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AN EVALUATION OF THE JOHNS HOPKINS
PROGRAM FOR INTERNATIONAL EDUCATION
IN GYNECOLOGY AND OBSTETRICS

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A NOTE ON THE ORGANIZATION OF THIS REPORT

This report is divided into four parts. Part I is an introduction to the evaluation. It contains a brief description of the team's qualifications, the objectives of the evaluation, and the methodology for the evaluation. Part II contains the evaluations of selected JHPIEGO programs in each country. These are presented by region (Latin America, Asia, and the Middle East). A separate chapter is devoted to each country the team visited. Where appropriate, additional explanatory or illustrative material is appended to each chapter.

Part III is an overview of JHPIEGO activities. In this section the team offers its observations of the program's strengths and weaknesses; presents its conclusions and recommendations for activities in the field and in Baltimore, Maryland; discusses the cost-efficiency of the university's efforts; and proposes activities for the future. Part IV contains the appendices to this report.

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ABBREVIATIONS

AAGL	American Association of Gynecologists and Laparoscopists
APHA	American Public Health Association
ANM	Auxiliary Nurse-Midwife
AVS	Association for Voluntary Sterilization
BENFAM	Brazilian Society for Family Planning (Affiliate of IPPF)
CDC	Centers for Disease Control (Atlanta, Georgia)
CPAIMC	Brazilian Family Planning Training and Development Center
CT	Clinical Training
DTEC	Central Coordinating Agency for Family Planning in Thailand
FCC	Fertility Care Center
FP	Family Planning
FPIA	Family Planning International Assistance
GOT	Government of Tunisia
ICARPAL	International Committee for Applied Research in Population/ Latin America
IEC	Information, Education, Communication
IFRP	International Fertility Research Program
IPAVS	International Project of the Association for Voluntary Sterilization
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
LDC	Less Developed Country
MCH	Maternal Child Health
MOH	Ministry of Health

MOPH	Ministry of Public Health
NFPP	National Family Planning Program (Thailand)
NTC	National Training Center
PAHO	Pan American Health Organization
PROFAMILIA	Colombian Association for Family Welfare
OB/GYN	Obstetrics/Gynecology
ONPFP	National Office of Family Planning and Population (Tunisia)
RAM	Repair and Maintenance
REHEP	Reproductive Health Education Program
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development

Part One

INTRODUCTION TO THE EVALUATION

INTRODUCTION TO THE EVALUATION

The United States Agency for International Development (USAID) requested the American Public Health Association (APHA) to evaluate the key aspects of the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO). The APHA selected four health professionals for the evaluation team. The team was unique, for each of its members has been actively involved in the administration of reproductive health services, as well as teaching and training, and each has the clinical and technical background required to provide family planning (FP) services. These are important qualifications, given the team's specific mandate to assess the evolution of this university-based training and education program in light of the perceived needs of less developed countries (LDCs).

Not once in JHPIEGO's seven-year history had an independent evaluation of the program been made overseas, although the U.S. Government audited the distribution and use of endoscopic equipment. (This comprehensive audit lasted almost two years.) Also, in 1976, Drs. Burnhill and Moulding reviewed JHPIEGO. The intent of the AID/APHA evaluation team was neither to duplicate the earlier efforts nor to raise issues which appear to have been satisfactorily resolved. Furthermore, the team, as well as AID officials, recognized that in three weeks it would not be able to assess every aspect of JHPIEGO's operations in the United States and abroad.

The team's focus was, therefore, programmatic. Among the questions the team hoped to answer were the following:

- How effectively is JHPIEGO fulfilling its mandate to provide international training and education in reproductive health?
- How effective are the Johns Hopkins University support systems?
- How relevant is the didactic and practical training?
- How efficiently is the transition from U.S.-based training to in-country training progressing?

The team was aware of JHPIEGO's earlier emphasis on training to provide therapeutic and diagnostic surgical services, and it comments on the appropriateness of this particular aspect of training in this report.

Perhaps the greatest challenge for the team was to try to anticipate JHPIEGO's future course. Clearly, AID wanted a summary of the team's views on the evolution of JHPIEGO activities over the next five years. To fulfill this request, the team had to try to determine the future objectives of the

host countries while simultaneously evaluating the program's strengths and its philosophy toward training.

A one-day briefing was held with staff of the AID Office of Population, in Rosslyn, Virginia. The team met with Dr. Stephen Joseph, deputy administrator for the Development Support Bureau, AID; Dr. Joseph Speidel, acting director of the Office of Population; and Dr. Andrew Wiley, project monitor of JHPIEGO. Dr. Wiley, who has direct responsibility for monitoring the JHPIEGO grant, was particularly helpful in identifying areas of activity that are of the highest priority to AID. In addition, the team met with representatives of the Training Division, the Family Planning Services Division, the Research Division of the Office of Population, and the Contract Office. Members of the regional divisions and regional bureaus offered their own perspectives on the broader population picture for each assigned country within a regional framework.

The countries which AID selected for evaluation appeared to be appropriate. Among them were Colombia, where JHPIEGO's largest established training project is located, and Brazil, where the activities of incorporated programs (e.g., the Santa Maria project) are just beginning. In all, the team evaluated seven programs in six countries. The team visited JHPIEGO-supported activities that:

- directly involve ministers of health or staff of family planning programs;
- directly support university-sponsored training;
- initiate training via private institutions;
- establish regional training centers;
- involve national family planning programs; and
- provide equipment maintenance facilities.

A review of these international initiatives, and of JHPIEGO's training activities in the United States, was presented during the team's two-day orientation at JHPIEGO's offices in Baltimore, Maryland. The team discussed its evaluations with Dr. Theodore King, president of the JHPIEGO Corporation; Dr. Ronald Burkman, director of JHPIEGO; and Dr. Ronald Magarick, director of JHPIEGO's Program Support Division.

The evaluation team met for two days with regional officers and members of the training and education units of JHPIEGO. These sessions were intense and fruitful. It was agreed that the notes on these sessions would be

reviewed only after the overseas training sites had been visited. The team recognized that, no matter how efficient the JHPIEGO operation might appear to be in Baltimore, if it does not adequately meet the needs of the LDC grantees, its structure and function would have to be modified.

The team took a field-oriented approach. It sought first to examine on-site individual overseas projects and then to determine the efficiency of the systems JHPIEGO has developed. It tried, wherever possible, to meet with the U.S. population officer and with staff of other grantee organizations supported by USAID funds. Where appropriate, information was sought from host government officials. The team was interested particularly in those officials' perspectives on JHPIEGO activities within the broader context of national health objectives. The team's recommendations are based on a composite picture of the Johns Hopkins program. Many of the suggestions for specific in-country programs come directly from the subgrantees themselves.

Part Two

EVALUATIONS OF JHPIEGO PROGRAMS
(By Region and Country)

LATIN AMERICA

I. AN EVALUATION OF THE BRAZILIAN FAMILY PLANNING
TRAINING AND DEVELOPMENT CENTER

I. AN EVALUATION OF THE BRAZILIAN FAMILY PLANNING TRAINING AND DEVELOPMENT CENTER

The Brazilian Family Planning Training and Development Center (CPAIME), in Rio de Janeiro, was visited on October 30-31, 1980, the last two days of the center's first year of operation under JHPIEGO. The evaluators visited also the headquarters of the subgrantee, located in Francisco de Assis Hospital. Because 63 percent of Brazil's population is urban-based, the program is appropriately located in a section of a large city where reproductive health needs are great. During the two days, meetings were held with Dr. Helio Aguinaga, project director; Dr. Leslie Scofield, project coordinator; Dr. J. Carlos L. Pinheiro, medical director; and other members of the staff (see attached list of contacts).

In-Country Program Development

JHPIEGO and CPAIME concluded a subgrant agreement with JHPIEGO/Baltimore on November 7, 1979, which called for the development of a capability in Brazil for training in endoscopy and surgical techniques. Surgical methods of family planning are not well established in Brazil, and CPAIME, with the cooperation of JHPIEGO, is trying to expand this activity by training and mobilizing various personnel in public service institutions.

JHPIEGO selected well in designating CPAIME as the in-country and international training site. The project director and coordinator are highly motivated, committed individuals who are deeply concerned about Brazil's future and willing to work full time to improve family planning and service delivery. Dr. Helio Aguinaga is unique in that he gave up his lucrative full-time practice when the university changed sites. He continues to work almost entirely without fee for the program.

CPAIME in the past year surpassed its objectives, which were:

- To provide didactic and clinical practice for 27 physicians, 9 nurses, and 9 anesthetists;
- To provide field training for the 25 institutions representing the 27 physicians who were trained;
- To establish and manage equipment maintenance activities; and
- To assist in establishing in-country clinical training centers.

Ten clinical practice centers were activated and are functioning.

All training projections, including the number of trainees, the number of endoscopic procedures, and the number of follow-up field visits, were met. Furthermore, there was a sizable surplus in the budget. The program trained a number of foreign physicians, especially from Africa, with no additional remuneration from JHPIEGO.

The program has been somewhat hampered by JHPIEGO/Baltimore's handling of financial matters. For example:

- Because of a delay in the receipt of funds, the director had to use personal funds until the money from JHPIEGO arrived.
- CPAIMC requested but did not receive guidance on the expenditure of funds carried over from last year's budget.
- CPAIMC requested but did not receive a three-month advance in funds to cover start-up costs for training programs. (Hotels, for example, require deposits well in advance of the program.)

The evaluators must limit their comments on JHPIEGO's involvement in CPAIMC activities for two important reasons. One, the population officer of the U.S. Embassy, Samuel Taylor, was unable to come to Rio from Brasilia. Thus, the evaluators could not get his views on the role CPAIMC might play in the total Brazilian context. Two, only two and a half days were scheduled for meetings. There was not enough time to interview other groups working in family planning. Among these would be BENFAM, the IPPF affiliate, and the university programs that offer family planning training.

Despite these constraints, the team believes that it can comment appropriately on JHPIEGO's relationship with CPAIMC and also make some observations on the organization's activities as they relate to the host country's needs.

The CPAIMC Program in Relation to Postgraduate Reproductive Health Training for Physicians and Nurses

Physician training in both didactic and clinical practice is being accomplished. Trainers are being trained in the 12 clinical practice centers. Dr. Scofield indicated that, in his opinion, Brazil will need approximately 300 endoscopy centers to meet the country's training needs.

CPAIMC training is unique, for it makes use of the team concept. This team approach is a useful model for training in other countries. Physicians, anesthetists, and surgical nurses are brought together for a one-week course

combining clinical and didactic training. The clinical practice for physicians includes an additional day of training because the centers elected to schedule the first year.

Vasectomy has not been identified as a major focus for family planning activities in Brazil, but, as the team learned, a physician in Sao Paulo has begun an active vasectomy program for which funding from the Association for Voluntary Sterilization (AVS) is pending. The team recommends that the grantee consider incorporating vasectomy training into CPAIMC training. This would enable CPAIMC to provide vasectomy on request and to direct increased attention to this important component of family planning services.

CPAIMC's Relationships with the Ministry of Health and Other Government Agencies

CPAIMC is a private program. It does not have a formal relationship with the Ministry of Health or with other government bodies. CPAIMC does have an informal and satisfactory relationship with the MOH, but it tries to maintain a low profile because family planning in general and voluntary sterilization in particular are sensitive issues in Brazil.

The CPAIMC Program in Relation to Priorities and Interests of the USAID Mission and the U.S. Embassy

The team was unable to get a firsthand report from the population officer on CPAIMC's relationship with the U.S. Embassy. It is known, however, that JHPIEGO is a priority project and that the population officer works closely with JHPIEGO projects. This relationship is appropriate, the team believes; the efforts closely parallel activities suggested in the Brazil Population Strategy Statement (October 1979).

