities related to AVS's service goals, allowing the World Federation to find outside financial support for other

**TABLE II.7.2 WORLD FEDERATION FOR VOLUNTARY SURGICAL CONTRACEPTION BUDGET**

PROGRAM PROJECTS	1982	1983	1984	1985
<b>PROFESSIONAL EDUCATION</b>				
Intl. Vasectomy Conf.	\$130,989			
Regional Arab Conf.	40,631			
Fifth Intl. Conf.		\$272,203		
Sub-Sahara Conf.		12,000	\$247,026	
Special pubs.				
\$24,000				
Staff work on background materials, research, and program development	70,470	83,421	84,312	36,735
Rent		9,900	9,900	8,850
<b>QUALITY ASSURANCE</b>				
Expert Committee on Safety	10,000	68,827	4,172	0
Legal & IEC Committee	8,000			
Counseling Manual Cmte.		14,873		
Expert Committee on Training			50,781	
Statistics Committee			10,000	
Voluntarism and monitoring seminars				102,000
Staff work on background materials, research, and program development	46,981	55,614	56,208	85,715
Rent		6,600	6,600	20,650
<b>LEADERSHIP AND POLICY DEVELOPMENT</b>				
Leaders speak for VSC & regional activities	19,235	21,313	13,000	33,000
Staff work & background research	46,981	55,614	56,208	48,980
Rent		6,600	6,600	11,800
<b>INFORMATION DISSEMINATION</b>				
Technical/Professional publications & printing	16,525	16,000	13,850	10,500
Communications, dissemination of info. & pubs & postage	9,000	5,000	7,000	10,000
Staff work to implement information dissemination	46,981	55,614	56,208	48,980
Rent		6,600	6,600	11,800
<b>PROGRAM MANAGEMENT RELATED TO ABOVE PROJECTS</b>				
WF Board meeting	30,000	29,000	21,700	26,000
Program management costs	46,443	34,782	35,722	25,200
<b>TOTAL PROGRAM COSTS</b>	<b>\$522,236</b>	<b>3753,961</b>	<b>3686,435</b>	<b>3504,210</b>
Administrative costs	23,490	51,107	77,167	75,890
<b>TOTALS</b>	<b>\$545,726</b>	<b>3805,068</b>	<b>3763,602</b>	<b>3580,100</b>

activities it feels are important. AID should assist the World Federation in this.

One indicator of the effectiveness and impact of the World Federation's subgrant dealing with professional education activities, such as international and regional conferences (see Appendix C), is the number of new AVS service projects that evolve as a result of contacts made at conferences. The AVS vasectomy initiative and growing male service programs are direct outcomes of the World Federation's Vasectomy Conference (1982) and Fifth International Conference (1983). Vasectomy projects have been developed in Pakistan, the Sudan, and Tunisia, countries in which services were almost nonexistent. (AVS sub-agreements with a male service component have increased by 20 percent since 1982.) The strong statement of VSC support from the 100 health leaders who attended the 1984 sub-Sahara Conference stimulated a virtual avalanche of new AVS projects in sub-Saharan Africa. Total attendees at World Federation meetings during the years 1982 to 1984 numbered 680 leaders representing 92 countries -- many of which are priority AID countries.

Some examples of the many AVS projects developed as a direct consequence of the Fifth International Conference include:

- o a VSC program in Bolivia;
- o a VSC service program at the Provincial General Hospital in Nyeri, Kenya;
- o a survey on "Demand for VSC in Rural Kenya";
- o a one-week workshop in Sierra Leone for increasing awareness about VSC and developing a national VSC data collection system;
- o minilaparotomy training for nationals of many countries; and
- o the printing and use of new informed consent forms for all VSC services in Sri Lanka (private and public).

The World Federation works to ensure quality in the areas of counseling, safety, and training. The World Federation Policy Document "Ensuring Informed Choice" is the key program development and counselor training resource in AVS-sponsored national and regional projects in Nepal, the Philippines, Sri Lanka, Thailand, Brazil, Mexico, Kenya, and Nigeria. Secretariat staff technically assist AVS in counseling, training, and service projects on an ongoing basis. The World Federation safety guidelines have been translated into local languages in Thailand, Indonesia, and Sri Lanka, whose national program has adopted them. The 1984 training guidelines have been adopted by the

Honduran government in its expanded VSC program through the MOH. The World Federation published 29 documents from 1981 to 1984, excluding periodicals (Appendix D). The materials, particularly those dealing with voluntarism and safety procedures, meet program needs, and World Federation publications on technical procedures are used worldwide.

## II.8 Subgrant Development, Approval, and Implementation

AVS operates through subgrant recipients, which use grant monies for sterilization services, training, and, a new approach, reimbursement to operating agencies (for example, ABEPP in Brazil).

### II.8.1 Subgrant Development

Potential subgrant projects come to AVS's attention through our channels.

- 1) USAID Missions. Where bilateral programs exist, the health or population officer contacts AVS staff and reports that the climate and host agencies are right for a VSC project. In the absence of a bilateral program, the USAID representative may fill this role.
- 2) Other Intermediaries. VSC is not introduced until other contraceptive methods are available. The purveyors of those methods (international family planning organizations), consequently, are often working in a country for several years before VSC becomes a viable option; these intermediaries may propose AVS to host-country agencies.
- 3) Regional Conferences. AVS, via the World Federation, has launched occasional conferences that bring together health professionals to discuss VSC. The most recent such conference, held in Sierra Leone, brought AVS staff into direct contact with officials of potential recipient organizations in Africa; several leads have grown from that conference.
- 4) AVS Grantees. Grantees with a working relationship with AVS may propose a new project for consideration. The clear advantage of these indirect approaches is the low cost to AVS. The disadvantages include partial and hearsay information, competitive referrals, and uninformed USAID representatives. Once an opportunity is discovered, a variable process begins. In general terms, however, a subproject is not developed until it is approved in principle.

### II.8.2 Subgrant Approval

Approval of a subgrant proposal has two distinct phases:

agreement in principle to support a proposal and fine-tuning of the proposal; the first phase seems to be faster and less formal than the second.

Approval in principle (not AVS's term) centers on the budgeting process. When the budget call is issued in the fall, regions are advised of their financial parameters. At that point, regional officials review and assess various project possibilities based on organizational priorities, develop a budget for each, and forward the most promising to New York. The budget cycle runs for approximately three months and mixes formal control points with an informal clearing process. Headquarters, including the International Committee, may modify the proposals from the field. The budget committee's meeting is the final, and formal, approval point for the draft budget.

According to most versions, this is the end of the subgrant approval process. Subprojects are ultimately funded at levels that approximate those in the draft budget; those rare subprojects that are not funded are normally deleted because of a major shift in circumstances in the recipient institution's country.

This process is noteworthy because de facto approval precedes project elaboration. The project is, at the moment of its approval, a few written lines identifying a recipient institution and the general type of activities it might undertake (and a cost estimate). The articulation of the project then resumes. An expanded write-up comes from the field or program managers. When in presentable form, the proposal goes, with all others, to the international committee of the board of directors. This committee reportedly discusses proposals, often taking issue with AID-imposed policies, but rarely rejects or modifies a proposal. Final authorization is granted by the board of directors which acts on the international committee's recommendations. Contracts are signed after AID approves the proposal.

The process is an anomaly: most of the work comes after -- not before -- the de facto acceptance of the proposal. This is not to indict the process; it is merely to point out that AVS's approach differs from that followed in other intermediaries. AVS does not have a record of failed subprojects. The process works. It exemplifies the decentralized approach to development planning that AID has preached for years, and it bespeaks great faith in the judgment of field and program personnel: central office staff accept the overall viability of the ideas that come from the field and direct most of their energies to converting the basic idea into a workable -- and defensible -- service project. The whole process moves relatively quickly, three to six months from inception of an idea to final authorization to disburse monies.

### II.8.3 Subgrant Implementation

AVS implements subgrants two ways. The first is by a direct contract, which specifies funding levels and services to be performed, with a recipient organization. The second is via an intermediary, the approach currently used in Brazil through ABEPF. Often referred to as the wholesaling of subgrants, the intermediary approach offers certain advantages and disadvantages. On the plus side, the project wholesaling probably reduces the administrative burden of the New York regional office. Furthermore, the intermediary, by dint of knowledge of local institutions, is often in a better position to identify and supervise promising recipients for sub-subgrants. On the negative side is cost-effectiveness. Twenty percent of the funding to ABEPF goes to administrative overhead; the question is whether an equivalent 20 percent would have to be spent to supervise the 30 projects that ABEPF has in its AVS portfolio?

Surveillance by an intermediary agency is presumably heightened, but an intermediary is also another layer between the donor and ultimate service provider. Apparently, ABEPF has been a faithful transmitter of AVS's medical quality and voluntarism guidelines and policies. Two medical supervision visits are made to each service organization annually, a level of attention impossible through direct funding. ABEPF, a self-governing organization composed of 150 family planning entities in Brazil, distributes available funds while reducing funding to push programs to greater self-sufficiency. ABEPF's success will hinge on its decision-making process being orderly and dispassionate.

Clearly ABEPF is a good idea in Brazil but not necessarily elsewhere. Few countries have a plethora of independent family planning service providers to consolidate. AVS must go through ABEPF to the service organizations to monitor service quality and voluntarism, two volatile issues that demand direct AVS supervision. However, many countries do have an excess of small subgrants -- those under \$7,500 -- and processing these individually is particularly onerous. AVS can further grant implementation through consolidation, as is currently being done in Bangladesh.

## II.9 Monitoring and Evaluation

### II.9.1 An Evaluation System

AVS monitors and manages its projects closely and well. Field and project personnel also carry out numerous evaluative exercises (surveys, audits, and special studies). However, AVS has not yet brought these various elements together in a well-thought-out evaluation system. Given that the goal of evaluation is good program management, and given that AVS's management is already laudable, the absence of a well laid-out evaluation system is not as serious as it would be in a less well-managed

organization. Nevertheless, AVS can improve its management and increase its achievements through improved evaluation and monitoring.

AVS appears to have a rather poor understanding of evaluation. It has always monitored and reviewed its projects quite competently, especially the medical quality aspects, but apparently it does not see this monitoring as an intimate part of evaluation. According to AVS staff in New York, it was only in 1982 that AVS began to focus on developing an evaluation capability. AVS/New York cites the following four types of activities as constituting its evaluation program from 1982 to present.

1) Information Gathering and Dissemination. Voluntary Sterilization: An International Fact Book by John A. Ross, Sawon Hong, and Douglas H. Huber, 1985 (forthcoming). It also has plans for an in-house paper series to present evaluative analyses of program issues in a case-study fashion to help staff better understand VSC-related issues and to create an institutional memory within AVS. (A call-for-papers has been prepared to launch the series.)

2) Evaluation of Voluntarism. A cross-national Female Sterilization Acceptors Follow-Up Survey has been carried out in five countries and results are being analyzed.

3) Staff Training. AVS held an evaluation training session in 1984 and will conduct another in 1985.

4) Evaluation Guidelines. AVS/New York has drafted guidelines for built-in evaluation plans that field staff are to include in project subagreements. These are a good first draft, but still seem too text-bookish and should probably be made easier to follow. Draft guidelines were sent to the regional offices in late 1984, and, as of 1985, all project subagreements are to include an evaluation plan based on these guidelines. The draft guidelines will be revised as experience dictates. The Asia regional office is gaining good familiarity with them and should be consulted for advice in the revision process.

To do this work, AVS/New York has had one, and for a while two, competent professionals working largely on the above tasks. In the opinion of one of them, groundwork has been laid but plans must now be implemented.

In fact, although these efforts are laudable, they still do not constitute an evaluation system. Publication of the Fact Book will contribute to furthering VSC, but it is not evaluation. The planned in-house paper series will be important, but does not constitute regular systematic evaluation. The evaluation guidelines, however, if improved, can become the basis for a meaningful evaluation system. AVS/New York is aware of the need for additional revisions.

What is encouraging, at least in the Asia region, is that many activities of an evaluative nature are already underway, although not perceived as such by the AVS regional office. For instance, the 1984 Annual Report prepared by AVS's Asia regional office lists only the follow-up study of BAVS female sterilization acceptors as "Research and Evaluation." In fact, however, the same report describes at least nine evaluative activities. For example, the regional office has initiated, with BAVS, an exceptional clinic program to evaluate clinic performance so that resources can be directed to the clinics that have proven themselves most effective. A special program development team has visited the poorly performing clinics to (1) learn the facts related to their poor performance and (2) produce an action plan for improving performance. The team will return to evaluate progress against the action plan after approximately one year and if no improvement is seen, resources will be cut or those clinics closed. The deputy director of the regional office described this activity as only "program development." In fact, it is an excellent example of program evaluation which is well designed to meet an explicit information need. It is precisely such activities that field and project staff should be carrying out as evaluation: analyses motivated by the need for information to manage programs more effectively. 26/

## II.9.2 Monitoring

In addition to a more sophisticated system of financial control (detailed in II.10.2), AVS has developed reporting procedures, or paper controls, for quarterly monitoring of project accomplishments. There also are frequent on-site visits from program managers and regional office representatives. Usually, large programs are visited three to four times a year; smaller programs are visited once or twice a year; and grantees can expect a medical supervisor every year-and-a-half to two. The frequency of these visits, of course, is increased if there is concern over subgrantee performance. Further, there may a country-level review may be carried out every year or two, on site, when a team conducts an ersatz needs assessment. (This has been done in El Salvador and may be undertaken shortly in Brazil.)

Three general categories of information are sought. One is financial data, which must be reported in local currencies and dollars (discussed in II.10.2). A second is program accomplishment statistics, most commonly training and sterilization. Finally, AVS seeks assurances, as well as negative reports, concerning the maintenance of the two foundations of the organization -- medical quality and voluntarism. This includes reports

of complications and deaths as well as data from impromptu field visits, audit reports, and surveillance systems or surveys (such as exist in Bangladesh and have been proposed for Nepal). There are no formal end-of-project evaluations.