Coordination with Other AID-Funded Population Programs in Brazil

"JHPIEGO is AVS and AVS is JHPIEGO." This statement was made to the team to highlight the excellent coordination and favorable association between the two organizations. According to Dr. Scofield, neither program can exist without the other; AVS covers the overhead costs of providing voluntary sterilization and JHPIEGO covers the costs of training. In addition, such organizations as the Pathfinder Fund, the United Nations Fund for Population Activities (UNFPA), and Family Planning International Assistance (FPIA) provide support for other family planning (FP) components of this project.

There do seem to be differences in the philosophy of BENFAM, the IPPF affiliate, and CPAIMC. The team recognizes, however, that each organization makes an important contribution to family planning efforts in Brazil. JHPIEGO/Baltimore should try to assess the individual and unique roles of each organization in fulfilling the country's family planning training needs.

Maintenance and Use of Endoscopic Equipment

The endoscopic equipment which Brazil receives from JHPIEGO is well maintained. CPAIMC has trained two young technicians who provide preventive maintenance at least twice a year to every center which has endoscopic equipment.

An adequate supply of spare parts and tubal rings is available. According to CPAIMC staff, major problems with equipment are rare. The staff use specific techniques which, they believe, prevent damage to the equipment. For example, they apply liquid silicone to the instrument weekly and prevent metal parts from coming into direct contact with each other. They willingly share these helpful hints with users. Ultraviolet light is also used, with excellent results, to sterilize equipment. (This technique has been used extensively in PROFAMILIA clinics in Colombia.)

Endoscopic equipment seems to be used effectively. A sufficient supply of equipment is available for qualified trainees. In addition to overseeing and monitoring the use of endoscopic equipment, CPAIMC staff provide to training centers technical assistance in administration, recordkeeping, and data collection.

Provision of Other Equipment and Supplies

CPAIMC indicated that there is a lack of training materials in Portuguese and requested that materials be translated. It requested that some of the Taylor slides, the Physician's Handbook (a publication of the IPPF), and the dialogue in the endoscopy film be translated into Portuguese. To date, this request has not been fulfilled. Furthermore, JHPIEGO/Baltimore has not informed program staff of the availability of educational materials, nor has it queried them to determine what training materials should be provided.

Quality training is dependent on well prepared graphic, audiovisual, and didactic materials. The Information and Education Division of JHPIEGO should respond to CPAIMC's requests for translations of teaching materials for in-country training programs.

Appropriateness of Equipment and Effectiveness of Delivery System

CPAIME is allowed to import, duty free, materials shipped by air. This gives the grantee a significant advantage in fulfilling its program objectives.

Technical and Medical Aspects of the CPAIME Training Program

The CPAIME program performs 80 voluntary sterilization procedures each week (40 a day for 2 days). Thus, during the training program, trainees receive sufficient clinical practice using the laparoscope. However, because they also receive laproscators, the trainees should have an opportunity for clinical practice with this model as well. The team recommends that CPAIME increase the emphasis on minilaparotomies to better balance the various sterilization procedures. A demonstration of tubal rings revealed that the suggested technique was not being followed (i.e., fingers, and not the tubal guide, were used to load the ring).

The Long-Range Effect of U.S.-Based Training

The concept of training the trainers is working. CPAIME has established 12 clinical practice centers around the country. It monitors and obtains data from each center and expects that the number of endoscopic procedures performed will increase geometrically as the training programs become entrenched and as each center conducts more training. The coordinator of CPAIME feels that he and his staff have a motivating effect on these centers and that by working with them they are able to increase the staff's enthusiasm for family health.

This success has been marred, according to CPAIME, because Johns Hopkins admitted an inappropriate candidate to the endoscopy program in Baltimore. This person was not an obstetrician-gynecologist but a coroner and, after his training, he was refused permission by the hospital in his area to install laparoscopic equipment. The physicians in the hospital were angered that he had received training at Johns Hopkins and brought the matter to the attention of the National Medical Society, which subsequently complained to CPAIME. This disturbance created political difficulties for the CPAIME program.

CPAIME is the key JHPIEGO training facility in Brazil, and it is used to train other non-Brazilians, particularly Africans. However, its advice on the selection of trainees for U.S.-based JHPIEGO training is rarely sought. This matter is compounded by the fact that CPAIME is responsible for clearing through customs endoscopic equipment and other commodities.

The unilateral selection of candidates by JHPIEGO/Baltimore can have an adverse effect on the in-country program, as the above example shows. The team recommends that CPAIMC be involved in the selection of candidates, since it is responsible for working with these individuals and for providing equipment maintenance and program support. CPAIMC should not be asked to install laparoscopic units unless the trainees are known to the training institution and are qualified to perform voluntary sterilization procedures.

CPAIMC requested that the name Johns Hopkins be noted on the certificates physicians receive upon completion of in-country training. It is believed that this would enhance the status of the training program.

CPAIMC appears to be in a position to train professionals in all aspects of family planning services, although some aspects of training in the broader issues of reproductive health do not seem to be strong. Stateside training for Brazilians should, therefore, be limited almost exclusively to specialty training or, on occasion, to the training of a few key individuals who might strengthen the focus on family planning at the regional or national level.

CPAIMC's Role in Supporting and Monitoring the In-Country Training Program

The in-country program appears to be effectively supported and monitored. The CPAIMC coordinator and his staff have established a follow-up system, and reports are solicited regularly. Reporting forms, which are sent from Baltimore, are needed in the language of the country for physicians who do not understand English. It was discovered that one physician never returns his forms simply because he cannot read English.

CPAIMC does not provide abortion services, and there appears to be no conflict with AID guidelines in this area. The consent form for voluntary sterilization is adequate and in accordance with the guidelines specified in AID Policy Determination No. 70 (see attached copy of a form in Portuguese). Also, because voluntary sterilization is a sensitive issue, CPAIMC is extremely cautious about approving candidates for the procedure. A candidate does not receive final approval until he has been screened by several physicians, a nurse, and sometimes a social worker.

The CPAIMC Program in Relation To Reproductive Health Training

At this time, CPAIMC is primarily meeting the needs for training in endoscopy, and not the broad-based approach of reproductive health. CPAIMC is not affiliated with any university. Consequently, training in reproductive

health for medical and nursing students has not been possible and formal relationships with the medical community have not been strong. The program has no academic relationship with any school of nursing. As nursing is a relatively underdeveloped profession in Brazil, there are more physicians than nurses in the country.

The consultants recommend that CPAIMC attempt to develop relationships with the heads of obstetric and gynecology departments to facilitate practical training of residents, interns, and nursing staff in reproductive health concepts. This approach would complement the REHEP* centers throughout Brazil, which are being funded separately by JHPIEGO/Baltimore. Additional funding would be needed to develop such training efforts.

Acceptability and Future Opportunities

One hundred doctors have been registered and are waiting to take CPAIMC's training program. This attests to CPAIMC's reputation and acceptability throughout the country. There is in this program more flexibility to obtain candidates for laparoscopy than would be possible in a university-based program. Future opportunities to continue training programs and to establish new training centers appear to be excellent. However, it is unlikely that Brazil will receive either bilateral AID funds or funds from the International Project of the Association for Voluntary Sterilization (IPAVS) after five years. This lack of funding has quite serious implications for service delivery. The CPAIMC program stresses the importance of funds and the linkage of service delivery and training. As the evaluators noted, each component depends on the other.

The team recommends that JHPIEGO/Baltimore continue to fund this program until training needs are met. This will require the establishment of more training centers. Sterilization plays an important role in Brazil, as IUDs are illegal and oral contraceptives have been severely criticized because of side effects. Although there has been no massive campaign against sterilization in the country, the government cannot actively support or sponsor endoscopic programs at this time. Thus, CPAIMC provides a much needed service in Brazil.

At this time, the Social Security system does not fund family planning activities and reimburses tubal ligations only if they are done for medical indications. In fact, Brazilian doctors are notorious for doing cesarean sections (C-sections) so that patients can be sterilized following delivery. It should be noted that, although the national rate for C-sections is 30-40

* Reproductive Health Education Program.

percent, in some maternity hospitals where endoscopy has been introduced, the C-section rate has been cut in half.

JHPIEGO should be responsive to the subgrantee's interest in further publicizing the inordinately high cesarean rate in Brazil. It should consider providing funds to convene a national meeting of interested professionals to discuss this technique, which poses serious risks to maternal and child health in Brazil.

CPAIME could be considered a major center for training in all aspects of reproductive health. This would be in keeping with JHPIEGO's future directions. To accomplish this goal, however, JHPIEGO would have to provide additional on-site technical assistance, thoroughly review curricula, and approve CPAIME as a formal gynecological service.

LIST OF CONTACTS IN RIO DE JANEIRO, BRAZIL

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Dr. Leslie Scofield, Project Coordinator

Dr. José Carlos Lima Pinheiro, Training Director

Dr. Antonio Carlos Ribeiro dos Santos, Clinical Instructor

Dr. Otogibison Pereira da Silva, Surgeon; Assistant Instructor

Ana Maria Albino Rodrigues, R.N., Nurse-Instructor

Donna Greve Scofield, R.N., B.S., NED; Administrative Assistant

Maria Madalena Tornovsky, Administrative Assistant, Operations

Marco Aurélio Vianna Nunes, Maintenance Technician

João Luiz Pirassinunga, Assistant Maintenance Technician

Karen Johnson Lassner, M.P.H., Information and Evaluation

Best Available Document

25

CENTRO DE PESQUISA
ASSISTÊNCIA INTEGRADA À MULHER E À CRIANÇA
C P A I M C

AÇÃO E AUTORIZAÇÃO PARA ESTERILIZAÇÃO

Data de início do Programa: ___/___/___ Matrícula nº _____

EU, _____
(NOME DA CLIENTE)

voluntariamente solicito a esterilização por intervenção cirúrgica e afirmo que foi devidamente explicado e que estou entendendo o seguinte:

1. Métodos anticoncepcionais temporários estão disponíveis e foram oferecidos;
2. Esterilização é uma intervenção cirúrgica que foi explicada pelo médico assistente;
3. Esta cirurgia envolve desconfortos e riscos como qualquer outra cirurgia;
4. Normalmente a intervenção cirúrgica elimina a possibilidade de conceber mas, a esterilidade não é garantida;
5. A intervenção é irreversível;
6. Eu posso decidir a não submeter-me à esterilização, sem me ser recusado qualquer outro serviço ou benefício do Programa.

DATA ___/___/___

ASSINATURA OU MARCA DA PACIENTE

DATA ___/___/___

ASSINATURA DO MEDICO

DATA ___/___/___

ASSINATURA DA TESTEMUNHA

Indicações:

Idade ___ Gesta ___ Para ___ Abortos ___ Provocados ___ Exp. ___
Filhos
Vivos

II. AN EVALUATION OF THE SANTA MARIA
REPRODUCTIVE HEALTH EDUCATION PROGRAM

II. AN EVALUATION OF THE SANTA MARIA REPRODUCTIVE HEALTH EDUCATION PROGRAM

Introduction

In an attempt to incorporate reproductive health into the curricula of medical and nursing schools, JHPIEGO, in collaboration with a number of key Brazilian medical institutions, developed the Reproductive Health Education Program (REHEP). (See attached document.) For this program, which expands the existing curriculum to include a minimum of 120 hours of theoretical and practical exercises in reproductive health, JHPIEGO provides tuition-based support and assistance in developing curricula, educational materials, and models. The program became operational in August 1980. It is located in the Santa Maria Institute of Reproductive Health, University of Santa Maria, Rio Grande do Sul, Brazil.

On November 2-3, 1980, the consultants visited Dr. Ronald Bossemeyer, program director and professor and chairperson of the Department of Gynecology and Obstetrics at the Medical School of the Health Sciences Center, and members of his staff, as well as the head of the University of Santa Maria School of Nursing, Leopoldina Viera da Silva, to discuss the outcome of the first JHPIEGO-funded REHEP.

REHEP represents a new and significant approach in funding. In this move to incorporate the broader concepts of reproductive health into the curriculum for undergraduate medical and nursing students, the aim is to educate future health professionals in these concepts before graduation. The program director and his staff are to be complimented for incorporating the team concept into this program at its inception.

Among those involved in REHEP are an obstetrician-gynecologist, a pediatrician-community health specialist, clinical nursing faculty, a neonatologist, and an anesthesiologist. All classes, small-group discussions, and community visits are interprofessional. This approach gives medical and nursing students an opportunity to experience the new program together.

The Santa Maria Institute of Reproductive Health will be a postgraduate training center in both family planning services and endoscopic and surgical techniques. Dr. Chagas, head of the Family Planning Clinic, told the evaluators that family planning services, and especially sterilization procedures, are in great demand. An effort is being made to link CPAIMC to the institute (Dr. Bossemeyer is trying to locate a site for the training center). Eventually, the Santa Maria Institute of Reproductive Health will have a fully functioning training unit. This unit will nicely complement the reproductive health education component.

Description of the Program

A four-week, 120-hour course was presented from August 25 to September 20, 1980. It was attended by 100 medical and nursing students and several clinical nursing instructors (see attached program). The didactic lectures covered basic materials important to human reproductive health, including preconceptional and interconceptional care, gynecology, pediatrics, and demography. Nutrition and public health concepts that can contribute to improved family and community health were singled out for special emphasis. Clinical management seminars covering 40 hours of training for groups of 10-12 students supplemented and reinforced the didactic presentations. The clinical management seminars bridged the gap between the didactic instruction and the clinical practice tutorial experience. Group discussions, case presentations, technical demonstrations, and exercises in clinical skills important in reproductive health care were emphasized. JHPIEGO provided training models which had not yet been received. (On the day of the consultants' visit, Dr. Bossemeyer received word that a large package, presumably the models, had arrived from Baltimore.)

JHPIEGO developed case-study presentations for reproductive health clinical management sessions, although Dr. Bossemeyer stated that the institute prefers to bring its own patients before the students for a discussion of case studies. Although most of the teaching materials which Johns Hopkins supplies are not in Portuguese, Dr. Bossemeyer said that this was not a problem because students usually learn from textbooks written in Spanish or English. He did not feel funds were needed to translate materials into Portuguese.

In the clinical practice tutorials, trainees actively participated in the application of skills important in the management and prevention of prenatal, postnatal, and interconceptional reproductive health problems. Satellite clinical facilities were used (one was visited by the team) to further reinforce, by practice, the didactic presentations and seminars. In implementing the clinical practice element, REHEP involved both the institution and the trainees in expanded community service outreach activities in reproductive health. JHPIEGO helped train key nursing and medical faculty to organize and execute this phase of the program. Two faculty nurses spent one month at PROFAMILIA, in Bogota, Colombia, before REHEP was started.

REHEP was projected to reach 150 students in two sessions. In fact, enrollment was exceeded, and the first session had to be cut off at 110 students. The first session took place during a student strike and while many student meetings were being held; nevertheless, more than 70 percent of the students attended. Make-up sessions are being held for those who missed class during the strike. The course is at this time offered as an elective for fifth-year medical students, but it is required for nursing students who must rotate on the obstetrics/pediatrics service in their sixth semester (at the end of the third year of the three-and-one-half year program).

Dr. Bossemeyer is concerned about sensitivity to the various topics, but has found students to be open and direct in asking questions about contraception, abortion, and sterilization, and very receptive to the course content. Dr. Bossemeyer indicated that he and his staff are qualified to teach all the topics in the REHEP curriculum, except human sexuality. The team recommends that several basic texts in human sexuality which provide medical, nursing, and sociological perspectives be added to the Institutional Educational Package for REHEP. Texts for similar programs should be provided on request.

The Santa Maria Reproductive Health Education Program has been received enthusiastically by medical and nursing students. Dr. Bossemeyer predicts that courses in reproductive health will eventually be integrated into the curriculum of the University of Santa Maria Medical School. If this occurs, further support from JHPIEGO after the grant ends would be unnecessary. (Dr. Bossemeyer indicated that past efforts to obtain funds for family planning activities have been unsuccessful, and he expressed his gratefulness to JHPIEGO for its financial support.)

The team recommends that the University of Santa Maria Medical School contribute an increasing proportion of funds to the program over the next two years to accelerate the incorporation of REHEP into the medical school curriculum. This action would reduce considerably the economic strain at the end of the third year, thus smoothing the transition to a self-supporting program.

To spur the integration of courses in reproductive health into medical school curricula throughout Brazil, Dr. Bossemeyer will convene a meeting in April 1981 to further discuss this topic. The meeting will be funded by The Pathfinder Fund and will be attended by 70 medical school educators. The team recommends that representatives from JHPIEGO/Baltimore be invited to attend the meeting and participate in the lectures and discussions.

Observations and Conclusions

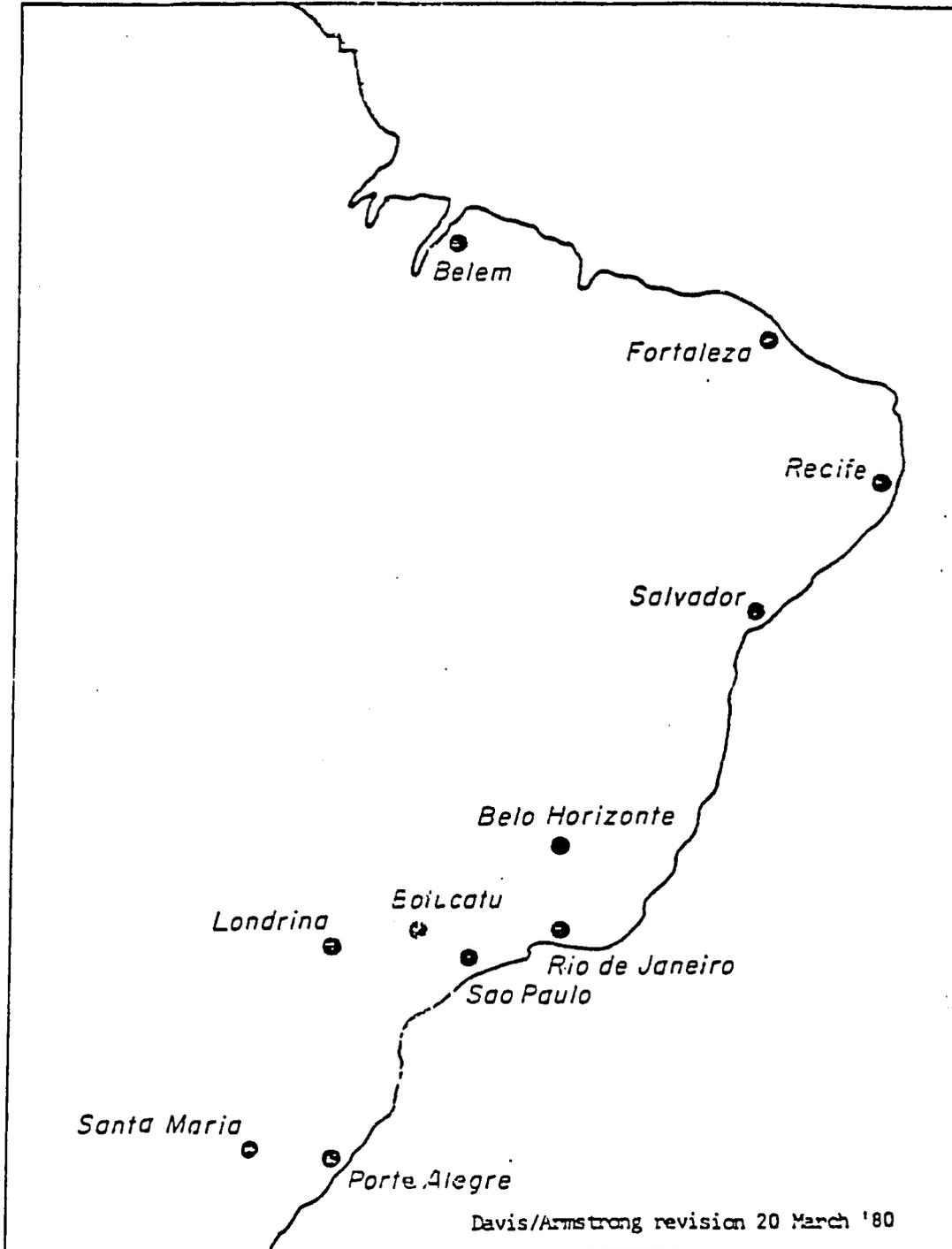
Johns Hopkins has indicated that reproductive health is one of its major interests. The REHEP program should be monitored closely, for it represents JHPIEGO's intent to move in new directions. It is, furthermore, a model approach to funding activities in countries where there are opportunities to integrate the study of reproductive health into the curricula of medical and nursing schools.

The faculties of the University of Santa Maria medical and nursing schools firmly support the concept of reproductive health education, and they plan to continue their efforts to incorporate this material into the curricula. The REHEP program is in the very capable hands of Dr. Bossemeyer

and his staff, and Mrs. Leopoldina Viera da Silva, head of the University of Santa Maria School of Nursing. It is most exciting to observe the excellent collegial relationship between the physicians and nurses involved in this interprofessional program.

JHPIEGO's support of the REHEP concept will have a ripple effect, stimulating Brazilian medical and nursing schools to train practitioners in the clinical and didactic content of reproductive health. This training eventually will lead to the development of programs that provide basic family planning services, including voluntary sterilization and treatment of infertility.

JHPIEGO/Brazil REHEP-CT* PLAN
KEY STATE INSTITUTIONS IN DEVELOPMENT, 1979-1980



* Latin Region Reproductive Health Education Program
Clinical Training
(Santa Maria tuition-based institutional development prototype
proposals linked with clinical training proposals for endoscopy
and surgical techniques)

CURSO DE SAUDE REPRODUTIVA PROGRAMA

1ª SEMANA - I CURSO SAÚDE REPRODUTIVA

DIA/HORA	2º F. 25/8	3º F. 26/8	4º F. 27/8	5º F. 28/8	6º F. 29/8
20,00 hs	ABERTURA	Nutrição da Criança Dr. Frederico	Introdução ao Planejamento Familiar Dr. Ronald	Determinação do Estado nutricional da criança Dr. Frederico	Implicações do crescimento populacional Dr. Ronald
21,30 hs	Anatomia e Fisiologia do aparelho genital masculino e feminino Dr. Ronald Dr. Seligman		DISCUSSÃO	DISCUSSÃO	DISCUSSÃO
21,45 hs	PRÉ-TESTE	IDEM DISCUSSÃO	Panorama populacional do Brasil e do Mundo Dr. Ronald	Mortalidade infantil Dr. Frederico	Dispositivo intra-uterino Dr. Chagas
23,00 hs			DISCUSSÃO	DISCUSSÃO Dr. Frederico D. Cláudia	DISCUSSÃO

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I CURSO DE SAÚDE REPRODUTIVA - 2ª SEMANA

DATA/HORA	2ª F. 1/9	3ª F. 2/9	4ª F. 3/9	5ª F. 4/9	6ª F. 5/9
20,00 ha	Tratamento pré-Natal. Objetivos e condutas	Doenças sexualmente transmissíveis	Gestação de alto risco	Avaliação e primeiros cuidados com o recém nascido	Métodos tradicionais de planejamento familiar: comportamentais e de barreira
21,30 ha	Dr. Bertoldo	Dr. Pedro Fº	Dr. Antônio	Dr. Oldemar	Dr. Ronaldo
	DISCUSSÃO	DISCUSSÃO			
21,45 ha	Conceito de risco reprodutivo; gestação de alto risco	Fatores de esterilidade feminina e seu tratamento	DISCUSSÃO	DISCUSSÃO	DISCUSSÃO
23,00 ha	Dr. Antônio	Dr. Dinato	Dr. Antônio	Dr. Oldemar	Dr. Ronaldo
	DISCUSSÃO	DISCUSSÃO			