Evidence of AVS's close monitoring can be found in the documented cases of grantees that AVS has terminated for under-performance. Similarly, AVS has been quick to hold up funds when it has felt that the recipient organization's financial controls were inadequate. Where grantees have performed well, however, AVS has renewed existing agreements and often increased the size of its grants. Given the tight program management exercised by AVS while a project is under way, and the amount of information that AVS staff has on the content of these projects, pro-forma end-of-project evaluations would appear superfluous and should probably not be required, given AVS's and its grantees' limited administrative resources.

The reporting forms used by AVS for its cooperative agreements are fairly comprehensive, with a major focus on the financial status of projects, which is justified for many countries. The report forms are not too complicated for AVS's grantees to complete. However, there is no linkage between these quarterly reports. Missing is a continuum, or linkage, between past performance, current activities, and future plans. While long anecdotal narrative reports are not the goal for project monitoring, some brief analytic look at where the project is in terms of planned output has value both to the donor and the recipient. Insofar as these quarterly reports may be the only formal data presentation activities of some grantees, the reports would be more useful if they depicted cumulative progress.

## II.9 J Future External Evaluations of AVS

As AVS works with AID to develop its next cooperative agreement, a more satisfactory evaluation plan for the overall evaluation of AVS should be worked out and written into the agreement. The present evaluation process has been a source of dissatisfaction to many AVS staff, USAID population staff, and host-country counterparts. This was not because of shortcomings uncovered in the course of the evaluation but because evaluation team spent too little time in New York and in the various countries and because most country visits were undertaken by only one team member. Principal AVS and USAID staff all said that, as long as they were being asked to disrupt normal work patterns, they would have welcomed a more intensive effort with more valuable feedback.

Despite the general constraints AID has in evaluation, it has developed many evaluation approaches that have been more satisfactory than this one. Building a good evaluation plan into the cooperative agreement will heighten satisfaction of all involved.

## II.10 Administrative Capabilities of AVS

### II.10.1 Central and Regional Administrative Systems

The administrative capability of AVS is quite strong. In the central office in New York, AVS has expended considerable effort to strengthen its administrative systems, but the primary focus has been on establishing reliable routines that can be operated by persons who lack specialized management training. At the regional level, the administrative strength seems to reside in individual actors, reflecting, no doubt, the different type of administration that the regional office is called upon to conduct. The primary administrative activities of the regional offices tend to be softer -- program supervision and evaluation. Consequently, it is unlikely that an investment in administrative systems in the regions similar to the one being made in New York would be cost-effective.

The divisional responsibilities in the delegation of authority from New York to the regions is, on paper, very sound. However, the practice falls far short of the theory. Nevertheless, in practice the arrangements seem to be working quite well. As noted earlier, the regional offices and program officers have extensive de facto authority for developing and providing new projects. They have, in theory, no responsibility for financial control. That resides with the New York office. But distinguishing between financial control and project development is difficult in practice because subgrantees address their questions on any topic, including financial administration, to the most readily accessible individual -- generally the regional office representative. Is it worth the effort to educate subgrant recipients about the division of responsibilities within AVS? Probably so. However, the roles of policeman and promoter, that is, of financial controller and project developer, should be kept as distinct as possible. This requires a special effort by both New York and regional staff to not blur the lines of responsibility by referring questions that fall within their domain to other offices. The South American region evidently has been working on maintaining these distinctions.

A medical supervisor is needed in each region. Such a position is consistent with the general posture of staff-supported, regional technical assistance and should reduce direct costs of medical supervision to subgrant recipients.

### II.10.2 Financial Administration

AVS has made rapid progress in financial administration. The discovery, a few years ago, of \$4 million in unliquidated obligations that had to be returned to the donor agency sparked heightened interest in financial controls and reporting. An

audit (by Arthur Anderson) turned up minor problems of noncompliance with "standard accounting practices" that further demonstrated weaknesses of the system. Since that time, the situation has turned around. Another Arthur Anderson audit is currently in progress that will reveal whether the system has been restored to full health, but the outward manifestations are very encouraging:

1) The system is fairly simple; bookkeepers and secretaries can operate the bulk of it.

2) The output is easily understood. This greatly increases its utility to program and technical staff members.

3) The output is accessible. Requests for financial data are normally met within an hour. Again, this immediate availability augurs well for the increased utility of the system to managers.

A further improvement, to computerize subgrant accounts, is planned for July 1985. The new system, although still requiring some interpretation, will prohibit overspending on a subgrant and will signal the presence of end-of-subgrant balances so that these cannot accumulate unseen, as before.

The new system can be taught to detect under- and overspending in a subgrant if cash flow projections for the subgrants are introduced to the system; the accuracy of the computer's forecasts will, of course, be a function of the accuracy of the cash flow projections. If these cannot be made with reasonable assurances of accuracy, continued reliance on interpretation is clearly the better course.

A lingering problem remains in the financial monitoring area: the reporting of funds denominated in fluctuating currencies. AVS has sent out some contradictory messages to its subgrantees about this. The most recent communication asked that the simplest calculations be made; the information provided would have to be reworked by AVS before being meaningful. There are two problems with this approach: first, the report is useless to the people preparing it, and second, the subgrantees know better. In Brazil, managers must develop financial control systems that smooth out the impact of a chronically unstable currency. It is no surprise that at least one recipient had an intelligible and accurate accounting system that effectively cancelled out devaluations; the results of the internal central system, however, bore little resemblance to the AVS required report.

AVS has begun to audit subgrant recipients systematically. Cost per audit runs 1 to 2 percent of the dollar amount of the subgrant and the auditors are selected by AVS. There is an occasional change of auditors, perhaps every two to four years, to avoid the temptation of bribery. More frequent changes of

auditors are inadvisable. For example, it was estimated that changing auditors for the New York office increased the direct and indirect cost to AVS by \$50,000; that figure includes both additional fees to the auditors as well as time lost to staff to orient the auditors and provide them with information. The integrity of foreign auditors has been tested by offering a small bribe to overlook something; if the bribe was refused, the auditors were contracted.

The letter of engagement with foreign auditors apparently differs from country to country -- and that is appropriate -- but consistency needs to be reached on a few points. For example, there were visible differences in the degree of management auditing conducted over the last year-and-a-half. Some auditors commented on whether the subgrantee performed abortions (the finding was uniform that they did not). Checking for informed consent forms also lacked uniformity. One audit came to the New York office with the client comment attached, which is useful when available; however follow-up action was difficult to determine.

Generally, however, the steps taken are very positive and the general approach to auditing information seems constructive. For example, the New York office places audit comments in three categories:

1) Those that require immediate attention -- for example, audits with a major omission in accounting information -- are immediately contacted by AVS to correct the situation as soon as possible.

2) The second category is routine omission. The integrity of the financial control system of the recipient organization is not called into question and the lapse is a minor violation of standard accounting procedures. Follow-up is done in due course.

3) The third category of auditor comments can be ignored; they may be valid for a private-sector profit-making organization but have no meaning for nonprofit service organizations.

The concern with tighter fiscal controls was signaled by the AVS board's doubling the budget for audits to \$200,000. After a brief period of demonstrated interest on the part of AVS in the financial controls exercise by subgrantees, some of this \$200,000 might be addressed to other problems -- perhaps to service delivery. Such a move, of course, depends on the recipient organization's ability to improve its own internal control systems.

An interesting experiment has been tried in two African countries where financial control has been, in effect, turned over to auditing firms. The auditors have direct responsibility for releasing disbursements to the organizations and, consequently, have taken on many of the routine accounting functions.

This is only a short-term solution, not a model for broad replication. The basic problem is that a critical management function is externalized when accounting responsibilities are turned over to an outside agent. In the worst case, the recipient organization may never develop adequate internal financial controls; in the best case, the program management may come to perceive financial management as outside its sphere of management responsibility.

#### II.11 Impact of AID Requirements on Program Implementation

AVS, as a cooperating agency receiving AID funding, has operated under both a grant and a cooperative agreement. The latter mechanism is currently in force. AVS has a limited amount of administrative flexibility under this agreement. It can adjust a line budget item without revising the agreement, and small subgrants of \$7,500 or less do not require AID approval. AID, however, has to approve travel of AVS personnel. AID also approves AVS staff levels and provisions included in subagreements.

Currently, AID requirements do not seriously constrain project implementation. AVS program staff keep the AID project manager well informed on current project status and provide adequate advance notice of any anticipated actions requiring AID approval. Any information requested by AID is immediately forthcoming, and the communication flow between the two agencies is constant and effective. External AID-requested auditors are routinely given the necessary documentation. However, new developments in AID requirements for cooperating agency support may delay projects. Specifically, the requirement that cooperating agencies in the population field must allow audit on non-AID funding to ensure compliance with nonabortion requirements could delay approval of future agreements between the two agencies. There was some desire on the part of missions that a new agreement between AID and AVS contain provisions for the use of bilateral funds to expand VSC activities in those countries where AID has missions.

#### II.12 AVS Interest in New Technologies

AVS's position of world leadership in VSC service delivery has enabled it to attract leaders in research and evaluation of new fertility-control technology to its science committee meetings and its medical safety conferences. Given this collection of expertise and the acknowledged experience of AVS in the application of existing technologies to developing country circumstances, it is highly appropriate that the medical division participate in the cluster of institutions engaged in sharing knowledge, ideas, and plans for developing new and improved methods.

The AVS board of directors supports this activity, and, with the emergency of Norplant as a proven effective contraceptive awaiting U.S. Food and Drug Administration approval, is considering a redefinition of VSC to include this method, which is both a surgical and a reversible contraceptive. Although AVS is not involved in laboratory biomedical research, the medical division strives to keep abreast of applied research in improved VSC technology, and accordingly has encouraged both dialogue and visits with individuals and institutions that are testing new methods. Current examples include interest in the Filshie Clip (United Kingdom).

This active interest on the part of the AVS medical division is consistent with AID's interest in searching for advances in fertility-control technology and does not detract from the effective discharge of its responsibility to supervise the medical programs of AVS. However, AVS's primary concern should remain to promote safe, ambulatory VSC in developing countries.

**III. RECOMMENDATIONS**

### III. RECOMMENDATIONS

#### III.1 Future Directions

- 1) AVS should focus on achieving its twin objective of expanding existing services and introducing VSC to new areas. Systems exist for monitoring voluntarism, fiscal responsibility, and medical quality control; less attention to these areas may now be feasible (Section II.6).
- a. Planned expansion. AVS should encourage its subgrantees to be more cost-effective and to become financially self-sufficient. This will probably require more technical assistance to subgrantees to (i) encourage studies on cost-effective delivery systems; (ii) invest in fixed, rather than variable, cost services; and (iii) identify and develop other income-generating activities.
- b. Provision of new services. AVS should place increased emphasis on overcoming barriers to the rapid expansion of services in countries where VSC has already been demonstrated as politically viable. This could be accomplished by working with the World Federation to develop specific policies for each of these countries.
- 2) AVS should help private physicians establish centers for surgical contraception by providing dedicated space or institutional reimbursement until these practitioners develop a client base.
- 3) AVS should establish a regional office for sub-Saharan Africa as soon as possible, in view of the potential for expansion of VSC services and the need for coordination with other donor agencies (Section II.6.1).
- 4) If a new cooperative agreement is signed, bilateral funding to complement central funds should be provided to missions to fund AVS projects in their respective countries. This will allow more flexibility to tailor projects to mission priorities; however, missions should consider resource limitations of centrally funded projects and be prepared to meet additional demands created by their interventions (Section 1.6.3).
- 5) Regional offices of AVS should develop regional strategies to supplement the country strategies now in force. The goal would not be to inflict on field staff another layer of paperwork but to allow regions to establish priorities within the various regions based in inputs and outputs (Section II.6.4).

6) AVS, while keeping abreast of new advances in VSC techniques, should have as its primary concern the promotion of safe ambulatory VSC in developing countries. This effort, however, should not detract from the effective discharge of its responsibilities to supervise the medical programs of AVS (Section II.1.2).

### III.2 Voluntarism

7) AVS should continue its monitoring and surveillance to ensure voluntarism. AVS and AID should continue to support local monitoring initiatives, follow-up studies, and experimentation with approaches that give quick and reliable results (as in the Dominican Republic) (Section II.4).

8) AVS should continue its efforts to improve counseling for informed consent so that all requestors are fully aware of the permanence of the operation. Because of cultural differences and logistical difficulties, it will not be possible to have counseling take place just as it does in a developed country. Further activities to improve counseling should therefore be undertaken chiefly on a country- or region-specific basis in order to develop approaches that are the most effective possible given the constraints that exist in each country (Sections II.4.1 and II.4.2).

9) Results of the cross-national follow-up survey of female VSC acceptors should be published in a professional journal (for example, Contraception or The International Journal of Obstetrics and Gynecology) as soon as possible to demonstrate the successful outcomes of the various country programs (Section II.4.4).

10) AID should make AVS's high-quality counseling materials available to other cooperating agencies in the population field (Section II.4.2).

### III.3 AVS's Medical Services

11) AVS should encourage national coordination of VSC training, and should limit training levels to VSC caseloads to assure sufficient training cases to acquire proficiency. In addition, trainee followup assessment measures recommended by the 1984 expert committee should be instituted as soon as possible (Section II.5.1).

12) The provision of dedicated space and equipment for safe ambulatory VSC service delivery is an appropriate AVS concept and should be encouraged in planning institutional service and

training projects (Section II.5.2).

13) AVS should complete the transfer of financial responsibility for RAMS to alternative sources of support as soon as possible (Section II.5.2).

14) Project directors should convey the details of reporting requirements of complications and fatalities in writing to each surgeon providing VSC services through an AVS subagreement (Section II.5.4.2).

15) If comprehension of English is in question, project directors should be required to translate AVS medical service standards and reporting requirements into the local language (Section II.5.4.2).

16) The medical division should promote conformity to the medical service guidelines, require compliance with the reporting of deviations from the standards, and support in-service training and retraining wherever necessary to achieve high-quality services (Section II.5.4.2).

17) If further resources are to be given to Tunisia for training out-of-country physicians, Tunisia trainers must be skilled in minilaparotomy and oriented toward presenting its use positively and accurately (Section II.5.5.2).

#### III.4 World Federation's Role

18) AID should continue supporting this component of AVS, including core costs for the secretariat. AID and AVS should agree on a set of specific written guidelines outlining the types of activities AID believes most important for the World Federation to undertake with AID funding. These guidelines should be reviewed and revised periodically as necessary (Sections II.7.2 and II.7.3).

19) The World Federation should take a more prominent role in increasing the number of countries in which VSC is an accepted method of family planning and a health measure for high-risk women of reproductive age. Country leaders, and their orientation and out-of-country training resources, should be identified in countries where successful VSC programs are operating. Technical assistance should be given to leaders in countries where VSC is not yet institutionalized to develop plans of action. The World Federation should inform AVS international and regional offices of impending activities so follow-ups can be done quickly before interest subsides (Section II.7.1).

20) The World Federation's information dissemination system should be continued and a feedback system encouraged so that subjects included in the materials are pertinent to the situations in the various countries (Section II.7.3)

21) To ensure that AID/Washington is cognizant of and supportive of AID-funded World Federation activities, the same approval process used in other AVS-supported proposals should be utilized (as stated in C.2, Approval Criteria, p. 7 of the current cooperative agreement) (Section II.7.3).

### III.5 AVS's Relationship with Other Private Voluntary Organizations

22) AID should ensure no duplication of effort or wasted resources among AVS, JHPIEGO, and other private organizations. This can best be accomplished by joint implementation meetings and subagreement reviews (Section II.6.6).

23) Missions should hold periodic meetings with all PVOs to review progress (as in Nigeria) (Section II.6.6).

### III.6 Meeting Existing Demand for VSC

24) Service statistics from locations where acceptors can conveniently obtain the contraceptive method of their choice should be used as crude indicators of VSC demand (as done in Bangladesh). AVS should collaborate with AID by providing service statistics from clinics that could serve as sample points to compute demand on a country-by-country basis.

25) In larger facilities, trials should be carried out where designated space and designated staff--with no other priority responsibilities--can be assigned to family planning. This would help meet existing demand.

### III.7 Strategic Planning

26) AVS should support the formation of national leadership groups, especially in countries where sterilization remains a culturally sensitive issue (Section II.6.6).

### III.8 Evaluation and Monitoring

#### III.8.1 General

27) AVS should continue its recent efforts to develop a

comprehensive monitoring and evaluation system. The goal should be to provide information most needed for decisions while avoiding requirements that only result in paperwork (Section II.9).

28) All monitoring and evaluative activities presently under way (not just the four listed in Section II.9.1) should be identified and the purpose of each analyzed. This will improve AVS's program management and will help AVS to inform AID more easily of its evaluative activities (Section II.9.1)

29) Determination should be made whether the present activities are adequate for meeting AVS's information needs at various levels. Are additional types of evaluation (and monitoring) needed? Or should certain ongoing activities just be improved (Section II.9.1)?

### III.8.2 Evaluation

30) AVS should follow through on the present intent to improve the guidelines that AVS/New York has developed for including evaluation plans in the cooperative agreements with its grantees, as well as for implementing these plans and for using the evaluation findings they produce (Section II.9.1).

31) Appropriate evaluation methodologies should be developed. Evaluation should be conceptualized in terms of inputs, outputs, process, outcomes, and impacts, and criteria or standards should be sought for measuring quality of services, project efficiency, and cost-effectiveness. Project objectives, developed during design, should incorporate these measures. At the same time, evaluations should be as simple as possible and focus only on information needed for decisions. Large-scale surveys should be used sparingly as they require expensive technical assistance, are time-consuming, and rarely produce results within the time needed (Section II.9.1).

32) AVS grantees should participate in the evaluation process. This might take the form of a brief narrative covering achievements, problems encountered, and plans to meet the next reporting period's requirements (Section II.9.1).

33) Determination should be made whether training, IEC, and other similar activities are being evaluated adequately. It appears that, at present, they are not. This will be increasingly important in countries where sterilization services are well established and AVS is trying to move into new approaches. Some activities, such as training and IEC, will be more difficult to evaluate than others -- or will at least demand an approach with which field staff and project personnel are less familiar

(Section II.9.1).

34) Evaluation should not become just bureaucratic paperwork. It is crucial to seek that delicate balance between a good evaluation system that provides only needed information and one perceived in the field as paperwork hoisted on the field by headquarters (Section II.9.1).

35) AVS must hire a professional experienced in evaluation to fill the empty evaluation position, ideally supplemented by an assistant. Proper staffing is essential for evaluation that is decision-focused and not an undue burden. With regard to the organizational location of the evaluation function, it should be understood that the objectives of the evaluation do not include one division within the New York office evaluating another, but rather with the New York office providing technical assistance to field personnel in carrying out utilization-focused evaluation (Section II.9.1).

### III.8.3 Monitoring

36. AVS should modify the quarterly reporting form it used for project monitoring. These should provide for built-in linkage from one quarter to the next to show current progress toward end-of-project objectives (Section II.9.2). Subagreements should specify self-assessment by grantees. Self-assessment might include establishing quantitative benchmarks by quarter, reporting achievements and problems during the quarter, and delineating future plans to meet the next reporting period's objectives. Similarly, present reporting does not require grantees to relate subgrant financial inputs to outputs; in the simplest case, cost-per-procedure data should be elicited.

37) Site visits should be adequately used for reviewing implementation progress. Site visits are, necessarily, relatively infrequent. When they do take place, they should be used to conduct an in-depth implementation review. In some countries, at least, site visits are too often dominated by discussion of new initiatives and plans; this is laudable, but should not be the only purpose of the visits (Section II.9.2).

38) Acceptor satisfaction with VSC should be carefully monitored during post-operative clinic visits.

### III.8.4 Future External Evaluations of AVS

39) AVS should work with AID to build into the next AID-AVS cooperative agreement a good evaluation plan for AID's evaluation of AVS. Examples of satisfactory evaluation approached used elsewhere by AID should be studied in developing this new plan (Section II.9.3).

BIBLIOGRAPHY

- 1) Alam, S. "Sterilization Follow-up Survey: Key Observations." [preliminary] Mitra and Associates, May 1985.
- 2) Alauddin, Mohammed and Nihar Ranjan Sorcar. "Focus Group Discussions and Sterilized Women in Bangladesh." Dhaka. November 8, 1984.
- 3) Ali, M. Nawab, Douglas H. Huber, Atiqur Rahman Khan, and Syed Waliullah. Bangladesh Fertility Research Programme Technical Report No. 25. 1979.
- 4) "1984 Annual Report, USAID/Bangladesh Cooperative Agreement with AVS."
- 5) "1984 AVS Annual Report of International Programs."
- 6) "AVS Asia Regional Office's Policy Directive No. 3 Recommendation Regarding the Increase in Provider and Acceptor Compensation in Bangladesh." January 8, 1984.
- 7) "BAVS Clinic-Wide Vasectomy and Tubectomy Rejection Statistics."
- 8) "BAVS Sterilization Acceptors Characteristics." Evaluation Unit, Bangladesh Association for Voluntary Sterilization, Reports no. 1 to 5.
- 9) Bertrand, Jane and Mark McBride. "Evaluation of the APROFAM Program for Voluntary Sterilization in Guatemala." Tulane University and USAID/Guatemala. February 1985.
- 10) Bertrand, J. et al. "Female Sterilization in El Salvador: Factors Influencing the Decision" Tulane University. November 15, 1984.
- 11) "GOT/USAID Evaluation of the Tunisian Family Planning Program." June 1984.
- 12) Jezowski, Terrence W. "Trip Report, El Salvador, 29 February - 3 March 1984." AVS. New York.
- 13) Kessel, E. and Mumford, S.: "Potential demand for voluntary female sterilization in the 1980s: The compelling need for a nonsurgical method," Fertility and Sterility, Vol. 37, p. 725, June 1982.
- 14) Koblinsky, M., R. Simmons, J. Phillips, and Md. Yunus. "Barriers to Implementing an Effective National MCH-FP Program."

ICDDR, B. 1984.

- 15) Ladjimi, Adly, M.D., "Etude sur la Conception Actuelle de la Planification Familiale dans un Pays Arabe et Musulman: La Tunisie." Tunis Center for Research on Human Reproduction. 1985.
- 16) McIntosh, E. Noel, Binny van Berger, Der Ratha Dhakhwa, Tika Man Vaidye, and Tara Bahadur Khatri. "Recent Changes in the Demographic Profile of Sterilization Acceptors Characteristics." Report No. 5, Evaluation Unit, Bangladesh Association for Voluntary Sterilization Acceptors in Nepal. Kathmandu. (John Snow Public Health Group, Family Planning Association of Nepal, and Nepal FP and MCH Project). 1985.
- 17) Philliber, Susan and William Philliber. "Social and Psychological Perspectives in Voluntary Sterilization : A Review." Studies in Family Planning, Vol. 16, no. 1. January 1975.
- 18) Pillsbury, Barbara, Lenni Kangas, and Alan Margolis. "U.S. Assistance to the Family Planning and Population Program in Bangladesh, 1972-1980." April 1981.
- 19) Quasem, M. A. & Co. "A Special Survey Report on the 'Outside Cases' of the Three Selected Upazilas for the 1984 April-June Quarter." Dhaka, April 25, 1985.
- 20) Quasem, M. A. & Co. "Report on the Evaluation of the Voluntary Sterilization Program for January-March Quarter 1985."
- 21) Quasem, M. A. & Co. "Report on the Evaluation of the Voluntary Sterilization Program for October-December Quarter 1984."
- 22) "Tunisian Female Sterilization Follow-up Survey", preliminary results, May 1985.
- 23) Wright, Nicholas, M.D. "Report on the Sri Lankan Incentive Program for Voluntary Sterilization." 26 October 1983.

## **APPENDICES**

**Appendix A**  
**LIST OF PERSONS CONTACTED**

Appendix A  
List of Persons Contacted

CONTACTS: Bangladesh

AVS Asia Regional Office

Farruk Ahmed Chaudhuri, Director  
Gary Newton, Assistant Director  
Bhuyan Aboul Quasem, Senior Program Officer for I&E and  
Counseling  
Dr. K. M. Rezaul Haque, Program Officer  
Dr. Sadia Afroze Chaudhuri, Program Officer  
Ahmed Al-Kabir, Program Officer  
Tulshi Das Saha, Junior Program Officer  
Anthony Gomes, Chief, Administration and Personnel

Bangladesh Association for Voluntary Sterilization (BAVS)

Dr. Azizur Rahman, President  
Habibur Rahman, Secretary General  
Syed Mansur-ul Haq, Executive Director  
Md. Quamrul Islam, Finance Manager  
Dr. A. J. Faisal, Regional Medical Supervisor-Dhaka  
Fazlul Karim, Program Manager for I&E and Counseling

USAID/Dhaka

John Westley, Director  
Suzanne Olds, Chief, Health & Population  
Sharon Epstein, Population Officer  
Dr. Carol Carpenter-Yaman, Population Officer  
Sigrid Anderson, Population Development Officer  
Mary Lee McIntyre, Population Development Officer  
Louisa Gomes, Program Specialist

NGO/PVOs

Dr. M. Alauddin, Country Representative, The Pathfinder Fund  
Hasse Gaenger, Director, UNFPA/Bangladesh  
Anwar Ali, Director, Social Marketing Project (SMP)  
Mufaweza Khan, Executive Director, Concerned Women for  
Family Planning  
Sondra Kabir, Executive Director, Bangladesh Women's Health  
Coalition

Bangladesh Government

Ministry of Health and Population Control (MOHPC)

A. B. M. Ghulam Mostafa, Secretary

National Institute for Population, Research, and Training (NIPORT)

A. K. M. Rafiquzzaman, Director (Training)

Mitra and Associates

S. N. Mitra, Executive Director and Principal Investigator,  
Follow-up Survey

S. Alam, Associate Director

BAVS Mymensingh

Dr. K. Zaman, President and Project Director

Mahmudul Hassan, General Secretary

Sadhana Acharya, Treasurer

Bareque Bhuiyan, Administrative Officer

Moynul Huq, Male Counselor

VSC Acceptors, Mymensingh

Shuva Rani Dey

Asia Khatun

Mymensingh Medical College Model Clinic

Dr. Bina Haque, Administrator

Dr. Aminul Islam, Medical Officer

Prof. Altaf Hossain, Deputy Director, Mymensingh Medical  
College Hospital

Prof. M. A. Jalil, Director, Mymensingh Medical College  
Hospital

Bhaluka Health Complex

Dr. Sirajul Islam, Upazilla Health and Family Planning  
Officer

Dr. Abdul Alim, M. O. (MCH & FP) and his operating room  
staff

**CONTACTS: Nepal**

**Family Planning Association of Nepal (FPAN)**

Dr. Badri Raj Pande, Vice President, FPAN  
Honorable Omkar Prasad "Gauchan", Vice President, FPAN  
Yadav Kharel, General Secretary, FPAN  
Dr. Tara Bahadur Khatri, Treasurer, FPAN  
Sharda Singh, FPAN Board Member  
Puru Risal, FPAN Board Member (Rising Nepal)  
Shanker Shah, Chief Executive, FPAN  
Dr. Tika Man Vaidya, AVS Project Director and Medical  
Division Chief  
Kanek B. D. Joshi, Chief of Finance Division, FPAN  
Mulepati, Chief, Research and Evaluation  
Sumitra Shahi, Training Division  
Dr. D. P. Upadhaya, Director of Family Planning Parasite  
Control Project  
Mana Rama, Director of B. B. Project  
Buddha Ratna Khadgi (Finance and Administration Officer)  
Kush N. Shrestha, Training and Program Division Chief  
Prabhat Rana, AVS Project Director/IEC Division Chief  
Shambu P. Acharya, AVS Project Manager  
Dr. S. B. Pande, Chief, Program Division