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ANEXO 3 - VALE DO SAUDE REPRODUTIVA - 3ª SEMANA

DATA/HORA	2ª F. 8/9	3ª F. 9/9	4ª F. 10/9	5ª F. 11/9	6ª F. 12/9
20:00 hs	Encefalopatia e acromegalia em relação ao crescimento	Doenças gastrointestinais e biologia oral na criança	Prevenção da "Gravidez inadequada"	Imunizações na criança	Contracepção hormonal
21:30 hs	Dr. Cláudio	Dr. Milton	Dr. Ronald	Dr. Frederico	Dr. Ronald
	DISCUSSÃO		DISCUSSÃO		
21:45 hs	Organização e fisiologia do sistema urinário		Controle do eixo neuroendócrino		Problemas de fertilidade nos extremos da vida
23:00 hs	Dr. Cláudio	DISCUSSÃO	Dr. Ronald Dr. Helton	DISCUSSÃO Dr. Frederico	Dr. Ronald
	DISCUSSÃO	Dr. Sérgio	DISCUSSÃO		DISCUSSÃO

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I CURSO DE SAÚDE REPRODUTIVA - 4ª SEMANA

DATA/HORA	2ª F. 15/9	3ª F. 16/9	4ª F. 17/9	5ª F. 18/9	6ª F. 19/9	Sabado 20/9
20,00	Neuterilização Masculina	Malformações congênitas	A MANCAR	I Jornada de Perinatologia de Santa Maria. 20,00 hs 22,00 hs	I Jornada de Perinatologia de Santa Maria. 9,30 - 11,30 hs 20,00 - 22,00 hs	I Jornada de Perinatologia de Santa Maria. 9,30-11,30 hs
21,30	Dr. Soligman	Dr. Amaral				
	DISCUSSÃO	DISCUSSÃO				
						ENCERRAMENTO
21,45	Neuterilização Feminina	Papel do Suferente no Planejamento Familiar.	PÓS-TESTE			
23,00	Dr. Chagas	Dr. Leopoldina				
		DISCUSSÃO				

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I.ª JORNADA DE PERINATOLOGIA DE SANTA MARIA

18/19/20 setembro 1980

PROGRAMA

Dia 18/09/80 — 5ª feira — 20,30 horas

Sessão Inaugural

Conferência : «NOVAS BASES PARA A ATENÇÃO AO PARTO E RECEM-NASCIDO NORMAL»

Prof. Raul Bustos — Centro Latinoamericano de Perinatologia — Montevideo - *Uruguai*

Dia 19/09/80 — 6ª feira — 9,30 horas

Conferência : «RACIONALIZAÇÃO NA SEMIOLOGIA DO CASAL ESTERIL»

Prof. Waldemar Diniz Pereira de Carvalho — Presidente da Sociedade Brasileira de Reprodução Humana.

10,30 horas

Conferência : «FATORES REGULADORES DA MATUREZA DO PULMÃO FETAL».

Prof. Raul Bustos.

20,00 horas

Conferência : «AVALIAÇÃO INTRAUTERINA DO CONCEPTO».

Prof. Fernando Monteiro Freitas

21,00 horas

Conferência : «CONDUÇÃO NA TERAPIA RESPIRATORIA NA DOENÇA DA MEMBRANA HIALINA».

Prof. Raul Bustos.

Dia 20/09/80 — Sábado

09,00 horas

Conferência : «AVALIAÇÃO INTRAUTERINA DO CONCEPTO» (continuação).

Prof. Fernando Monteiro Freitas

10,00 horas

Conferência de encerramento : «TRATAMENTO DOS FATORES ENDÓCRINOS DA ESTERILIDADE».

Prof. Waldemar Diniz Pereira de Carvalho.

Coordenação : Prof. Frederico Nussbaumer

Prof. Ronald Bossemeier

PROMOÇÃO : DEPARTAMENTO PEDIATRIA E PUERICULTURA
DEPARTAMENTO DE GINECOLOGIA E OBSTETRICIA

LOCAL : EDIFICIO DA CACISM

INSCRIÇÕES : Secretaria Dpto. Pediatria e Puericultura (Sr. Mariano)
Secretaria Dpto. Ginecologia e Obstetricia (Srta. Idalice)
Hospital Universitário Setor Centro
Rua Floriano Peixoto, 1750 — 97.100 — Santa Maria.

Médico Cr\$ 500,00

Residente Cr\$ 200,00

Estudantes inscritos no curso de Reprodução humana Cr\$ 100,00

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III. AN EVALUATION OF PROGRAMS IN COLOMBIA

III. AN EVALUATION OF PROGRAMS IN COLOMBIA

Program Summary

Colombia is Latin America's fourth most densely populated country, with 27 million people and an annual growth rate of 1.9 percent. The government family planning program is located in the Maternal and Child Health Department in the Ministry of Public Health (MOPH). The largest provider of family planning services in the private sector is PROFAMILIA, the Colombian Association for Family Welfare.

At the request of the Colombian Ministry of Health, JHPIEGO developed and implemented an in-country training program in endoscopic sterilization. It provided assistance to PROFAMILIA to train teams of MOH physicians and nurses from the regional hospitals.

JHPIEGO provided equipment to the MOH for distribution to the trainees. It also helped set up a repair and maintenance (RAM) center for endoscopic equipment. This center will be supported by the MOH. JHPIEGO and PROFAMILIA have signed an agreement to provide clinical practice and training in endoscopic sterilization to foreign doctors (mostly from Latin America) who have already completed didactic training at JHPIEGO/Baltimore.

JHPIEGO has prepared with the MOH and PROFAMILIA a proposal to implement the second phase of a program to train teams of government physicians and nurses. The emphasis in the second phase will be on minilaparotomy. The proposal is pending approval.

JHPIEGO awards scholarships to appropriate candidates from Colombia to attend training courses in Baltimore in microsurgery, infertility, academic skills, and administration.

Achievements

Because of political and religious sensitivities in Colombia, JHPIEGO is the most acceptable external FP organization, as it is university-based and viewed as an educational rather than a service organization. By directly involving the government in its work, JHPIEGO has been able to legitimize the voluntary sterilization program in Colombia. This has been its most significant achievement to date, and, as a consequence, other organizations, including those in the private sector, have been able to expand their efforts to provide voluntary sterilization services.

JHPIEGO's role is particularly important, and it is of interest to the Office of Population, USAID/Colombia. According to the population officer, JHPIEGO has been especially sensitive to the political situation and it

promptly responded to the request from the MOH, initiating training in May 1979, only a few months after the request was received. JHPIEGO speedily transferred equipment to the MOH through the Pan American Health Organization (PAHO); thus, equipment was available when training began. As of September 1980, 119 teams of government physicians and nurses had been successfully trained and provided with equipment. Furthermore, the MOH has assumed responsibility for the RAM center and subsidizes sterilization procedures. It is reasonable to assume that, if it were not for JHPIEGO, the MOH would not have an official sterilization program.

JHPIEGO must be highly commended for selecting appropriate subgrantees and personnel, and for bringing the public and private sectors together. The coordination and cooperation among JHPIEGO, the MOH, and PROFAMILIA are outstanding. The skills and capabilities of these agencies have been successfully blended. The population officer holds a monthly meeting with MOH and PROFAMILIA, and JHPIEGO is immediately informed of their concerns and action. JHPIEGO does not appear to overlap or duplicate the work of any other organization.

JHPIEGO has acted wisely in selecting PROFAMILIA to provide clinical training and practice to doctors who have completed the didactic course in Baltimore. The quality of the training has been outstanding, and the trainees invariably perform many more procedures than are required. Twenty-seven Latin American doctors have completed clinical training at PROFAMILIA before returning to their countries.

The future plans of JHPIEGO and the MOH are realistic and practical. The second-year grant places emphasis on expansion to rural areas and minilap training. Sufficient attention is given to supervision, follow-up, and reporting. The staff of JHPIEGO, the MOH, PROFAMILIA, and the Office of Population, USAID/Colombia, enjoy a good working relationship. Indeed, JHPIEGO has instituted a successful program which meets an important need in the country and which has already had a measurable impact.

Training of MOH Teams (Physicians and Nurses)

Teams are selected by the MOH and sent to one of eight of PROFAMILIA's regional training centers. The trainers at each of these centers are highly qualified and experienced physicians. They report to the director of training in Bogota. The course involves six days of didactic and clinical training. Only one or two teams are trained at a time, which means trainees receive direct, personal attention. The didactics are essentially discussions, and not structured lectures, and they are considered to be effective. Only endoscopic sterilization and equipment maintenance are emphasized. All aspects of these topics are covered in detail. Other family planning methods are mentioned but not discussed.

The sterilization procedures are performed most efficiently at the training centers. The trainees not only learn the technique well, but they also have an opportunity to observe the organization of the program. Teaching staff emphasize that the program is voluntary, that it is important to observe the guidelines for selecting women for sterilization and to obtain informed consent. The anesthetist thoroughly trains students in every aspect of local anesthesia, including resuscitation techniques. The training centers are equipped with both laparoscopes and laproscators, but the laparoscope is used most often for training because the visual acuity of the laproscator is inadequate when a teaching scope is attached to it. The trainees receive excellent training and practice and, individually, they perform many more cases than are required. All trainees receive laproscators for use at their respective institutions.

Recommendations

1. The candidates for training should be screened more effectively. Disinterested persons should not be selected, even if an alternative candidate from a particular hospital is not available. Given the rapid turnover of personnel in government services, lower priority should be given to physicians who are expected to leave shortly.
2. The course should be upgraded to include didactic and clinical training in all family planning methods. The management of septic, incomplete abortion should be included in the curriculum, as this is a serious problem. Dr. Daza agrees that such training would be helpful. PROFAMILIA is confident that it can provide this additional training within the same six-day period, if JHPIEGO can provide further support for staff time.
3. Minilap should be made an integral part of endoscopic sterilization training. A minilap kit should be provided routinely to ensure backup, should equipment malfunction. If a physician moved to another institution that has no endoscopic equipment, he would be able to perform minilap procedures.
4. Training in diagnostic laparoscopy should be provided. Each interested physician should receive a set of slides on various pathological conditions as viewed through an endoscope.
5. The trainers should be encouraged to use the laproscator instead of the laparoscope for training. JHPIEGO should

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fund research to improve the visual acuity of the teaching scope, so that physicians can be trained with the equipment that will be used.

6. Selective training in male sterilization should be provided to appropriate personnel. But, because only 1,000 procedures are performed each year in Colombia, this training should not be "pushed" until the unmet demand for female sterilization has been fulfilled.

Educational Materials

JHPIEGO provides adequate educational materials to the training centers, although individual trainees receive only manuals on the laproscator and a book on sterilization. JHPIEGO has been thoughtful in providing all materials in Spanish.

Recommendations

1. The MOH and PROFAMILIA would like to develop their own educational materials, which would be more appropriate for their use. They would like to prepare slide presentations on reproductive health, the use of oral contraceptives, IUD insertion, motivation and informed consent, and administrative procedures. This audiovisual system would be useful for continuing education. They would also like to develop a manual on the importance of sterilization. This manual, which would represent a local point of view, would describe simply the techniques of sterilization.
2. Regional hospitals and participating university hospitals should receive educational materials (including films) for use in training.
3. All ob/gyns who receive endoscopic training should be provided with a set of slides on pathologic conditions as viewed through an endoscope.
4. PROFAMILIA/Bogota would appreciate the donation of a camera, with accessories, to take endoscopic photographs. The photographs would be used to prepare slides.

Follow-up and Reporting

The PROFAMILIA consultants visit sites and assist trainees in installing and using equipment. Each of the centers that performs sterilizations is required to submit a monthly report to the MOH. However, this has not been done, and it is estimated that only 20 percent of the voluntary sterilization procedures are being reported. The MOH reserves the right to recall equipment if it is not used and to reassign it to another center.