**National Commission on Population (HMG)**

Dr. Ved Prakash Upreti, Secretary  
P. K. Manandhar, Advisor, NCP, Singh Durbar

**Family Planning -- Maternal and Child Health Project (HMG, MOH)**

Dr. Tara Bahadur Khatri, Chief  
Dr. Pramila Sharma, Deputy Chief

**USAID/Nepal**

Dr. David Calder, Chief, Office of Health and Family  
Planning  
Barbara Spaid

**John Snow International**

Dr. Noel McIntosh

**Nawalparasi District**

Dr. N. Sharma, Director, Parasi District Hospital  
Dr. Shailesh Kumar Erpoohyaya, Deputy Director  
Shilendra Soinju, Health Inspector, ICHSDP

GPB

A4

Shekher Roak, Supervisor from Kathmandu  
Ms. Ghale, RN from Kathmandu

Karinhi Village

Mr. Ganesh, Supervisor, Integrated Kharinhi Project

Banepa, District Kavri FPAN Branch

B. B. Thapa, Administrator, Volunteer board and paid staff

## CONTACTS: Indonesia

Ida Bagus Gde Manuaba, Obstetrician Gynecologist, General Public Hospital

Govinda Chitrakar, President, Youth Activities Coordination Committee of Social Service National Co-ordination Council

Dr. Joedo Prihartono, Public Health Department, School of Medicine, University of Indonesia

Dr. Eudang Basuki, MPH, School of Medicine, University of Indonesia/Department of Public Health

Dr. Abdullah Cholil, Senior Expert, Staff to the Chairman, National Family Planning Coordinating Board

Dr. Hermini Sutedi, Chief, Bureau of Contraceptive Services, BKKBN

Dr. R. Hasan Moeh. Hoesni, Chief, Division of Medical Technology, BKKBN

Dr. Qarmi Amri, School of Medicine, Department of Public Health

Dr. Ig. L. M. Rudartha, Rogemy Hospital

K.L. Bhushat, Secretary, FPAM

K.K. Shrestha, Member of P.P.A Branch

K. Malla, E. Member of Chitawau Branch

P.L. Praohan, E. Youth member of Chitwau Branch

Kirau G. Amabys, Executive Member Chitwau Branch

Bandhu Rj. Neupaue, Assistant Treasurer, FPAN

Rajin Gire, Medical Officer

Roykamar Shvesla, Branch Officer

David C. Denman, Population Officer, USAID/Jakarta

Dr. F.A. Moelek Ph.D., President, Indonesian Society for Secure Contraception (PKMI)

Dr. Azrul Azwar, Executive Secretary, PKMI

Dr. Ida Bagus GDE. MANUABA, Project Director, U.S.C. Project, Denpas, Bali

Dr. Inne Susanti, Assistant Project Director, VSC Project, Den Pasar, Bali

Dr. G. P. Sura, Assistant Project Director, VSC Project, Den Pasar, Bali

I.A.M. Wirati, Chief, Operational and Maintenance Division, National Family Planning Board, Province of Bali

Dr. I. G. Ketut Ranayana, Director Menguri Health Center, Den Pasar, Bali

CONTACTS: Tunisia

IPAVS, Africa and Middle East Regional Office (AMERO)

Fathi Dimassi, Regional Director  
Phyllis Butta, Assistant Director

Office National de la Famille et de la Population (ONFP)

Dr. Mahmoud Khiri, Director, Medical Division  
Ahmed Beltaief, Director, Coordination Division  
Taoufik Kislani, Coordinator, Unite Rurale  
Habis Fourati, Researcher, Population Division

USAID/Tunis

James Vermillion, Chief, HPN

Ariana Clinic

Prof. Rafik Boukhris, Director of Research  
Dr. Adly Ladjimi  
Dr. Ridha Ben Salem Chief gynecologist in VSC  
Abdellatif Daagi, Administrator  
Counseling staff

Hamam Lif Clinic

Fathi Ben Messaoud, Delege Regional, Tunis Sud.  
Staff

**CONTACTS: Brazil**

**Araken Irere Pinto, Chief Obstetrician Gynecologist, BEMFAM**  
**Napoleao Leao, Director of Medicine, BEMFAM**  
**Lia Junquera Kropsch, Director of Administration, CPAIMC**  
**Helio Aguinaga, Director, CPAIMC**  
**Karen Johnnton-Lassner, Director of Education, CPAIMC**  
**Jose Arruda, Director of Research, BEMFAM**  
**Carmen Gomez, Director of Planning, BEMFAM**  
**Howard Lusk, AID Representative, Brazil**

## CONTACTS: Colombia

Gabriel Ojeda, Director of Evaluation, PROFAMILIA  
 Floralba U. Garcet, Motivator Pasto Clinic, PROFAMILIA  
 Maria del Pilar Urbana, Motivator Pasto Clinic, PROFAMILIA  
 Fernando Gomez, Director SARO-AVS  
 James Smith, Office of Population and Training, AID/BOGOTA  
 Gabby Ruiz, Secretary Pasto Clinic, PROFAMILIA  
 Miriam Ortiz, Nurse Pasto Clinic, PROFAMILIA  
 Cecilia Cadauid Calvo, Director of Social Work, PROFAMILIA  
 Alvaro Hernando Bucheli, Sterilization Motivator, Pasto Clinic,  
 PROFAMILIA  
 Amanda Sta. Cruz, Nurse, Pasto Clinic, PROFAMILIA  
 German Revelo, Director, Pasto Clinic, PROFAMILIA  
 Floralba Rubio, Motivator Pasto Clinic, PROFAMILIA  
 Fernando Tamayo, President of Board of Directors, PROFAMILIA  
 Bjorn Holmgren, SARO/AVS  
 Alcides Estrada, Medical Advisor, SARO/AVS  
 Fernando Reyes, Director of Medical Attention, MOH/Colombia  
 Cecilia Cadauid, Coordinator of Sterilization Programs,  
 PROFAMILIA  
 Gabriel Ojeda, Director of Evaluation, PROFAMILIA/Colombia  
 Miguel Trias, Executive Director, PROFAMILIA  
 Victor Jaramillo, Director of Administration & Finance,  
 PROFAMILIA  
 Eduardo Rodriguez, Director Piolet Clinic Medical Services and  
 Training, PROFAMILIA  
 Maria Luz Mejia Gomez, Professional, Population Dynamics Divi-  
 sion, MOH/Colombia

**CONTACTS: Dominican Republic**

Dr. Alcides Estrada, South American Regional Office, AVS  
Dr. Ramon Portes Carrasco, Executive Secretary, CONOPOFA  
Dr. Elias Dincey, Medical Director, CONOPFA  
Dr. Angel Adames Felix, Head of MCH Division, Ministry of Health  
Dr. Lee R. Hougen, Chief, Division of Health, USAID  
Dr. Vinicio Calventi, Director, Hospital Maternidad de la  
Altagracia Calle  
Dr. Bernardo Fernandez Dilone, Hospital Maternidad de la Altagra-  
cia Calle  
Dr. Carmela Cordero, Hospital Maternidad de la Altagracia Calle  
Magaly Caram de Alvarez, Executive Director, Asociacion  
Dominicana Pro-Bienestar de la Familia (PROFAMILIA)  
Jose Rafael Martinez, Associate Director, PROFAMILIA  
Dr. Milton Cordero, Medical Director, PROFAMILIA  
Dr. Luis Figueroa, Hospital Lorenzo de Lar Minas  
Dr. Angel Adames Felix, Mauricio Baez Medical Group  
Dr. Rafael A. Coplin, Hospital San Francisco de Assisi  
Dr. Frank Alvarez, Director, Family Planning Research Unit,  
Hospital Moscoso Puello  
Craig Bank, Deputy Director, USAID

10/1

**CONTACTS: Nigeria**

- Beverly Ben Salam, AVS Program Manager, Francophone Africa/Middle East
- Dr. M. Ezimokhai, Department of Obstetrics and Gynecology, University of Benin Teaching Hospital
- Javed Ahmed, Program Development Manager, AVS
- Dr. E.M. Akinluge, Chief Consultant, Obstetrics and Gynecology, Benin City Specialist Hospital
- Dr. Linus Ajobor, President, West African College of Surgeons, Benin City
- Dr. Gabriel Aletor, Private Clinic, Obstetrics and Gynecology, Benin City
- Dr. M.F.E. Diejomoo, Director, Department of Obstetrics and Gynecology, University of Benin Teaching Hospital, Benin City
- Dr. A.E. Omu, Lecturer, Department of Obstetrics and Gynecology, University of Benin Teaching Hospital, Benin City
- Dr. O.A. Ladipo, Director, Family Planning and Fertility Research Center, University of Ibadan Teaching Hospital, Ibadan
- Dr. E.O. Otolorin, Coordinator, Out-Patient Surgery Unit, University Ibadan Teaching Hospital, Ibadan
- Prof. A.O. Osoba, Director, Department of Microbiology, University of Ibadan Teaching Hospital, Ibadan

105

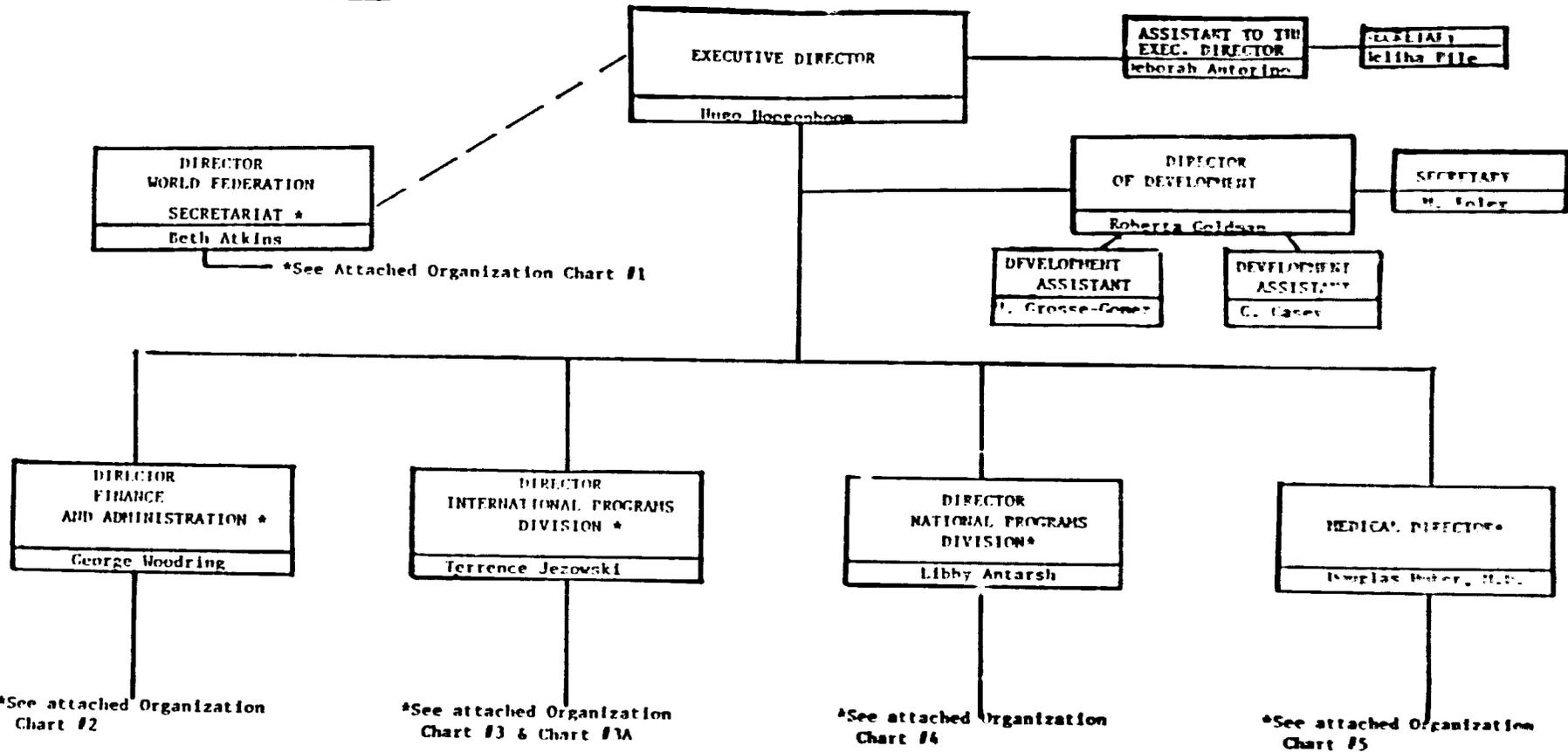
**Appendix B**  
**ASSOCIATION FOR VOLUNTARY STERILIZATION, INC.**  
**ORGANIZATION CHART**

APPENDIX B

ASSOCIATION FOR VOLUNTARY STERILIZATION, INC.

ORGANIZATION CHART

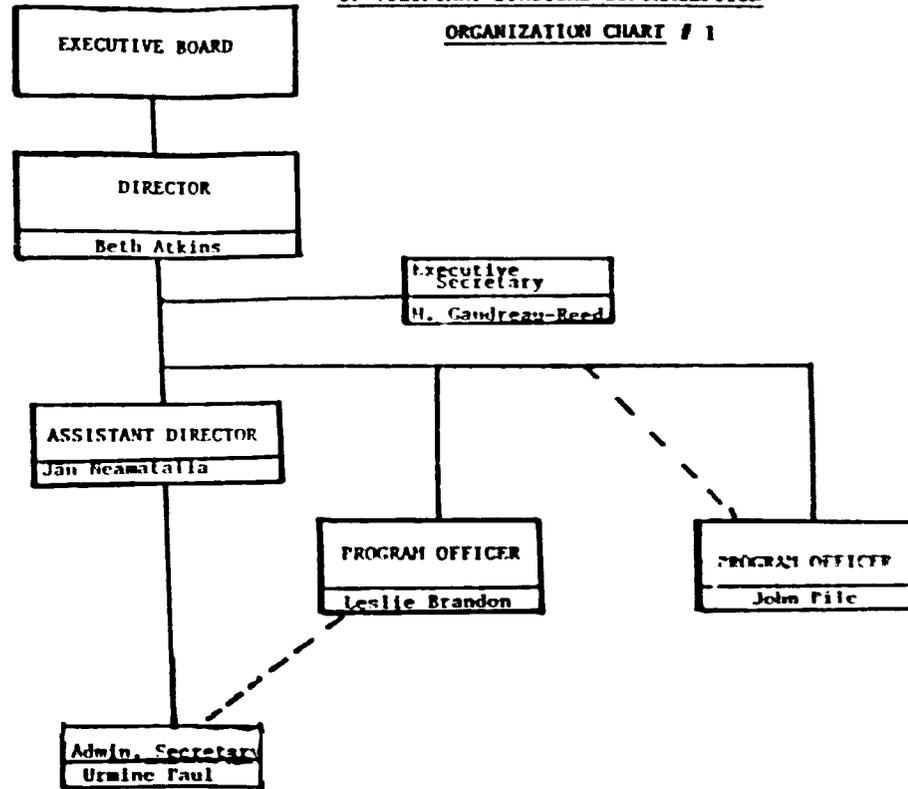
101



Revised 2/19/85

OF VOLUNTARY SURGICAL CONTRACEPTION

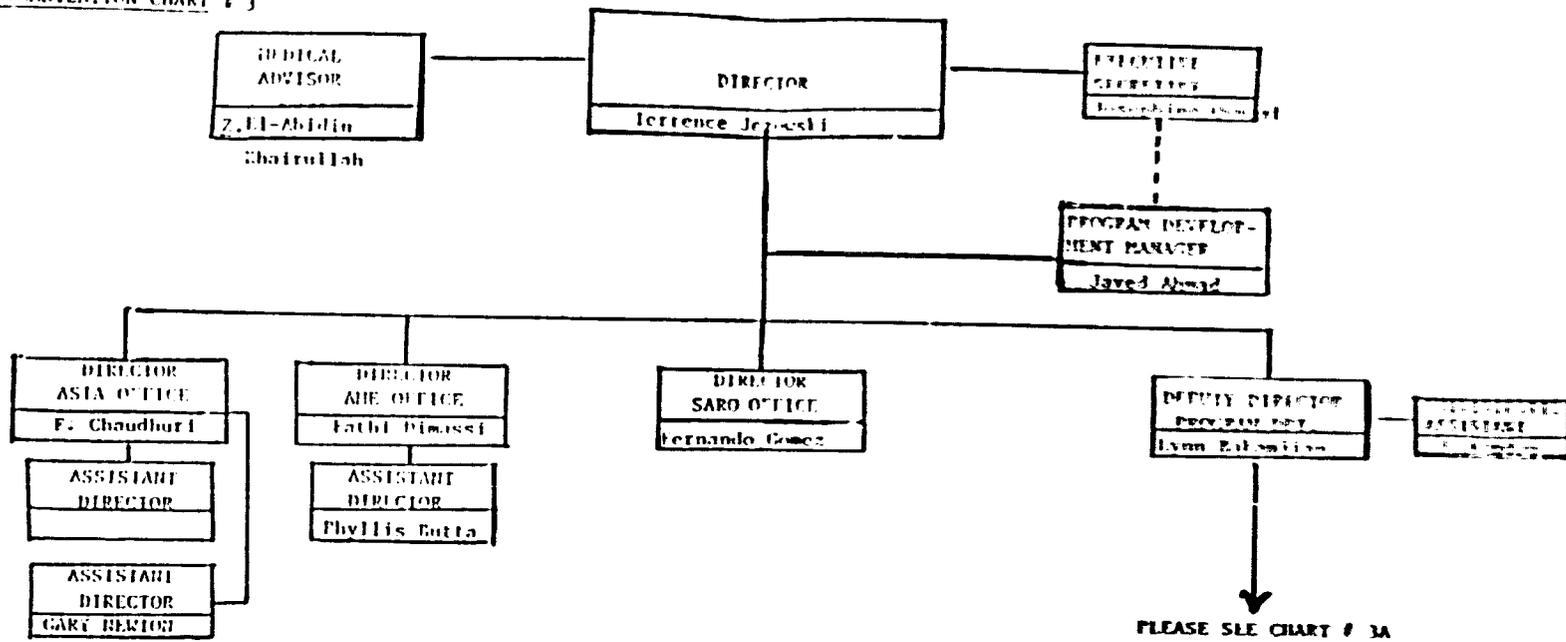
ORGANIZATION CHART # 1



98/1



ASSOCIATION FOR VOLUNTARY STERILIZATION, INC.  
 INTERNATIONAL PROGRAMS DIVISION  
 ORGANIZATION CHART # 3

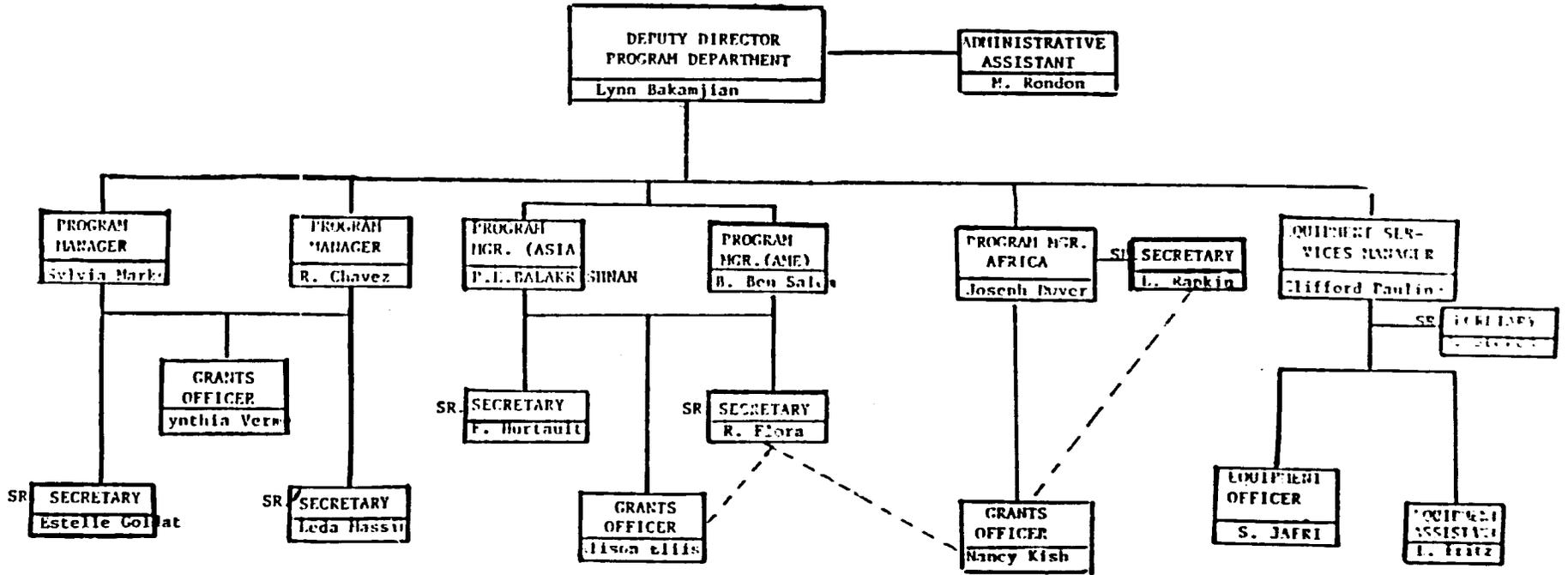


Revised 2/19/85

ASSOCIATION FOR VOLUNTARY STERILIZATION, INC.

INTERNATIONAL PROGRAMS DIVISION

ORGANIZATION CHART # 3A



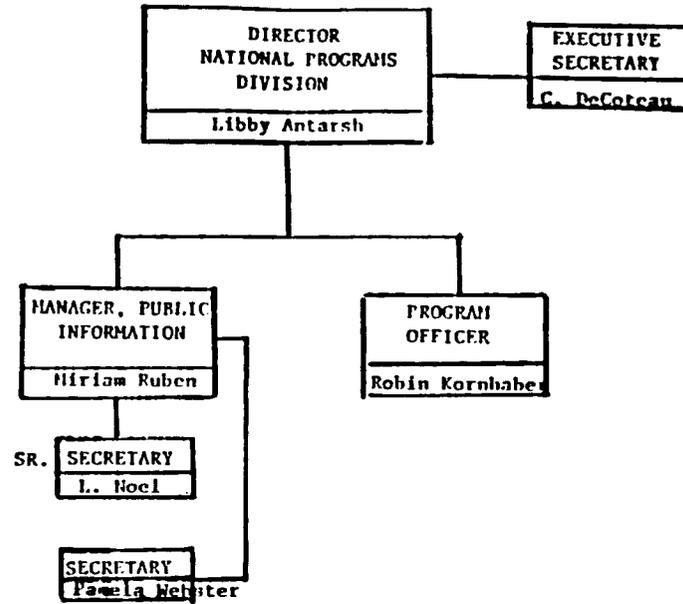
Revised 1/2/85

ASSOCIATION FOR VOLUNTARY STERILIZATION, INC.

NATIONAL PROGRAMS DIVISION

ORGANIZATION CHART # 4

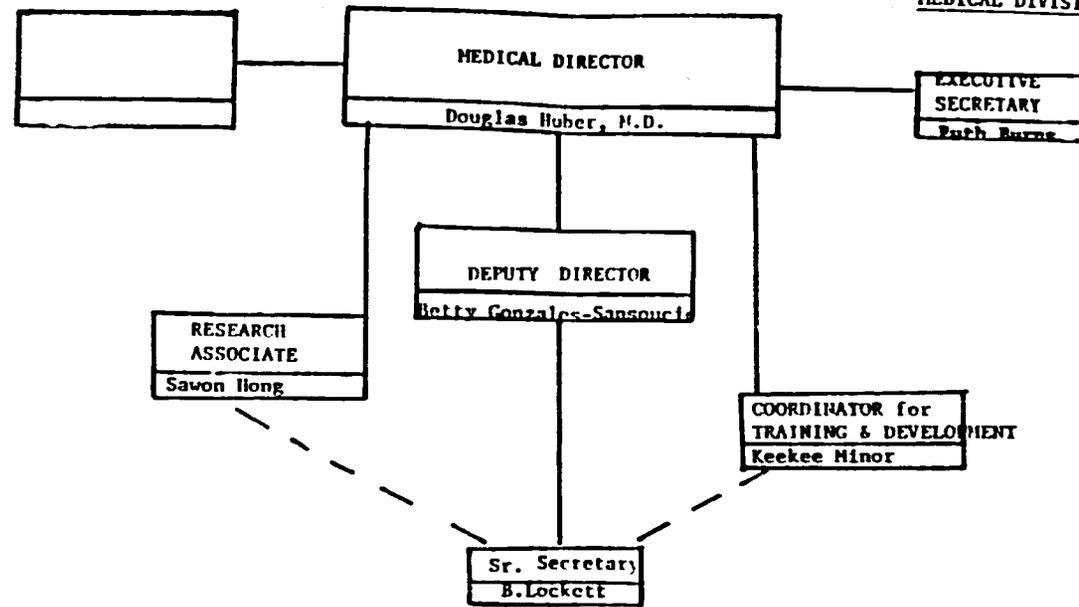
211



Revised 1/2/65

ASSOCIATION FOR VOLUNTARY STERILIZATION, INC.

MEDICAL DIVISION - ORGANIZATION CHART # 5



Rev. 2/19/85

**Appendix C**

**WORLD FEDERATION CONFERENCES AND MEETINGS (1981-1984)**

## APPENDIX C

### WORLD FEDERATION CONFERENCE AND MEETINGS (1981-1984)

#### INTERNATIONAL

First International Conference on Vasectomy, Colombo, Sri Lanka, October 4-7, 1982

Fifth International Conference on Voluntary Surgical Contraception, Santo Domingo, Dominican Republic, December 5-8, 1983

#### REGIONAL

World Federation Latin American/Caribbean Regional Meeting, Bogota, Colombia, November 2-3, 1982

First Scientific Conference - Regional Federation of Associations for Voluntary Fertility Care, Khartoum, Sudan, December 13-15, 1982

Conference on Reproduction Health in Sub-Saharan Africa, Freetown, Sierra Leone, November 5-8, 1984

#### EXPERT MEETINGS

Joint Meeting of Legal and Information and Education Committee on Ensuring Informed Consent, New York, New York, December 2, 1982

Expert Committee on Safety of Voluntary Surgical Contraception, Manila, Philippines, May 9-12, 1983

Expert Committee on Counseling, Dhaka, Bangladesh, July 23-28, 1983

Expert Committee on Female VSC Safety Surveillance, London, England, June 4-6, 1985

Expert Committee on Training for Voluntary Surgical Contraception, Rio de Janeiro, September 26-28, 1984

**Appendix D**  
**WORLD FEDERATION PUBLICATIONS AND REPORTS LISTING**  
**March 1985**

**Executive Board**

John C. Cutler, MD (USA), President  
 Azizur Rahman, MBBS (Bangladesh), Past President  
 Joaquin A. Nuñez, MD (Honduras), President Elect  
 Mahmoud F. Fathalla, MD (Egypt), Secretary-Treasurer  
 Helio Aguinaga, MD (Brazil)  
 Lydia A. Alfonso, MD (Philippines)  
 Dinah E. Jarrett, MD (Sierra Leone)  
 Zein Kharullan, MD (Syria)  
 Anne-Marie Dourien Roiler, JD (France)  
 Wickrema Weerasouria, Ph.D. (Sri Lanka)  
 Beth S. Atkins, MPH (USA), Executive Secretary, Ex Officio

FEDERATION  
 PUBLICATIONS AND REPORTS LISTING  
 March 1985

**PUBLICATIONS**

**Report on the First International Conference on Vasectomy, Colombo, Sri Lanka, October 4-7, 1982.** 7 p. (Published in Studies in Family Planning, Vol. 14, Number 3, March 1983).