The program has been evaluated three times in the last few months. At the request of the MOH, in April 1980, the Centers for Disease Control (CDC) conducted a "quickie" evaluation to determine why procedures were under-reported and to comment on the use of equipment. This study was followed by evaluations by Mr. Bill Bair in May and by Dr. H. Davis in July 1980.

Recommendations

1. The evaluation team strongly endorses all but one of the recommendations of the CDC team (Drs. Spekhard and Oberle).* JHPIEGO should assist the MOH in implementing these recommendations to ensure that equipment is used and procedures are reported. The consultants disagree with the one suggestion to provide large carbon dioxide cylinders because they are difficult to handle and transport. The small cylinders contain enough gas for at least 500 procedures. An additional small cylinder could be provided. The trainees should be advised to check for gas leakage.
2. The MOH has requested that JHPIEGO fund a detailed in-country evaluation of the program with the objective of increasing the program's effectiveness. The evaluation team endorses this request, but advises that JHPIEGO carefully hand-pick the team because this program has had more than its share of evaluations during its brief existence.

Equipment

JHPIEGO promptly provided the equipment, making it available immediately to all physicians who completed their training. However, because of funding

* See attached recommendations.

problems between AID/W and JHPIEGO, the shipment of spare parts was delayed more than six months. Between 15 percent and 20 percent of the laproscopos are non-operational, and this has caused considerable unhappiness among the trainers and trainees. Among the problems with the laproscopos are the following:

- The length is too short, particularly in obese women.
- The handle and ring are too close to the eyepiece.
- The lens frequently becomes foggy.
- The intensity of the light is low and inadequate for training when the teaching scope is attached.
- The mini-light connection on the laproscopos comes out easily. (This is such a frequent problem that technicians are bolting the connection in place.)
- The thumb ring in 80 percent of the laproscopos is broken. Doctors are managing without it.
- The valve on the cannula becomes loose and falls off frequently.

JHPIEGO has sent the MOH 300 minilap kits, of which 125 are incomplete, in most cases, missing the seven instruments that are packed outside the metal box in the carton. These instruments either fall out of the carton during the customs inspection or are stolen. The quality of the instruments is not satisfactory. The joints become loose easily and often rust. The tips of the hemostats often do not align properly.

PROFAMILIA is using ultraviolet light to sterilize equipment and is satisfied with the results. No cases of infection have been reported.

Fewer MOH-trained physicians than expected use the laproscopos. The CDC team has determined the causes for underutilization. In 1979, 5,000 procedures were reported by MOH centers. The projection (after taking into account underreporting) for this year is 12,000.

Recommendations

1. JHPIEGO should take every measure to ensure that spare parts are constantly available and replenished.



2. Admittedly, the problems with the laprocator cannot be rectified immediately, but the MOH and PROFAMILIA deserve a response to their frequent complaints. JHPIEGO should inform them of the action it is taking and seriously consider their problems. The impression in the field is that the comments are being ignored.
3. The minilap kits should be checked for quality and quantity. All instruments should be packed inside the metal case, and not placed in the outer cardboard box.
4. JHPIEGO should support a study (or request a study from the International Fertility Research Program (IFRP)) of the effectiveness of sterilization of equipment using ultraviolet light. If cultures are negative, the technique may be worth sharing with other countries.
5. The CDC's recommendations to increase use of equipment are excellent and are strongly endorsed by the evaluation team.

Repair and Maintenance Center

JHPIEGO assisted the MOH in establishing a central RAM center in Bogota and five subcenters across the country. Eight technicians have been trained. Each is responsible for maintaining equipment at specific hospitals. The MOH provides the place and pays the salaries of the technicians. The technicians have been active in installing the equipment, but they have not been able to provide maintenance services because there are not enough spare parts. Nevertheless, they have been innovative in fixing equipment whenever possible. The RAM centers have ample stocks of tubal rings and washers for cannulas.

Recommendations

1. JHPIEGO should ensure an adequate supply of spare parts.
2. JHPIEGO should send portable tool kits for technicians working at RAM subcenters.

Clinical Practice Centers

Twenty-seven physicians from Latin American countries who completed the didactic course at JHPIEGO/Baltimore have received clinical training and completed a practicum at one of eight PROFAMILIA training centers. PROFAMILIA and JHPIEGO collaborated extremely well on this joint training program, and the physicians benefited from exposure to the theoretical course at Johns Hopkins, a prestigious American university, and from the five and a half days of clinical practice in Colombia. The trainers are highly qualified and experienced, and the trainees have an opportunity to perform many more cases than are required. PROFAMILIA can accommodate 10 trainees at a time at the eight training centers.

JHPIEGO has effectively organized this collaborative effort. It usually gives PROFAMILIA adequate advance notice (at least two or three months) of the arrival of trainees. The major administrative problem is JHPIEGO's delay (three or four months) in reimbursing funds. This delay causes considerable inconvenience to PROFAMILIA because it must advance funds to trainers from its own budget.

Significantly, PROFAMILIA has assumed the responsibility for training Latin American doctors in an effort to assist JHPIEGO, but staff are not at all enthusiastic about this. Apparently, the strain of training new physicians week after week has left the trainers exhausted. The financial reimbursement is neither attractive nor important to them. PROFAMILIA is happy to continue training Colombian doctors; it would prefer not to assume the burden (and risks) of training foreign doctors. PROFAMILIA would like to phase out gradually the clinical practice centers for foreign physicians. It feels that a sufficient number of physicians in other countries (e.g., Brazil) have been trained and that these physicians should not be in a position to train other physicians. PROFAMILIA would like to continue its role as a consultant, to visit sites, and to participate in an exchange program with other countries where physicians are being trained.

Recommendations

1. JHPIEGO should explore the possibility of setting up in-country training centers in other Latin American countries. PROFAMILIA could help establish these centers and offer its services as a consultant.

Courses at JHPIEGO/Baltimore

All the courses continue to be useful and attractive to Colombian doctors. The participants generally feel that too much time is spent on theory; they would like to spend more time in hospitals and clinics. Colombian doctors do not participate in the course for clinicians because in-country training is available. From a political point of view, the microsurgery course is considered to be the most important course. There are two centers equipped to perform sterilization-reversal operations. The MOH estimates that three more such centers are needed.

Recommendations

1. JHPIEGO should notify participants in advance of their acceptance so that they can obtain clearances for leave and travel.
2. JHPIEGO should arrange more visits to hospitals and clinics so that participants can observe the clinical work, even though they may not get to perform any clinical procedures.

Management by JHPIEGO/Baltimore

The major problem with all JHPIEGO activities is the delay in reimbursement. This is causing considerable problems and inconvenience to both the MOH and PROFAMILIA. Funding has been delayed for as long as six months following the submission of bills and receipts. JHPIEGO could do more to share information and decisionmaking with PROFAMILIA and the MOH.

Recommendations

1. JHPIEGO should explore the possibility of setting up a revolving account and advance at least 25 percent of the funds before a project begins. Subsequent reimbursements should be made promptly. JHPIEGO should make every effort to overcome the bottlenecks to funding, because they are causing tremendous problems in the field.
2. JHPIEGO should increase its efforts to share information with field staff. PROFAMILIA collaborates in the clinical training of foreign doctors, and its staff are obviously

interested in any follow-up information. JHPIEGO should send them a copy of the report on the survey of trainees and minutes of meetings convened to discuss the training program. The MOH would like its trainees to receive the JHPIEGO newsletter and would appreciate a new section with profiles of different countries.

3. JHPIEGO should consult with PROFAMILIA and involve it in decisions about its activities.

Opportunities for the Future

JHPIEGO is a highly acceptable organization in Colombia because its major emphasis is on education. It must continue to support and build up the MOH program so that it can effectively take over some of the services which PROFAMILIA now provides. Because of a severe cut in funding, PROFAMILIA will have to gradually decrease its activities and let the MOH take over. Even though Colombia is considered to be a "graduate" country which merits low priority for funding, JHPIEGO should continue its support because Colombia is an important model for other Latin American countries.

Recommendations

1. The second-year subgrant proposal is appropriate and meets an important need in the country. It should be approved and implemented expeditiously.
2. PROFAMILIA has extensive experience in the organization and management of successful health and family planning outreach programs that involve communities. JHPIEGO should provide support to PROFAMILIA so that it can conduct a training course in this subject for administrators and physicians from developing countries. Such a course would be most appropriate for participants from some African countries. In undertaking the task, JHPIEGO would expand its role.
3. The current in-country training program concentrates exclusively on sterilization. In the future, the courses should be upgraded to include other aspects of reproductive health. It would also be worthwhile to include minilap as an integral component of laparoscopic training. PROFAMILIA and the MOH have the capability to conduct a complete course in reproductive health for their own and foreign physicians.

4. A special in-country training course for nurses would meet a very important need. Currently, nurses are trained exclusively in the maintenance and sterilization of laparoscopic equipment. Both the MOH and PROFAMILIA are enthusiastic about conducting a course for nurses in reproductive health. This course would include training in the insertion of IUDs and management of all family planning acceptors.
5. Although in general JHPIEGO does not train private doctors, it should make an exception in Colombia. A significant number of physicians are performing female sterilization in their private practices, and many are using the traditional method, laparotomy. JHPIEGO should offer these physicians an opportunity to receive training in minilap.
6. JHPIEGO should support the efforts of the MOH and PROFAMILIA to launch an educational campaign to inform physicians that minilap does not require hospitalization. Traditionally, it is widely believed that women undergoing minilap must be hospitalized. Laparoscopic sterilization can be performed on outpatients.
7. JHPIEGO should sponsor a two-week training course in reproductive health that includes clinical training in minilap. For residents and younger doctors, this course would serve an important need. It is believed that such a course would be well received.
8. JHPIEGO should make an effort to involve the Social Security hospitals in its programs and to train the hospitals' staff physicians to perform sterilizations. These hospitals now serve 2.5 million members. The significance of this fact should not be underestimated.
9. It is difficult to introduce family planning into the medical curriculum because universities in Colombia are highly politicized. If JHPIEGO succeeds in its efforts at Javeriana University, it may wedge its way into other institutions. JHPIEGO should pursue efforts to assist other universities in developing lectures on reproductive health.

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ASIA

I. AN EVALUATION OF JHPIEGO'S PROGRAM IN THE PHILIPPINES

I. AN EVALUATION OF JHPIEGO'S PROGRAM IN THE PHILIPPINES

The JHPIEGO program in the Philippines differs considerably from programs in other countries. The Philippine program is not university-based, is not a government program, and has received funding from other USAID grantee organizations.

To JHPIEGO's credit, the commitment and talent of one of its early trainees, Dr. Virgilio Oblepías, have been recognized. Indeed, JHPIEGO has taken advantage of Dr. Oblepías's facility and initiative to mount a meaningful program.

Description of the Program

The JHPIEGO project at Mary Johnston Hospital has three components:

- Establishment of a center to maintain the endoscopic equipment that USAID has sent to the Philippines.
- Establishment of a training center for Filipino physicians and nurses in institutions that have laparoscopes.
- Use of the Fertility Care Center (FCC) as a regional center for practical training in endoscopy and family planning.

It is important to view the three objectives of this program in the context of priorities established by the Population Commission of the Philippines. No matter how creative a program may appear to be on paper, if it does not parallel the objectives of an established and well funded national program, its relevance must be questioned.

Some people have questioned the appropriateness of continuing laparoscopic activities in a country where the primary emphasis is on minilaparotomy and where little use has been made of endoscopic equipment. The grantee, it is recognized, offers perhaps the most competent training in laparoscopy in the Philippines. Program staff perform fully two-thirds of the 30,000 laparoscopic sterilizations in the country. (The total number of all voluntary sterilizations is estimated to be approximately 320,000.)

Because of earlier, positive publicity on "band-aid surgery," consumers have continued to demand services in both minilap and laparoscopy. Mr. Samuel Haight, USAID population officer, and Dr. Conrad Lorenzo, executive director of both the Population Commission and the Population Center Foundation of the Philippines, confirm that both services are needed.