**Standard Terms for Voluntary Surgical Contraception.** 1983. 20 p. (English, US\$2.50). (French and Spanish editions published as World Federation Report Number 8; see in list below.)

**Safety of Voluntary Surgical Contraception: Report of an Expert Committee, Manila, The Philippines, May 9-12, 1983.** (English, US\$3.25; French and Spanish editions forthcoming.)

**Family Planning Methods.** 1984. 197 p. (Published in Arabic only, US\$5.00.)

**Meeting the Needs for the 80's: Report of the Fifth International Conference on Voluntary Surgical Contraception, Santo Domingo, Dominican Republic, December 5-8, 1983.** (In press). (English, French, Spanish.)

**Counseling for Voluntary Surgical Contraception.** (Forthcoming). (English, (US\$10.00); French and Spanish.)

**Training for Voluntary Surgical Contraception: Report of an Expert Committee, Rio de Janeiro, Brazil, September 26-28, 1984.** (Forthcoming). (English, French and Spanish.)

**Reproductive Health Management in Sub-Saharan Africa: Report of a Conference, Freetown, Sierra Leone, November 5-8, 1984.** (Forthcoming). (English, French.)

**WORLD FEDERATION REPORTS**

1. **Report of the Program Year 1980-1981 and the Seventh General Assembly, Bangkok, Thailand, November 3-5, 1981.** 46p.
2. **Expansion of Voluntary Surgical Contraception into Rural, Remote, and Peripheral Areas: Report of an Expert Study Committee, October 1982.** 27 p. (English, French, Spanish, US\$2.00.)
3. **Report of the World Federation Latin American/Caribbean Regional Meeting, Bogota, Colombia, November 2-3, 1982.** 35 p.

4. Guidelines for Developing a Leadership Committee for Voluntary Surgical Contraception. November 1982. 11 p.
5. Meeting the Needs for the 80's: Proceedings of the International Planning Meeting, New York, New York, December 1, 1982. 33 p.
6. Report on the First Scientific Conference - Regional Arab Federation of Associations for Voluntary Fertility Care, Khartoum, Sudan, December 13-15, 1982. 19 p.
7. Ensuring Informed Choice for Voluntary Surgical Contraception: Guidelines for Counseling and for Informed Consent. December 1983. 30 p. (English, French, Spanish).
8. Standard Terms for Voluntary Surgical Contraception. 1983. 24 p. (French, Spanish, US\$2.50).
9. Guidelines for the Establishment of a National Leadership Organization for the Advancement of Voluntary Surgical Contraception. 1984. 5 p.

#### POLICY STATEMENTS AND GUIDELINES

The Health Rationale for Voluntary Surgical Contraception. November 1981. 1 p. (English, French, Spanish).

The Use of Paramedics in Voluntary Surgical Contraception Education and Service Delivery. November 1981. 2 p. (English, French, Spanish).

Suggested Guiding Principles for Legislation and Administrative Regulation of Voluntary Surgical Contraception. November 1981. 2 p. (English, French, Spanish).

Incentives and Disincentives Relating to Voluntary Surgical Contraception. November 1981. 3 p. (English, French, Spanish).

Ensuring Informed Choice for Voluntary Surgical Contraception: Guidelines for Counseling and for Informed Consent. December 1983. 30 p. (English, French, Spanish). (Available as World Federation Report Number 7; see listing above).

#### RESOLUTIONS, DECLARATIONS, AND PLANS OF ACTION

Santo Domingo Declaration and Plan of Action. December 1983. 4 p. (English, French, Spanish).

Arab Region: Plan of Action. December 1983. 4 p. (English, French, Spanish)

Asia Region: Plan of Action. December 1983. 1 p. (English, French, Spanish)

Europe: Plan of Action. December 1983. 3 p. (English, French, Spanish)

Latin America: Plan of Action. December 1983. 5 p. (English, French, Spanish)

North America: Plan of Action. December 1983. 4 p.  
(English, French, Spanish)

Sub-Saharan Africa: Plan of Action. December 1983.  
3 p. (English, French, Spanish)

Sierra Leone Resolution, Declaration, and Recommendations.  
November 1984. 6 p. (English, French)

#### PAMPHLETS

World Federation By-Laws. November 1981. 18 p.

World Federation - Goals, Philosophy, Activities, History  
Structure. (English, French, Spanish)

#### COMMUNIQUE (Newsletter)

Vol. 1 No. 1 December 1980  
Vol. 2 No. 1 July 1981  
Vol. 3 No. 1 May 1982  
Vol. 3 No. 2 December 1982  
Vol. 4 No. 1 May 1983  
  
Vol. 4 No. 2 August 1983  
Vol. 4 No. 3 November 1983  
Vol. 5 No. 1 April 1984  
  
Vol. 5 No. 2 September 1984  
Vol. 5 No. 3 December 1984  
Vol. 6 No. 1, May 1984

#### Special Issue Topics

Sixth General Assembly  
Rural Services  
Seventh General Assembly  
Vasectomy Conference Outcomes  
Voluntary Surgical Contraception  
in the Arab World  
Safety of Voluntary Surgical  
Contraception  
Counseling for Voluntary Surgical  
Contraception  
Outcomes of the International  
Conference on Voluntary  
Surgical Contraception  
Communications in Voluntary  
Surgical Contraception  
Sub-Saharan Africa Conference  
Outcomes  
Training in Voluntary Surgical  
Contraception

Individual copies of World Federation publications are available at no cost to individuals and institutions based in developing countries. Information on bulk orders is available on request from the World Federation Secretariat, 122 East 42nd Street, New York, New York 10168, telex: 425604 AVS-UI, cable: WORLDFED NEWYORK.

**Appendix E**

**PUBLICATIONS PRODUCED WITH AVS SUPPORT, BY CATEGORY AND  
YEAR OF PUBLICATION, January 1982 - May 1985**

## APPENDIX E

### PUBLICATIONS PRODUCED WITH AVS SUPPORT, BY CATEGORY AND YEAR OF PUBLICATION, January 1982 - May 1985

#### a) Guidelines, Standards, Policies

1982

Minimum medical service standards for male voluntary surgical contraception programs. New York: Association for Voluntary Sterilization. (French, Spanish in 1983)

Minimum medical service standards for female voluntary surgical contraception programs. New York: Association for Voluntary Sterilization. (French, Spanish in 1983)

Guidelines for developing a leadership committee for voluntary surgical contraception. New York: World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception.

1983

Equipment handbook for voluntary surgical contraception programs. New York: Association for Voluntary Sterilization. (draft)

Standard terms for voluntary surgical contraception. New York: World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception. (English, Spanish, French)

Ensuring informed choice for voluntary surgical contraception: Guidelines for counseling and informed consent. New York: World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception. (English, French, Spanish)

1984

Vasectomy: Voluntary surgical contraception for men. New York: Association for Voluntary Sterilization. (training slides)

Minilaparotomy: Voluntary surgical contraception for women. New York: Association for Voluntary Sterilization. (training slides)

Safety of voluntary surgical contraception. New York: World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception. (French, Spanish, forthcoming)

Arabic textbook on family planning. New York: Regional Arab Federation for Voluntary Fertility Care. (Arabic)

\*Counseling for voluntary surgical contraception: Guidelines for programs in the United States. New York: Association for Voluntary Sterilization.

1985 and Forthcoming

\*Guidelines for vasectomy services. Geneva: World Health Organization.

Counseling for voluntary surgical contraception. New York: World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception.

Technical assistance manual for grantees. New York: Association for Voluntary Sterilization.

Grants-management procedures manual for staff. New York: Association for Voluntary Sterilization.

Reporting forms. New York: Association for Voluntary Sterilization. (revision)

Postpartum female sterilization. New York: Association for Voluntary Sterilization. (training slides)

Minilaparotomy under local anesthesia. New York: Association for Voluntary Sterilization. (training slides)

Open laparoscopy. New York: Association for Voluntary Sterilization. (training slides)

Training for voluntary surgical contraception. New York: World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception.

Bibliography of audiovisual materials. New York: Association for Voluntary Sterilization.

\*Counseling guidelines for physicians in the U.S. New York: Association for Voluntary Sterilization.

\*Minilaparotomy: A training module for use in the U.S. New York: Association for Voluntary Sterilization.

\*Laparoscopy: A training module for use in the U.S. New York: Association for Voluntary Sterilization.

b) Study Reports1982

\*Wimberley, E.T. The RSP method of tubal occlusion. Biomedical Bulletin 3, no. 1.

\*Rubin, G. L.; Ory, H. W.; and Layde, P. M. The mortality risk of voluntary surgical contraception. Biomedical Bulletin 3, no. 2. (French, Spanish in 1984)

Expansion of voluntary surgical contraception into rural, remote, and peripheral areas. New York: World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception.

1983

\*Fishburne, J. I. Anesthesia for outpatient female sterilization. Biomedical Bulletin 4, no., 1. (English, French, Spanish)

\*Wimberley, E. T., and Ablanalp, J. M. Poststerilization regret among women: Methodological considerations for the next decade. Biomedical Bulletin 4, no. 2 (French, Spanish in 1984)

Jezowski, T. W., and Trias, M. Programmatic considerations in meeting the demand for voluntary surgical contraception in the 1980s. Background paper for Fifth International Conference on Voluntary Surgical Contraception, Santo Domingo, December 5-8.

Huber, D. Medical and health aspects of voluntary surgical contraception. Background paper for Fifth International Conference on Voluntary Surgical Contraception, Santo Domingo, December 5-8.

Ross, J. A., and Hong, S. Voluntary sterilization: A factbook of international data from surveys and service statistics. Background paper for Fifth International Conference on Voluntary Surgical Contraception, Santo Domingo, December 5-8.

Ahmad, J. S. Information, education, and communication for voluntary surgical contraception. Background paper for Fifth International Conference on Voluntary Surgical Contraception, Santo Domingo, December 5-8.

Philliber, W. W., and Philliber, S. G. 1983. Social and psychological perspectives on voluntary sterilization. Paper prepared for Fifth International Conference on Voluntary Surgical Contraception, Santo Domingo, December 5-8. Published in 1985 as Social and psychological perspectives on voluntary sterilization: A review, Studies in Family Planning 16, no. 1: 1-29.

1984

- \*Hasson, H. M. Open laparoscopy. Biomedical Bulletin 5, no. 1. (French, Spanish in 1985)
- \*Richards, I. S., ed. Reversal of vasectomy. Biomedical Bulletin 2, no. 3. (Spanish) (French in 1985)

1985 and Forthcoming

- \*Ross, J. A.; Hong, S.; and Huber, D. H. Voluntary sterilization: An international fact book. New York: Association for Voluntary Sterilization.
- \*Petitti, D. B. A review of epidemiologic studies of vasectomy. Biomedical Bulletin.
- \*Wilson, E. W. A review of WHO studies on voluntary sterilization. Biomedical Bulletin.
- \*Porter, C. Asepsis and infection control for voluntary sterilization. Biomedical Bulletin.
- \*Richards, I. S., ed. Menstrual function following tubal sterilization. Biomedical Bulletin 2, no. 1. (French)
- Working paper series. New York: Association for Voluntary Sterilization.

c) Conference Reports1982

- Report of the World Federation Seventh General Assembly. New York: World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception.
- Meeting the Needs of the 80's: Proceedings of the International Planning Meeting, New York. New York: World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception
- Report on the First Scientific Conference -- Regional Arab Federation of Associations for Voluntary Fertility Care, Khartoum, Sudan. New York: World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception.

1983

Atkins, B. S., and Jezowski, T. W. Report on the First International Conference on Vasectomy. Studies in Family Planning 14, no., 13: 89-95.

1985 and Forthcoming

Meeting the Needs of the 80's: Report of the Fifth International Conference on Voluntary Surgical Contraception. New York: World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception.

Report of the Conference on Reproductive Health Management in Sub-Saharan Africa. New York: World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception.

d) Promotional and Informational Materials1982

Communique. May, December issues.

Vasectomy Conference Program.

World Federation Brochure. (English, Spanish)

Vasectomy Initiative Brochure.

1981 Annual Report to AID.

\*1981 AVS Annual Report.

\*AVS News. Four issues.

1983

Grant Application Brochure. (English)

Communique. May, August, November issues.

International Conference Program. (English, Spanish, French)

International Conference Brochure. (English, Spanish)

1982 Annual Report to AID.

\*1982 AVS Annual Report.

\*AVS News. Four issues.

125

1984

- Grant Application Brochure. (French, Spanish)
- Communique. April, September, December issues.
- Program for Conference on Reproductive Health Management in Sub-Saharan Africa. (English, French)
- 1983 Annual Report to AID.
- \*Brochure on the National Division.
  - \*AVS: Who We Are, What We Do. (brochure)
  - \*Capital Campaign Brochure
  - \*1983 AVS Annual Report
  - \*AVS News. Four issues.