Most agree on the importance of the FCC. To determine how the sub-grantee perceives JHPIEGO's project at the Mary Johnston Fertility Care Center, the consultants met with Dr. Oblepias and his staff.

In general, Dr. Oblepias is more than pleased that Mary Johnston Hospital was designated as a training and maintenance center. He wants not only to continue but also to expand his activities. Dr. Oblepias discussed with the team the earlier problems he had had with JHPIEGO, pointing out that if these problems were solved, the program would function more effectively as a result of his training and administrative efforts.

It is difficult to understand why the conversion from cautery to tubal rings has not been accomplished after a full 17 months of activity. Almost all the trainees said that because of fear of the cautery, the scopes are not used. There is more than one reason that equipment is not being used. Selection criteria have been poor. The payment by the Philippine government of institutional subsidies for voluntary sterilization has been delayed, with the result that staff are not motivated to use equipment efficiently.

Of the 58 laparoscopes which were distributed earlier by various agencies working in the Philippines, only 9 were functioning when the retraining program began. Many have never been used. JHPIEGO's effort to link the maintenance center to the proper deployment of endoscopic equipment was appropriate.* At this time, almost every laparoscope which is not used by an institution has been recalled by the maintenance center team, repaired, and redistributed among new graduates of the FCC training program.

It is important to note that lessons have been learned. Trainees are now accepted only after they have been screened carefully by Dr. Oblepias and only after the requesting institution has assured JHPIEGO that it is committed to the provision of voluntary sterilization services and that the trainee plans to remain with the facility for some time. Unfortunately, because conversion to the tubal ring has not been accomplished, follow-up to procedures must be delayed.

Follow-up maintenance visits have proceeded smoothly and are being made regularly (once each quarter). The maintenance team seems to be efficient and has been able to stimulate center staff to complete trainee field reports and to communicate problems to the parent training institution. It was observed during recent field visits that good use is being made of the laparoscope as a diagnostic tool. Trainees reaffirmed that voluntary sterilization services will be provided as soon as converted equipment is received.

One might question the necessity of four full weeks of didactic and practical training. The patient flow is sufficient to ensure 15 cases per

* This action was recommended by earlier AID auditors.

trainee in about half that time. It is important, however, that trainees have an opportunity to participate in the delivery of voluntary sterilization services in rural areas. The program has trained more physicians than it projected. It appears that the curriculum meets the needs of the trainees. The program offers lectures on the appropriate use of Diazepam and Meperidine, resuscitative techniques, and didactic and practical training in vasectomy and minilaparotomy. Trainers emphasize the importance of informed consent,* which is in fact required by the Population Commission of the Philippines, which subsidizes the program.

It is imperative that training not be limited solely to endoscopy. Many trainees leave the institution where they learned to use the endoscope. They should be competent in all methods of female and male sterilization.

Refresher training and training for nurses are also provided. The refresher courses are designed as a practicum for trainees who have been trained but cannot perform procedures because the equipment is in disrepair. The objectives of this component of the training program have not been reached because many of the physicians who were trained have left one institution to practice in another or to open a private practice. Dr. Oblepias wisely has increased the number of trainees from hospitals where redeployed scopes are likely to be used.

The provision in the second-year grant for training for nurses is wise, a recognition of the problem inherent in attempts to provide surgical services without appropriately trained teams. Two nurses from each institution have been trained in endoscopic techniques, pre- and postoperative management, and maintenance of laparoscopes. The curriculum would be improved by the addition of other aspects of fertility regulation, particularly IUD insertion. By upgrading their skills, the program can ensure that professional nurses have an impact in their respective communities.

A third component of the program at Mary Johnston is regional training. More manpower can be deployed for this effort than perhaps for any other. Twenty non-Filipino Asians were selected for training under the initial two-year grant. To date, with one exception, the selection of trainees has been limited to physicians who have received didactic training at JHPIEGO's headquarters in the U.S. The Fertility Care Center has been treated as an ancillary resource to provide practical training in endoscopy. Appropriately, JHPIEGO is now emphasizing overseas training at national and regional (in-country) training sites. Mary Johnston is a particularly suitable site for an expanded training program. Dr. Oblepias is well respected and well motivated. He has already acquired considerable experience by following up his training in other LDCs. There is an ample clinical caseload available

* See USAID PD No. 70.

at the Fertility Care Center. The training team is eager to train international colleagues and to provide appropriate follow-up in the field. It is more cost-effective to use the Mary Johnston site than to bring trainees to the U.S.

Should the FCC evolve into a regional training center, other aspects of training will have to be emphasized, including curriculum review, distribution of training materials, and training in minilaparotomy, vasectomy, and laparoscopy.

This project's three objectives were realistic and timely. The success of the program can be attributed perhaps to the selection of Dr. Oblepias as the subgrantee. Given the enthusiasm for the program, JHPIEGO should renew its commitment to provide the support the grantee needs to make the program function efficiently.

Recommendations

1. In this program the monthly reimbursement of costs is effective only after an initial disbursement of funds. At a minimum, funds for three months should be provided to the grantee when the program begins so that activities can be implemented early and without delay.
2. If the decision is made to convert to non-electrical tubal occlusion, training programs should not be instituted until the equipment which the trainee will be using at his institution is available. In the Philippines, the 58 endoscopes must be converted to ensure meaningful follow-up evaluation in the field. If equipment is not converted, few, if any, procedures will be performed.
3. The Fertility Care Center should take the following action:
 - a. Extend follow-up visits to institutions receiving scopes, and provide an opportunity for on-site refresher training when conversion to tubal rings has been completed.
 - b. Expand the formal curriculum to include minilaparotomy and vasectomy and distribute minilaparotomy and vasectomy kits to each trainee.

- c. Establish the FCC as a regional training center. Applicants should be processed by training center staff and by JHPIEGO. The FCC has already established itself as a quality training institute, and it has had experience with trainees from Burma, Nepal, Indonesia, Malaysia, New Guinea, Syria, and the Solomon Islands. Funds should be made available for appropriate follow-up activities at the end of three months and after one year of training.
4. JHPIEGO has an opportunity to contribute to curriculum development. Dr. G. Aragon, dean of PGH Medical School, and other key professionals have indicated that they are willing to convene a meeting of representatives of the nine major medical institutions to review and attempt to standardize the curricula in reproductive health.

II. AN EVALUATION OF JHPIEGO'S PROGRAM IN THAILAND

II. AN EVALUATION OF JHPIEGO'S PROGRAM IN THAILAND

Program Summary

Thailand has a population of 46 million. The annual growth rate is 2.19 percent. The National Family Planning Program (NFPP), in the Ministry of Public Health, is responsible for the significant decrease in the growth rate, which was 2.5 percent in 1976. The goal for 1986 is 1.5 percent. To achieve this goal, an estimated 4.6 million births will have to be prevented in the next five years. The NFPP has placed a major emphasis on voluntary sterilization; last year, 138,732 female sterilizations and 35,000 male sterilizations were performed in the country. In the Fourth National Economic and Social Development Plan, the NFPP set as the target 485,000 procedures. It is expanding and improving sterilization services throughout the country.

The Thailand National Endoscopy Educational Research Program, which is supported by JHPIEGO, meets the needs identified by the government. Its priorities are those established by the government. The project has provided in-country didactic and clinical training in laparoscopic procedures to 62 physicians from provincial hospitals and 14 ob/gyn residents. The Ministry of Public Health closely monitors (monthly) the performance of these physicians and provides financial reimbursement for each procedure they perform. In addition, data on all sterilizations performed by trainees are being collected on a standardized form. This information will be analyzed to assess the safety, acceptability, and effectiveness of the tubal ring technique applied with the laprocator.

The project works directly with the MOPH and is therefore an important component of the country's program. The two university hospitals, Siriraj and Chulalongkorn, where training is conducted, are the most prestigious institutions in Thailand. JHPIEGO is to be highly commended for its selection of personnel and delegation of responsibilities. The MOPH provides office space and personnel time, performs administrative services, is involved in selecting and following up trainees, and coordinates all activities.

JHPIEGO, the USAID Office of Population in Bangkok, the MOPH, and the two university hospitals have established a good working relationship. Coordination among the organizations is excellent. The population officer has found JHPIEGO to be very responsive to all requests. The only major setback was the one-year delay in the implementation of the project. The MOPH could not begin training until funds and equipment were available.

Achievements

Goals were exceeded within nine months of the project's initiation.

The MOPH takes a sensible and practical approach to laparoscopic sterilization, a stance that is encouraged by JHPIEGO. Before initiating the second phase of training, it will evaluate the impact of the first phase and then decide what plan of action would be most appropriate. The MOPH believes that the laproscator increases the options to acceptors, is a diagnostic tool, and is an incentive to the physician.

The selection of trainees has been excellent. Surveys show that each trainee is using the laproscator. To date, none of the centers where training has been conducted and equipment installed is inactive. All the physicians are familiar with minilaparotomy, and equipment is always available as a backup. At most of these centers, the number of sterilization procedures has increased following training. This trend is likely to continue.

The MOPH, in collaboration with the two universities, trained several nurses to use and maintain endoscopic equipment. The nurses came from centers where equipment had already been installed. Training was conducted at the universities' own initiative, without any funds from JHPIEGO.

An excellent system is in place for monitoring and reporting procedures. In addition, the MOPH is arranging to take over the RAM center from the Thai AVS.

In conjunction with JHPIEGO and the two training hospitals, the MOPH completed the schedule for a meeting on laproscator training. This meeting will be held in January. It will be attended by all the trainees, who will have an opportunity to discuss any problems which have arisen since training.

JHPIEGO has done an excellent job of organizing this project, selecting the most appropriate grantees, and maintaining perfect coordination between all parties. The program's ultimate impact has yet to be measured, but the signs are encouraging.

Didactic and Clinical Training

All the trainees simultaneously attended the five-day didactic course arranged by the MOPH. The faculty of both universities participated. All aspects of the subject were covered thoroughly. An anesthetist was invited to speak on the different types of anesthesia, anesthetic complications, and management. The course was attended by 60 physicians from provincial hospitals and 14 ob/gyn residents from the two universities. Pre- and posttests were administered.

The clinical training continued over the next nine months. Two physicians were trained simultaneously at each center. Physicians who had previous experience with the laparoscope received one week of training. The

training for the others lasted three weeks. The trainers (Dr. Suporn and Dr. Kobchitt) are experts, eminently qualified. They showed great interest in the training. All the trainees were able to perform more than the minimum number of required cases. Major emphasis was placed on counseling for women, the importance of voluntariness, and the importance of informed consent.

Recommendations

1. JHPIEGO should provide funds to train teams of nurses in sterilization and the maintenance of endoscopic equipment.
2. If the second phase of the protocol is undertaken, the didactics should be expanded to incorporate other methods of contraception and sterilization, including male sterilization. The use of the laproscator as a diagnostic tool should also be emphasized.
3. JHPIEGO has provided only educational literature and films to the university training hospitals. Selected materials would be useful also to the trainees.
4. JHPIEGO should provide funds to develop appropriate in-country materials.
5. The regional development officer for Asia at JHPIEGO/Baltimore should visit and observe the program to determine its future needs.

Supervision and Follow-Up

All the trainees report each month to the MOPH and provide information on the number of voluntary sterilizations they have performed using the laproscator and other methods. They also report any problems with equipment. Dr. Suvanee of the MOPH, coordinator of this project, personally monitors the performance of each trainee and investigates any problems trainees may have. In addition, the trainees complete a standardized form on each sterilization procedure. These data collection forms are sent to the Siriraj Family Planning Research Unit, where all the data are analyzed.

The consultants from the training centers have not begun to visit trainees to provide on-site assistance and training. It is planned that visits will be made six months after training to allow the physicians to increase the number of cases.

Recommendations

1. The consultant should plan to visit the trainees immediately, and not wait six months. It will be easier to correct errors before the physicians establish a work pattern.
2. JHPIEGO should discuss with local consultants the feasibility and usefulness of administering the equipment test before the consultants' visit instead of during training.