1985 and Forthcoming

- Informational Brochure on the International Programs Division, Association for Voluntary Sterilization.
- Slide Program on the International Programs Division, Association for Voluntary Sterilization
- World Federation Brochure. (English, Spanish) (revision)
- Communique. Three issues per year.
- Communique. (French) As needed.
- Communique. (Spanish) As needed.
- Annual Reports to AID.
- \*AVS Annual Reports.
  - \*AVS News. Four issues per year.
- e) Patient Education Materials

1983

- \*Birth control for men. (brochure)

- \*Birth control for women. (brochure)
- \*Vasectomy. (brochure)
- \*Prevencion permanente. (brochure)
- \*Amor y responsabilidad. (brochure)
- \*Para el hombre. (brochure)

1984

- \*Vasectomy. (brochure)
- \*Female sterilization. (brochure)

---

\*Supported fully or partly with private funds.

**Appendix F**  
**ASIAN COUNSELING EFFORTS AND TECHNICAL**  
**ASSISTANCE NEEDS FOR 1985**

## APPENDIX F

ASIAN COUNSELING EFFORTS AND TECHNICAL ASSISTANCE NEEDS FOR 1985

SL NO.	PROJECT IDENTIFICATION	PROGRAM OBJECTIVES	AREAS OF TECHNICAL ASSISTANCE (TA)	HOW AND WHEN TO PROVIDE IA
1.	INDONESIA Subagreement # INS-29-TR-1-A	<ul style="list-style-type: none"> <li>* Establish Steering Committee</li> <li>* Develop curriculum and training material</li> <li>* Train 144 Nurses and Midwives</li> <li>* Trainee follow-up and supervision.</li> </ul>	<ul style="list-style-type: none"> <li>* Curriculum, training material and program implementation strategy development.</li> <li>* Evaluation of achievement.</li> </ul>	<ul style="list-style-type: none"> <li>* Early 1985 by an AVS/ NewYork consultant.</li> <li>* Late 1985 by a local consultant. To be identified by ARO.</li> </ul>
2.	THAILAND Proposal # THA-08-CO-9-A	<ul style="list-style-type: none"> <li>* National counseling policy development thru three regional workshops.</li> <li>* Development of counseling material in Thai language including a counseling manual &amp; needed audio-visual aids.</li> <li>* Training in counseling for hospital director and information and education officer from thirty district hospitals.</li> <li>* Initiation/support of VSC counseling pilot project in thirty hospitals.</li> <li>* Monitoring and evaluation of the program.</li> </ul>	<ul style="list-style-type: none"> <li>* National counseling policy development.</li> <li>* Curriculum &amp; training material development</li> <li>* Program implementation and evaluation</li> </ul>	<ul style="list-style-type: none"> <li>* Need a consultant (who knows Thai) to review the national counseling policy, &amp; assist in the development of training curriculum material in early 1985.</li> <li>* Program implementation IA can be provided by ARO.</li> <li>* NewYork IA may be needed for evaluation in early 1986.</li> </ul>
3.	PHILIPPINES Subagreement # PHI-08-NV-7-A	<ul style="list-style-type: none"> <li>* Develop a national level VSC counseling training curriculum.</li> <li>* Conduct one workshop for training of 30 trainers.</li> <li>* Conduct six workshops by trained trainers for field workers and motivators.</li> </ul>	<ul style="list-style-type: none"> <li>* Curriculum development</li> <li>* Training material development</li> </ul>	<ul style="list-style-type: none"> <li>* Review of National VSC curriculum by ARO and AVS/NewYork.</li> <li>* Provide IA for training material development.</li> </ul>

ASIAN COUNSELING EFFORTS AND TECHNICAL ASSISTANCE NEEDS FOR 1985

SL. NO.	PROJECT IDENTIFICATION	PROGRAM OBJECTIVES	AREAS OF TECHNICAL ASSISTANCE (TA)	HOW AND WHEN TO PROVIDE TA
4.	SRILANKA Subagreement # SRL-02-NV-6-A	<ul style="list-style-type: none"> <li>* Sensitization of policy makers and professionals on the need for VSC counseling by forming a national counseling coordination council and conducting seminars and speakers program.</li> <li>* Develop counseling training material such as slides, flash cards, flip charts, etc.</li> <li>* Conduct 2 training courses in VSC counseling for trainers, they will man the nine demonstration projects.</li> <li>* Conduct counseling training for midwives, public health nurses etc.</li> <li>* Establishment of counseling demonstration project in 9 VSC service facilities of 3 districts where SLAVSC works.</li> <li>* Evaluate the impact of the demonstration projects after one year of completion.</li> </ul>	<ul style="list-style-type: none"> <li>* Development of training curriculum.</li> <li>* Development of training material .</li> <li>* Evaluation of demonstration projects.</li> </ul>	<ul style="list-style-type: none"> <li>* AVS provided TA to SLAVSC through JSA in February '84 to help SLAVSC crystalize Counseling Country Action Plan and incorporate into the continuation proposal. BGS was the resource person on counseling at the National Counseling Seminar organized jointly by MOPI &amp; SLAVSC at Colombo, May 1984.</li> </ul> <p>Once the counseling curriculum is finalized by the national committee, then ARO will determine with SLAVSC the need for further technical assistance.</p>
5.	NEPAL Proposal # NEP-01-CO-9/10-A	<ul style="list-style-type: none"> <li>* Develop counseling capability at FPAN through training of trainers/ evaluators, supply of materials, etc.</li> <li>* Improve counseling at FPAN service sites, particularly mobile sites.</li> <li>* Assist the national program establish/improve family planning counseling.</li> </ul>	<ul style="list-style-type: none"> <li>* Formation of national policy.</li> <li>* Development of training curriculum.</li> <li>* Development of counseling programs and their evaluation.</li> <li>* Development of staff.</li> </ul>	<ul style="list-style-type: none"> <li>* AO has requested technical assistance from NY on several occasions. Such assistance is still needed. In the meantime, ARO staff is providing help and</li> </ul> <p align="right">(continued)</p>

SL NO.	PROJECT IDENTIFICATION	PROGRAM OBJECTIVES	AREAS OF TECHNICAL ASSISTANCE (TA)	HOW AND WHEN TO PROVIDE IA
5.	NEPAL Proposal # NEP-01-CO-9/10-A (continued)	<ul style="list-style-type: none"> <li>* Activities to date (1) The convening of an Inter-agency Counseling Task Force which produced a report which has been edited with AVS/ARO and local expatriate assistance (2) The convening of a national level seminar and the production of proceedings also edited with external technical assistance.</li> <li>* Plans include (1) establish counseling unit at FPAN Chitwan branch (2) develop training curriculum (3) organize counseling workshop for 15 Govt. training officers (4) organize a refresher course for sixty FPAN field workers.</li> </ul>		<ul style="list-style-type: none"> <li>- have furnished FPAN with every available resource.</li> </ul> <p>Technical assistance in Counseling for Nepal remains an ongoing priority.</p>
6.	BANGLADESH Proposal # BGD-35-TR-1-B	<ul style="list-style-type: none"> <li>* Develop a nationwide standardized counseling training curriculum.</li> <li>* Organize Training of Trainers</li> <li>* Constitute Inter Agency Task Force for developing national level counseling policy and to recommend project for establishing a centralized counseling training center.</li> </ul>	<ul style="list-style-type: none"> <li>* Review of all current FP training programs and resources for need assessment of incorporating counseling curriculum in all the FP training programs.</li> </ul>	<ul style="list-style-type: none"> <li>* NewYork IA may be made available sometime in mid-April for approximately two weeks.</li> </ul>

ASIAN COUNSELING EFFORTS AND TECHNICAL ASSISTANCE NEEDS FOR 1985

SL. NO.	PROJECT IDENTIFICATION	PROGRAM OBJECTIVES	AREAS OF TECHNICAL ASSISTANCE (TA)	HOW AND WHEN TO PROVIDE TA
7.	MALAYSIA Smallgrant #S-760	<ul style="list-style-type: none"> <li>* Two 3-day counseling training program for 20 physicians in each training session.</li> <li>* Assess training needs of family planning personnel and their interest based on the needs and interest of training course participants.</li> </ul>	<ul style="list-style-type: none"> <li>* Development of training curriculum.</li> </ul>	<ul style="list-style-type: none"> <li>* TA needs assessment to be made.</li> </ul>

FAC:scs  
130285

**Appendix G**

**MEDICAL SAFETY EVENTS AND MATERIALS PRODUCTION**

**SUPPORTED BY AVS 1982-1984**

Appendix G

MEDICAL SAFETY EVENTS AND MATERIALS PRODUCTION  
SUPPORTED BY AVS 1982-1984  
(Report prepared for Evaluation Team by  
T. Jezowski, June 10, 1985)

AVS actively promotes the medical safety and quality of VSC services in several interrelated ways. These include inter alia:

- o the development of clear medical policies and guidelines;
- o on-site monitoring of VSC service and training projects (i.e., medical site visits);
- o complications and death report investigations and followup;
- o support of local medical supervision and medical surveillance systems;
- o support of quality training;
- o collaboration with other donor and international agencies concerned with VSC medical quality, including WHO, IPPF, CDC, FHI, JHPIEGO, and AID;
- o investigation of new technologies (e.g., NORPLANT, Chinese "non-surgical" methods), new VSC techniques (e.g., Filshie Clip), and refinements of medical procedures (e.g., local anesthesia);
- o selection, procurement, and development of appropriate and safe medical equipment for distribution to VSC service programs;
- o organization and sponsorship of professional meetings (i.e., conferences, workshops, and similar group events) with some aspect of medical safety as a main theme; and
- o support for production and distribution of publications and other materials relating to medical safety and quality assurance.

This report specifically addresses the last two types of activities, that is, support of professional meetings and publications.

Professional meetings and publications concerning the medical safety of VSC are supported by the World Federation and the Medical and International Programs Divisions of AVS.

#### A. WORLD FEDERATION ACTIVITIES

Professional meetings conducted by, and publications supported by, the World Federation are particularly important and useful because they are done at an international level for an international audience, and planned and developed with the active input and participation of professionals from developing countries and the international health community. They thus help to develop, promote, and legitimize sound and safe medical practices in ways that would be difficult or impossible for an American organization, such as AVS.

Below are a list of meetings sponsored by the World Federation where medical safety was the primary theme, or was included as an important component. Often a report or publication results from such meeting and these are indicated.

- |               |   |
|---------------|---|
| December 1982 | First Regional Conference of the Regional Arab Federation of Associations for Voluntary Fertility, Khartoum, Sudan -- this meeting included medical issues in its overall agenda. An important outcome was a mandate to develop a textbook on family planning, including VSC, in Arabic for medical students. |
| May 1983      | Expert Committee on the Safety of Voluntary Surgical Contraception, Manila, Philippines -- a pivotal event that consolidated and codified world-wide experience with VSC medical safety and quality assurance. It resulted in the establishment and international endorsement of safety guidelines.           |
| December 1983 | Fifth International Conference on Voluntary Surgical Contraception, December 1983, Santo Domingo, Dominican Republic -- safety and quality issues figured prominently in this major triennial event.  |

- May 1984 Special Task Force Meeting of the World Federation's Committee of Voluntary Surgical Contraception Statistics, London, England -- this small expert group met and developed a model proposal for VSC medical surveillance systems that involves the collection, analysis, and feedback of service statistics and complications data from VSC service sites.
- September 1984 Expert Committee on Training for Voluntary Surgical Contraception, Rio de Janeiro, Brazil -- this committee meeting reviewed and established recommended guidelines for planning and implementing VSC training programs.
- November 1984 Conference on Reproductive Health Management in sub-Saharan Africa, Freetown, Sierra Leone -- medical safety issues were important topics in this regional meeting.

In addition to the publications referred to in the above list, the following two medical safety publications were sponsored by the World Federation during the period review:

- o "Expansion of VSC into Rural, Remote and Peripheral Areas: Report of the Expert Committee."
- o "Standard Terms for Voluntary Surgical Contraception." This booklet provides definitions and promotes their consistent use and the collection of comparable international data for VSC medical quality studies.

#### B. SUBGRANTEE MEETINGS AND PUBLICATIONS

Concern for and attention to medical quality assurance matters is further realized when local, national, and regional programs specifically consider them. Thus, the International Programs field staff work with well-positioned grantees to undertake medical safety events and publications. These often precede or lead to development of national policies or guidelines. The relevant reports and publications from World Federation meetings, as well as AVS's own medical guidelines, often are the departure point for such meetings and publications.

Below is a partial and illustrative listing of some of the regional, national and local professional meetings and publications supported by AVS from 1982 to 1984.

Philippines

o "Minimum Medical Standards for Comprehensive Family Planning Services," a publication, Family Planning Association of the Philippines, 1982.

Sri Lanka

o "Minimum Medical Standards for VSC," a publication, Sri Lanka Association for Voluntary Surgical Contraception, 1983.

o National Workshop of Policy Level Administrators on Counseling and Quality of VSC Services Delivery, 3 May 1984.

Banladesh

o 3rd Annual Medical Workshop of the Bangladesh Association for Voluntary Sterilization (BAVS), January 1-2, 1982. Theme: Maintaining medical standards, obstacles, and dilemmas.

o 4th Annual Medical Workshop of BAVS, March 6-7, 1983. Theme: Client recruitment, counseling and follow-up.

o 5th Annual Medical Workshop of BAVS, January 18-19, 1984. Theme: Clinic management with quality service.

o Four BAVS regional medical workshops for government and BAVS physicians: implementation of minimum medical standards and management of emergencies, May 1982.

o Four BAVS regional medical workshops: preoperative client preparation and emergency preparedness, July - October 1983.

o Selected BAVS publications:

- BAVS Medical Standards and VSC Service Guidelines (1983, 1985 - revised)
- BAVS Medical Emergency Handbook, 1985
- Autoclaving Manual (Bengali), 1984
- Bimanual Pelvic Examination (Bengali), 1984

Nepal

o National policy makers workshop on surveillance, evaluation training and maintenance of medical standards at all VSC service delivery sites with special emphasis to the mobile sterilization teams, Family Planning Association of Nepal (FPAN), July 1985 (scheduled).

o Workshop on infection control in VSC, FPAN, October 1985 (scheduled).

o Premobile VSC service delivery season refresher training of physicians, FPAN, August 1985 (scheduled).

o FPAN publications:

- Minimum Medical Standards for Male VSC, June 1983

- Minimum Medical Standards for Female VSC, July 1984

- Training Manual for Physicians, 1983

Indonesia

o Scientific meeting for the Indonesian Association for Secure Contraception (PKMI) including a workshop on complications and safety issues, November 1983; results led to formulation of minimum VSC medical standards.

o PKMI workshop on evaluation and development of secure contraception training for medical students, October 1983.

o PKMI 3-day seminar on male secure contraception, August 1985 (scheduled).