Equipment and the RAM Center

Sixty-four laproscators have been distributed, and 20 are in storage. There are several problems with the equipment. No spare parts are available. Staff have complained that the instrument is too short; that the edge of the cylinder is very sharp; that the thumb ring breaks easily; and that the point where the spring and cylinder are joined breaks or bends frequently.

There are also problems with sterilizing the equipment at the provincial hospitals. Only formaldehyde is available, and staff have been advised to soak the instruments for more than an hour, which limits the number of procedures that can be performed. Thirty laparoscopes with unipolar cautery have not yet been converted to tubal ring and are not being used.

When the MOPH takes over this function from the Thai AVS, the MOPH would like to train three of its own technicians to manage the RAM center and to provide preventive maintenance.

Recommendations

1. JHPIEGO should expedite the shipment of spare parts. At this time, new equipment is being dismantled to obtain replacement parts.
2. The cautery laparoscopes should be converted as soon as possible so that they can be used.
3. JHPIEGO should work with the manufacturer of the laproscator to correct some of the common problems frequently reported from all over the world. JHPIEGO should keep the MOPH and the trainees informed of progress.
4. JHPIEGO should provide guidance on the sterilization of the laproscator, recognizing that at provincial hospitals the recommended disinfectants are not available.

5. JHPIEGO should provide support for the training of MOPH technicians before it takes over the RAM centers. At least two of the technicians should receive their initial training in the U.S.
6. JHPIEGO should work with the MOPH to establish criteria for the distribution of laproscopators. Such action would be helpful in the second phase, preventing distribution at sites where it would be difficult to use and maintain the equipment.

Courses at JHPIEGO/Baltimore

The courses in Baltimore are useful and popular among Thai physicians: The microsurgery course is considered to be the most significant from a political point of view. Two centers for sterilization reversal will be established shortly. Dr. Kobchitt (Chulalongkorn Hospital) receives five requests each week for this operation. She has reversed eight cases, 75 percent of which have been successful.

The Central Coordinating Agency for Family Planning in Thailand (DTEC) makes the final selection of candidates. This is a cause for concern among those who want to take the courses. Furthermore, the participants are required to undergo a test conducted by the DTEC. Final approval is considerably delayed.

Recommendations

1. JHPIEGO staff should meet with the DTEC to work out an agreement to facilitate physicians' participation in the courses offered at Johns Hopkins.

Medical Curriculum

Family planning is taught in the third year of medical school and is included in the curriculum for nurses. The Thai Medical Association has ruled that each student must be able to do a minilap before he is licensed to practice medicine. All nine medical schools teach minilaparotomy, although there is a considerable variation in their actual training programs and syllabi.

Recommendations

1. JHPIEGO could assist the MOPH in standardizing family planning training at the medical schools. The MOPH could sponsor a meeting of representatives from the seven universities, including the deans and the chiefs of ob/gyn departments. They should be given an opportunity to adopt some resolutions and be asked to convene again in three months to follow up the implementation of their recommendations. The MOPH and JHPIEGO could plan an important role as coordinators of these meetings.

Future Opportunities

To achieve the demographic targets set for the country, reproductive health education and sterilization must be emphasized strongly. JHPIEGO will continue to play an important role in the future, for there is a great need for high quality in-country training. An evaluation of the present laproscator training program will show whether more medical doctors need to be trained and whether minilap should be emphasized. JHPIEGO must be especially cautious in distributing laproscators in rural areas.

JHPIEGO needs to make a special effort to improve the working relationship between the AVS RAM center and the two JHPIEGO-sponsored university training centers. Also, the funding mechanism must be improved to prevent continued long delays.

Recommendations

1. JHPIEGO should provide support for an evaluation of the program and for the development of in-country educational materials. JHPIEGO should also encourage and support training for nurses who have not been trained in the sterilization and maintenance of endoscopic equipment. The chief operating room nurse in Chulalongkorn Hospital has proven her proficiency in instructing the nurses and could make site visits which would be very helpful.
2. To date, training has been limited to the 14 ob/gyn residents at Siriraj and Chulalongkorn Hospitals. In the future, all final-year ob/gyn residents should be included in the training.

3. JHPIEGO should assist the MOPH in standardizing family planning training in all the medical schools. It also should upgrade the quality of reproductive health education.
4. There are three trained microsurgeons in Thailand. The number of requests for reversal is increasing continuously. JHPIEGO should explore the possibility of setting up a microsurgery regional training center or clinical practice center for Asian physicians at either Siriraj Hospital or Chulalongkorn University in Bangkok.
5. JHPIEGO should support and study the results of a pilot project sponsored by the MOPH to train male nurses and sanitarians to perform vasectomies. For political reasons, the MOPH would prefer to have independent data on vasectomies.
6. Since 1978, the MOPH has been conducting a pilot project to train operating room nurses to perform postpartum sterilizations. This program has been immensely successful. The number of sterilizations at these hospitals has increased significantly. The complication rate with nurse-operators is comparable to that for physicians. The MOPH would like JHPIEGO to support the program to train nurses in the 500 district hospitals to perform postpartum tubal ligation. The MOPH has worked out a plan for this training. Approximately 1,000 nurses would need to be trained over the next five years. It would be appropriate for JHPIEGO to support this activity.
7. JHPIEGO should consider supporting the training of auxiliary nurse-midwives (ANMs) to insert IUDs and dispense barrier methods and oral contraceptives. This training would include all aspects of counseling and management.
8. In planning for the future, an in-country training course in reproductive health should be considered for physicians and nurses.
9. Most training activities are centered now in Bangkok. The decentralization of activities to other provinces should be considered for future programs.
10. JHPIEGO should actively participate in the meeting on laproscopator training, which will be in January 1981. It would be appropriate to distribute educational materials at the meeting

(this has not been done before). To encourage the trainees to speak openly about their problems, and to provide a forum for a discussion of future opportunities for JHPIEGO, trainees should be divided into small groups.

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MIDDLE EAST

I. AN EVALUATION OF THE HUMAN REPRODUCTION TRAINING CENTER
AT SHATBY UNIVERSITY HOSPITAL, ALEXANDRIA, EGYPT

I. AN EVALUATION OF THE HUMAN REPRODUCTION TRAINING CENTER AT SHATBY UNIVERSITY HOSPITAL, ALEXANDRIA, EGYPT

In-Country Program Development

This project is designed to teach physicians and paramedical personnel the current concepts of human reproduction. The emphasis is on improved care of pregnant women, identification and management of infertility, and promotion of the use of effective contraception. An objective is the more effective participation of medical personnel in national programs to improve the health of mothers and children. The use of the endoscope is elucidated and stressed in didactic sessions and clinical practice. The ultimate objective of the project is to develop a number of strategically located endoscopic centers with well trained and well equipped medical and paramedical staff.

The consultant team visited the director of the program, Dr. Samir El Sahwi, and his staff on November 8-9, 1980. The first of four three-week courses for physicians had recently concluded (September 15.- October 6, 1980), as had the first of five one-week courses for non-physicians, including nurses and nurse-midwives, most of whom were graduates of the Higher Institute of Nursing in Alexandria (October 15, 1980).

The course for physicians included 40 lectures and 18 clinical sessions. Clinical sessions were held each morning and were followed by lectures in the afternoon. Dr. El Sahwi feels that a combination of clinical and didactic sessions is more effective than separate study of each of the two components, but he acknowledges that this approach is more expensive. (Handouts on the program, including pre- and posttests, are attached as appendices to this report.)

As a result of the first course, Dr. El Sahwi is making two changes:

1. Four sessions with 10 physicians each will be held instead of 5 sessions with 8 physicians.
2. Some lectures will be modified. A lecture on voluntary consent procedures has been added.

A lecture on vasectomy has also been added, although, according to Dr. El Sahwi, few physicians are receptive to this particular topic. Dr. El Sahwi thinks it is important to continue to expose the medical community to this topic, despite unfavorable reactions.

The JHPIEGO Program in Relation to Postgraduate
Reproductive Health Training for Physicians and Nurses

The goal of the first year of the program is to provide didactic and clinical training to 40 physicians. There will be 10 trainees in each course. Eight will be Egyptian physicians, primarily from Alexandria and surrounding district hospitals in rural areas, and two will be physicians from neighboring Middle Eastern and African countries. Once a physician is certified, the trainee's institution will receive appropriate equipment to begin services after one of the faculty members makes a field visit and after agreements between the institution and Dr. El Sahwi are signed. These agreements will enable Dr. El Sahwi to control and ensure the proper use of equipment. Large institutions with heavy caseloads will receive system B laparoscopes; the small institutions will receive laproscators.

Nurses and nurse-midwives will receive instruction in the proper sterilization and maintenance of equipment and learn current techniques in reproductive health. It is planned that these courses will reach 40 paramedical personnel.

These courses will follow the usual pattern of focusing primarily on the nurse's role in assisting the physician to provide care and maintain endoscopic equipment. The team recommends that didactic and clinical material be broadened to encompass reproductive health concepts and that information be provided on a wider range of family planning services. At this time it is illegal for nurses and nurse-midwives to insert intrauterine devices, and physicians are unwilling to train them in this technical skill. The nurse's role in family planning could be greatly expanded if she were allowed to perform this procedure.

Nurses are not brought to the Human Reproduction Training Center at the same time as physicians. The team approach, in which the physician, nurse, and anesthetist teach and learn from each other, has been used successfully in Brazil and would be a useful model for this project.

Because of the small number of procedures which are done each day at the Shatby University Hospital, most physician-trainees perform only seven or eight endoscopic procedures during the three-week program. The minimum number required is 15 procedures.

Further, the bulk of the endoscopic procedures is useful for diagnosing infertility, but not for performing sterilization. Dr. El Sahwi stated that non-Egyptian physicians have an opportunity to acquire more experience with endoscopic procedures than Egyptian physicians because the former are not available for further training. He feels that the Egyptian physicians will

receive further training at their own institutions after equipment is installed. (The consultants emphasized that Dr. El Sahwi would save time if the number of procedures were increased. Physicians would receive adequate training while at the training center and not have to depend on further training in the field.) Unfortunately, training is conducted only with laparoscopes, even though many trainees will be provided with laproscators.

The team was concerned about the exclusive use of general anesthesia for endoscopic procedures. The team was informed that Egyptian women have a low tolerance for pain and insist upon being "put to sleep." It was also observed that the program does not stress minilaparotomy because Dr. El Sahwi and his staff believe it is impractical. It was stated that, too often, minilap becomes a "maxilap" because of the obesity of Egyptian women. The team recommends that an anesthesia consultant be brought in to reorient this program to the use of local anesthesia.

The Human Reproduction Training Center is planning to do approximately 500 voluntary sterilization procedures in the coming year. Dr. El Sahwi indicated that the number of voluntary sterilization procedures can be increased only if more staff, such as nurses and social workers, are hired to recruit patients for the procedure and to assist in providing services. With additional assistance, Dr. El Sahwi feels that his program could do approximately 1,500 voluntary sterilization procedures each year. The team recommends that other organizations be contacted to provide funds for the service component of this program. It appears that proper attention is given to consent for the voluntary sterilization procedure, and the program is in apparent compliance with AID Policy Determination No. 70.

At the end of the first year of this project, a five-day international conference on different aspects of reproductive health will be held at Shatby University Hospital for 40 physicians, most of whom will have graduated from the training program. The team recommends that Dr. El Sahwi invite Dr. King or Dr. Burkman (or both) to participate in the conference.

Relationships with the Ministry of Health and Other Government Agencies

The Human Reproduction Training Center is completely autonomous; it has no administrative relationship with either the Ministry of Health or Alexandria University. Dr. El Sahwi is particularly insistent that the program remain free of any administrative constraints that might be imposed upon it by another Egyptian governing body. He feels that the success of the program depends upon its autonomy.