Thailand

o National Medical Standards and VSC Safety Guidelines, a publication, Thai Association for Voluntary Sterilization, 1984 and 1985.

Mexico

o National Symposium on Tubal Occlusion, National Institute of Nutrition, Mexico City, January 1984.

o Workshop for Medical Directors of Mexican Family Planning Private Programs, FEMAP, Celaya, Mexico, May 1985.

Guatemala

o Regional Central America Workshop for the Prevention of Accidents and Complications in Voluntary Surgical Contraception, August 1984.

Columbia

o Safety workshop for PROFAMILIA surgeons, March 6-7, 1985.

Dominican Republic

o Seminar for CONAPOFA and PROFAMILIA regional supervisory teams on VSC safety regulations, April 25 to 26, 1985.

C. OTHER RELATED PUBLICATIONS

The Medical Division publishes the Biomedical Bulletin, an occasional report by recognized experts authoritatively reviewing a particular aspect of VSC. Recent titles included:

- 1982        The Mortality Risk of Voluntary Surgical Contraception
- 1983        Anesthesia for Out-Patient Female Sterilization (F.shburne)
- Post-Sterilization Regret Among Women (Wimberly, et al.)
- Open Laparoscopy (Hasan)

**Appendix H**  
**SCOPE OF WORK**

## APPENDIX H

### SCOPE OF WORK

Scope of Work for Evaluation of the Association for Voluntary Sterilization Cooperative Agreement AID/DPE-0968-A-00-2001-00 and Grant AID/pha-G-1128

#### I. Background

The Association for Voluntary Sterilization (AVS) is a non-profit organization which seeks to make permanent contraception available on a voluntary basis. Since 1972, AID has financed the majority of its international operations with contracts and grants totalling approximately \$90 million.

The purpose of the current AID Cooperative Agreement with AVS is to make high quality voluntary surgical contraception (VSC) services available as an integral part of developing country health and family planning programs.

The current AID Cooperative Agreement (AID/DPE-0968-A-00-2001-00) was authorized on December 22, 1981. The immediately preceding grant (AID/pha-G-1128) was authorized on August 25, 1977. The last external evaluation of AVS was conducted by APHA in December, 1979. An AID audit of Cooperative Agreement AID/DPE-0968-A-00-2001-00 and Grant AID/pha-G-1128 was conducted by RIG/A in September, 1984, reviewing AVS financial activities from 1977 through September, 1984. A management review of the AVS New York operation was conducted by the AID/W Project and Contracting Officers in May, 1984.

#### II. General Plan for the AVS Evaluation

A four-member evaluation team will spend approximately four-five weeks in June-July, 1985, evaluating AVS program and management operations by visiting AID/W, AVS headquarters in New York City, and several countries in which AVS has major country-specific and regional projects.

Following the visits to countries in Asia, Latin America, and Africa, the team will reassemble at ISTI headquarters, Washington D.C. (or at AVS/New York) to prepare its evaluation report. The group will provide a debriefing for AID/W staff upon completion of the written report.

#### III. Purpose and Scope of the Evaluation

The evaluation will serve as a basis for developing A.I.D. program documentation that would authorize/extend the AID/AVS Cooperative Agreement from January 1, 1987, to December 31, 1992. The evaluation will focus on AVS programmatic achievements as compared to targeted goals and objectives taking into account the level of funding that AVS has received over this period; assess AVS strategies which have been employed to reach these goals and objectives including the role of the World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception; examine the issues of voluntarism and medical quality (including medical back-up and cost benefits) of sub-project services being supported; and study the overall management of the AVS overseas program. The evaluation findings will enable AVS, under its Cooperative Agreement, to improve the planning, management and evaluation of its subgrants. This evaluation will concentrate on activities during the period April 1, 1982, to the present but will also cover the period from December, 1979, to April, 1982. Nothing in this scope of work will limit the

evaluation team from examining other issues that they find to be important.

#### IV. Topics to be Addressed in the Evaluation

##### Programatic Achievements

1. To what extent has AVS achieved the anticipated magnitude of outputs that were envisaged in the Project Paper Log Frame given the level of funding which they received? How have these outputs contributed to attaining the overall goal and purpose of the Project and to the goals of the AID Population Strategy?
2. Has the creation of pilot VSC sub-projects increased indigenous awareness and demand for services, lowered costs, and institutionalized VSC services by host country organizations?
3. To what extent has the creation of national leadership groups generated greater political commitment to provision of VSC services by host governments?
4. How much have the training, international travel, and conferences funded by AVS contributed to the achievement of the Project goal and purpose?
5. To what extent have AVS sub-grants and activities influenced the medical safety, medical quality, quality of counseling services, and quality of IFC activities in countries where AVS has provided assistance?
6. To what degree has AVS been able to respond to the existing demand for VSC services which exists in AID-assisted LDC's.

##### Quality Control and Voluntarism

1. Does AVS have adequate medical supervision and provide medical backup for its sub-projects? Are the required emergency equipment items available and sufficient to respond to unexpected situations? Are the medical safety guidelines sufficient and are they enforced by AVS in its sub-projects? Has the AVS system of medical site visits by approved consultants maintained a high level of quality and safety in the VSC services provided? Is the system for reporting mortalities and complications providing all needed information and are the actions taken by AVS when complication/mortality reports are received sufficient to insure the safety of VSC requestors?
2. Has AVS rigidly enforced AID's and its own regulations concerning voluntarism in the VSC programs which it supports? Is counselling of VSC requestors adequate to give them a thorough understanding of the procedure, its permanency, and the availability of other temporary methods of family planning? Does AVS monitor its sub-projects to insure that no coercion or incentives are used to influence a potential client's decision on VSC? Are written informed consent forms utilized in all projects which demonstrate that all client decisions to utilize VSC are voluntary?

3. Do the IEC programs supported by AVS give accurate and helpful information on the VSC procedure? Have they created additional understanding of the procedure including its benefits, permanence, and voluntary nature for the general public? Have AVS-supported clinics been able to respond to the additional demand created by its IEC programs?

#### Sub-Grant Planning and Implementation

1. Do the processes which AVS uses for strategic planning and for subproject development adequately identify needs and effectively allocate resources? Does AVS acquire sufficient information about relevant projects supported by other donors and LDC organizations to plan its subproject support accordingly?
2. To what extent have AVS's associations with certain LDC institutions directed AVS away from potential alternative subgrantees and projects?
3. Do AVS reporting requirements for sub-grantees combined with AVS site visits provide sufficient information for AVS to adequately monitor its sub-grantee's activities?
4. Have AVS equipment shipments and currency transfers arrived in a timely manner for sub-projects to begin activities promptly?
5. Has AVS responded effectively and correctly to the rapidly fluctuating currency exchange rates in many of the countries in which it provides assistance?
6. Has the system of sub-grantee audits combined with AVS site visits and reporting requirements provided adequate fiscal control over sub-grantees. Are negative audit findings promptly resolved.

#### Role of the World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception

1. The evaluation team will examine the role and achievements of the World Federation sub-grant over the last three years. Of particular concern is how effectively the World Federation contributes to the goals and objectives of the Cooperative Agreement and how cost-effective is their effort.

#### Evaluation

1. Does the AVS subproject evaluation system accurately identify project accomplishments and shortcomings? To what extent are evaluation findings acted upon? How can this system be improved and used as a management tool? Do AVS project managers pay adequate attention to the need for evaluation in the preparation of their sub-project documents?
2. How does AVS evaluate its programs on a regional or worldwide scale? Is this information being used effectively in resource allocation decisions both geographically and between the programs of each of its Divisions?

3. How well is client followup conducted in AVS supported sub-projects? Have the special AVS VSC client followup surveys served to identify client perceptions and/or misperceptions of the VSC procedure and are surveys of this type a cost-effective method of collecting information in the future on a routine basis?

### Organization, Structure, and Management

1. Is the composition and organization of AVS adequate for carrying out its programs? Should any changes in staffing or structure be considered?
2. Has the system of delegation of authority to local Regional Offices contributed to improved planning, implementation, and quality of sub-projects? Are the divisions of responsibility and lines of authority between New York and the Regional Offices optimally defined to support the program?
3. Are the staffing levels and resource allocation between each of the New York Divisions commensurate with program needs of the AID-supported international assistance?
4. Does the allocation of resources between service projects and AVS core costs reflect a proper mix for providing the maximum amount of services possible while maintaining the high quality of services required by the Cooperative Agreement and the AID Population Strategy?
5. What administrative procedures and practices should be revised to make management more effective? - Specifically, which A.I.D. procedures and practices, and which AVS procedures and practices?

### IV. Evaluation Procedure and Proposed Chronology

#### A. Procedure

The evaluation will be conducted by interviews with AVS staff members, USAID mission population and health officers, host country officials, AVS regional office staff, selected subgrant staff, and AID/W staff. Project documents, records, reports and other evaluations will be examined. Subject to USAID mission concurrence, members will visit several of the following countries: Brazil, Dominican Republic, Mexico, Colombia, Nigeria, Kenya, Sierra Leone, Morocco, Egypt, Tunisia, Nepal, Bangladesh, Sri Lanka, the Philippines, and Indonesia. (See appendix A)

The countries cited above include those with regional offices, and those with major in-country activities. They include a variety of projects in the functional areas of service delivery and training, in leadership activities, IEC activities, and human resources/rapid response grants. Other AVS and USAID field staff and subgrantees may be canvassed by mail and requested to respond in writing to questions similar to those outlined in this scope of work.

1994

## B. Proposed Chronology

The evaluation will begin in June 10, 1985, and last four weeks. A preliminary debriefing should be conducted at AID/W about July 4. The sequence of events will be as follows:

### One day at AID/W (June 10, 1985)

1. Meet with the Office of Population/Family Planning Services Division Chief and Deputy Chief, the Project Manager, the Director, Deputy Director, and Associate Director for Program Coordination of the Office of Population and a representative from the Office of Contract Management;
2. Meet with S&T/POP regional coordinators and the staffs of the regional bureau technical offices.

### Four days at AVS headquarters in New York City (June 11-14)

1. Meet with the Executive Director, and Division chiefs and functional division staff.
2. Review selected subagreement documents;
3. Review field reports and other relevant documents.

### Two weeks of field visits to selected countries (June 15-30)

1. Discuss the activities and role of AVS with USAID population/health officers and other relevant staff; discuss AVS collaboration with representatives of other cooperating agencies working in-country;
2. Meet with field and regional AVS representatives;
3. Meet with representatives of subgrant recipient organizations.

### Four days at AVS or ISTI headquarters

The team will spend four days in New York or Washington to prepare a draft of the evaluation report and to consult with AVS/AID headquarters staff as necessary.

### One day (July 4)

1. Debriefing at AID/W

Note: This proposed schedule may be extended by one additional week if required by the Evaluation team

115

Appendix A

Proposed Countries and Rationale

Bangladesh, Nepal, and Indonesia. All of these countries have longstanding AVS sub-projects which have provided services to many VSC requestors. AVS has a regional office in Dhaka.

Brazil, Colombia, and the Dominican Republic. These countries are among the largest recipients of AVS assistance in Latin America. The AVS regional office is located in Bogota.

Morocco, and Tunisia. These countries all receive significant AVS assistance. The AVS regional office is located in Tunis.

Nigeria or Sierra Leone. Sierra Leone has a longstanding AVS sub-project and is a good example of the very difficult working conditions which exist in Africa. Nigeria is targetted for major AVS investments and has many newly approved sub-projects. There is currently no regional AVS office in Sub-Saharan Africa but the Tunis Office is responsible for coverage of Francophone Africa.

Appendix B

Proposed Composition of Evaluation Team

The evaluation team will consist of four members with the following qualifications:

1. A Team Leader with longstanding experience in family planning service delivery in LDC countries and in the evaluation of these services.
2. A physician with ob/gyn expertise and experience in the provision of family planning services in LDC countries.
3. A social scientist who would concentrate on voluntarism, counselling, IEC, and indigenous demand for services. Suggest a person not previously connected with AID/AVS supported programs.
4. A management expert with financial/accounting expertise.

At least one team member should be proficient in French and one member proficient in Spanish

APPENDIX I

PD-3 (SEPTEMBER 1983)  
AID POLICY GUIDELINES ON VOLUNTARY STERILIZATION

## APPENDIX I

### PD-3 (SEPTEMBER 1983) AID 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 which 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 (VS) services.\* Such requests are partially in response to the preparatory work conducted by 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 advanced training in obstetrics and gynecology. These organizations have contributed to signifi-

cant 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 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.

\*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 document, 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/treatment facility for sterilization.

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 inducements 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 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.

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 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 practices, 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.

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-3 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.

(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.

**Addendum to PD-3 (formerly Addendum to PD-79, 1/9/81)  
Additional A.I.D. Program Guidance for  
Voluntary Sterilization (VS) Activities**

**1. INTRODUCTION:** The previously provided Policy Determination No. 3 (PD-3), remains in effect. However, in light of several years experience, additional clarification of a number of points relating to the application of PD-3 and specific interpretation of its provisions appears to be needed.

**2. APPLICABILITY OF PD-3:** PD-3 states "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-3 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-3, "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-3 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-3 applies only to those areas with VS program activities supported by A.I.D. PD-3 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-3 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-3 (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 payment to providers of VS (guidance applicable to providers of VS services is described in para 4. B. below). As stated in PD-3, para C, "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 a 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