To date, Dr. El Sahwi has had no difficulty with either the university or the hospital in conducting his program. In fact, Shatby University Hospital has contributed over 10,000 LE to upgrade operating room facilities

and office space for Dr. El Sahwi's program. The hospital's administrator is beginning to ask how the hospital will benefit from this rather sizable investment of funds. The consultants gave Dr. El Sahwi information on other funding agencies which might be able to assist the hospital in providing surgical supplies, such as gowns and gloves, to the project. The team also suggested that Dr. El Sahwi request assistance from JHPIEGO/Baltimore to visit The Pathfinder Fund in Boston and IPAVS and the FPIA in New York when he comes to Baltimore in May to attend the microsurgery course.

The Program in Relation to Priorities and Interests of USAID Mission

The consultants met briefly with the population officer, Thomas Reese, and his assistant, Laura Slobey, in Cairo, on two occasions only. The team's view of USAID/Cairo's priorities is, therefore, necessarily limited. (When the consultants returned to Cairo, USAID offices were closed in observance of Veterans Day.) It appears, however, that USAID's primary emphasis at this time is on community-based family planning programs in rural areas and commercial distribution of family planning supplies in urban areas. The USAID mission personnel will be able to more fully understand Dr. El Sahwi's program after they have had an opportunity to travel to Alexandria to observe the project. The consultants suggested to both Tom Reese and Laura Slobey that they visit Dr. El Sahwi's program as soon as possible to observe his efforts firsthand.

Coordination with Other AID-Funded Population Programs

At this time, the Human Reproduction Training Center has no relationship with other AID-funded population-related programs in Egypt. The Egyptian Fertility Care Society, the IPAVS branch in Egypt, does not interact with Dr. El Sahwi's program. Unfortunately, despite the potential benefits, cooperation between the two organizations is not possible at this time.

Clearly, Dr. El Sahwi's program focuses primarily on use of the endoscope to diagnose infertility and gives less emphasis to voluntary sterilization. Furthermore, the center wishes to remain as independent as possible. Staff expressed a fear of interference from outside organizations.

Maintenance and Use of Endoscopic Equipment

The maintenance of endoscopic equipment is handled by the RAM center at Assuit. This RAM center is the responsibility of the IPAVS. Relocation of

the center from Assuit to Cairo has been planned for some time. Although the center is capable of repairing equipment, it has difficulty delivering and returning equipment because it is located far from the training programs in Cairo and Alexandria. The consultants recommend that a second RAM center be established in either of the two cities and that a technician be trained to handle equipment in those areas.

Provision of Other Equipment and Supplies

The Human Reproduction Training Center has a sufficient supply of equipment and educational materials for the program. Dr. El Sahwi said that JHPIEGO refused his request for the AAGL* collection of endoscopic slides. The consultants recommend that this slide series be sent to Dr. El Sahwi as soon as possible. Dr. El Sahwi also asked if funds could be provided to purchase a camera because he has the opportunity to take photos of a variety of pathologic conditions associated with infertility. He could use these photos to develop an excellent set of slides for educational purposes. The team recommends that this request be considered carefully.

Requests have been made to purchase a copying machine, a typewriter, and other similar equipment. The team suggested to Dr. El Sahwi that he seek permission from JHPIEGO to rent, rather than purchase, this equipment.

Effectiveness of JHPIEGO's Delivery System

Dr. El Sahwi reported that, on one occasion, a shipment from JHPIEGO was sent directly to him. He had to pay a sizable amount of his own money for duty to clear the package of educational material through customs. In the future, shipments from JHPIEGO should be stamped with the words "free gift" and sent to the university in care of Dr. El Sahwi

The Long-Range Effect of U.S.-Based Training

Dr. El Sahwi received U.S. training in endoscopy and has used this training to promote health care in his country. The team feels that the training capabilities of Egyptian physicians in endoscopy are adequate to meet the country's needs. U.S.-based training is still required, however, for those interested in the courses in academic skills, administration, and microsurgery. Dr. El Sahwi plans to take the microsurgery course at

* American Association of Gynecologists and Laparoscopists

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Johns Hopkins in May, as infertility, from either primary or secondary causes, is a significant health problem in Egypt. Dr. El Sahwi informed the team that only 10 percent of the infertility cases can be considered for further surgery.

Training and Equipping Doctors in Private Practice

The Human Reproduction Training Center could play a significant role in educating private practitioners in the broader concepts of reproductive health. There is an urgent need for such training in Egypt. Training in endoscopy is not sufficient to meet the family planning needs of women in the country. The team recommends that educational programs be offered to physicians in private practice to upgrade their skills in preventive obstetrics and the treatment of sexually-transmitted diseases, and to enhance their capability to deliver a broad range of family planning services, including insertion of intrauterine devices. Dr. El Sahwi believes that preventive obstetrics deserves greater emphasis because infertility frequently is a consequence of an infection contracted after delivery or during an illegal abortion.

In Egypt, nurses are not legally licensed to insert IUDs. Therefore, physicians must meet this need. The team was told that physicians in rural areas occupy a powerful position in the community, and their support of family planning services could have a significant impact on the delivery of family planning care to women. In view of this situation, the team believes that JHPIEGO should direct its attention to private practitioners who are in a favorable position to meet the family planning needs of rural Egyptian women.

Summary

In Egypt, several programs that train physicians in the use of endoscopic equipment are operating. A similar training program funded by JHPIEGO is located in Cairo at Al Azhar University. Unfortunately, the team could not visit this program because Dr. Gamal Serour was attending a microsurgery course in the U.S. and Dr. Fouad Hefnawi was traveling.

The USAID mission believes that the duplication of training efforts in Egypt may be the only way to adequately reach the professional community and gain acceptance of family planning services. However, it is possible that, in another year or two, the training needs of physicians will have been met.

The Human Reproduction Training Center is well administered and has the capability of providing training in all aspects of family planning.

The program provides specialized training to a small number of obstetrician-gynecologists. Egypt's needs, however, encompass a broader field. A wider range of health professionals, including private practitioners and nurses, is needed. The high birth rate, and the severe morbidity associated with poorly managed deliveries and illegal abortions, demand that greater emphasis be given to preventive obstetrics and to a wide range of family planning services, including the management of IUD insertion. The Shatby University Hospital has a busy family planning clinic which could provide excellent clinical practice in all forms of family planning, including voluntary sterilization. In addition, although the Human Reproduction Training Center is not consulted about the curriculum for medical or nursing students at Alexandria University, Dr. El Sahwi and his associates could initiate efforts to this end.

The team recommends that JHPIEGO/Baltimore continue its relationship with Dr. El Sahwi, but direct future funds toward projects which demonstrate a broader, more comprehensive approach to meeting the reproductive health needs of Egyptian women.

II. AN EVALUATION OF JHPIEGO'S PROGRAM IN TUNISIA

II. AN EVALUATION OF JHPIEGO'S PROGRAM IN TUNISIA

Introduction

Mr. Chekir, former president and director-general of the National Office for Family Planning and Population, stated in February 1978 that "the female sterilization operation is performed in a clinic or hospital and requires six to seven days of hospitalization."* In November 1980, the consultants visited a modern facility in Tunis which performs an average of five to six outpatient endoscopic procedures a day. To understand the change** that took place over the past four years, some background information on the health program and manpower is needed. Money and manpower are critical to the continuation of JHPIEGO activities in Tunisia.

The Tunisian Government has recognized the importance of slowing rapid population growth, and it has given broad political and religious support to its national family planning program. Restrictions on the sale of contraceptives were abolished in 1961. Abortion laws were amended favorably in 1965 and again in 1973. At this time, abortions may be performed by qualified physicians, for either social or medical reasons, through the first trimester of pregnancy. After 12 weeks, abortions can be performed for medical reasons only.

Other legislation has been enacted to restrain population growth. The minimum age for marriage has been raised; polygamy has been abolished; and family allowances have been limited to the first four children. In recognition of the importance of a national family planning effort, the National Office of Family Planning and Population (ONPFP) was established in 1973 as a semi-autonomous agency under the Ministry of Health.

Despite considerable expansion of facilities, government and external support, publicity and public education, the national program has made only modest progress. In 1979, the estimated number of family planning acceptors was 21.2 percent of the 800,000 married women of childbearing age.

Until 1964, medical training was not available in Tunisia, and all physicians had to be trained abroad. In 1964, the medical faculty of the

* "Voluntary Sterilization in Tunisia Family Planning and Health Service Programs," New Advances in Sterilization, Marilyn F. Schima and Ira Lubell (eds.), pp. 67-71.

** This change was effected not only by the JHPIEGO program; the country was undergoing a demographic transition and was receiving a massive sum of money for the family planning program.

University of Tunis admitted the first class of 59 students to its five-year program of study. Twenty-four physicians were graduated from the program in 1969.

In 1973, there were 846 physicians (one physician for every 6,335 persons) in Tunisia, 405 of whom were Tunisians. The remaining 441 were foreigners. Foreigners (mainly from Eastern Europe) are hired under contract and are generally assigned to outlying areas. Recently, the government established new medical schools at Sousse and Sfax. In 1974, between 120 and 150 first-year students entered the medical school at each location. To attract students who are more likely to practice outside Tunis, the schools give preference to applicants from outlying regions.

The objective of training is to meet the need in Tunisia for more general practitioners. Less emphasis is placed on specialties, with the exception of general surgery, gynecology, and pediatrics.

Although the nursing profession attracts some students, limited funds are available to support them after training. Lack of prestige, low pay, few substantive duties, and the indifference of the medical profession handicap the profession. Data available through 1972 show that there were 1,303 nurses, 509 public health hygienists, and 3,472 nurses aides. Specialized nurses and midwives are in critically short supply. Officials are especially hesitant to delegate to this group of workers the responsibility and authority they normally assume in a progressive health system.

Tunisia has nine government-operated schools that train midwives, nurses aides, and male rural hygienists. These schools are located in various areas throughout Tunisia: Tunis, Sousse, Sfax, Kairouan, Nabeul, Menzel, Bourguiba, Gabes, Gafsa, and Le Kef. The midwifery program is at the Avicennes School of Tunis. Other programs are located in Sfax and Sousse.

Foreign assistance is available for programs for medical personnel, and particularly for family planning projects in rural and underserved areas. Consideration is being given to the provision of hardship bonuses to Tunisians willing to serve in these areas.

Although the health status of the population has improved considerably in the last 20 years, a number of problems must be overcome before Tunisians can enjoy a higher standard of health.

Training

With the establishment of the National Training Center (NTC) in 1979, the ONFPF began to revise training methods and materials. The development

of on-the-job skills and of good doctor-patient relationships, decentralization of training to five regions, and encouragement and assistance in developing basic curricula that include family planning are now part of the training program. New course material has been added to the training programs for midwives at all three universities and in three of the 14 paramedical training schools. Increased educational training is important to the development of integrated medicine.

Tunisia's International Role

Tunisia is a small, stable country with a moderate foreign policy. Other developing countries may point to its family planning program as an example to highlight both the problems and benefits of such activity. The importance of the Tunisian family planning program cannot be overestimated. The program is a model for other Arab and francophone African nations and a forerunner in the field, establishing legal, philosophical, and religious guidelines for promoting and delivering family planning services.

In the last two years, ob/gyns and midwives from 17 countries in francophone Africa, 2 nations in the Caribbean, and 4 countries in the Near East have been trained in Tunisia in surgical contraception with support from JHPIEGO. In the future, under the Tunisian family planning program, increased numbers of foreign medical and paramedical personnel will be trained in Tunisia. Tunisia has assisted in providing orientation and motivational training in family planning for religious leaders from other Muslim countries. This kind of training may be expected to expand.

Tunisia has become involved in conferences on health and family planning. For example, it had a prominent role in the Maghrebian Conference on Demography, Family Planning, and Maternal Child Health. The ONPFP has arranged to have family planning featured at meetings scheduled for 1981, including the meetings of the Association of Arab Physicians in Tunisia and the Maghreb Medical Congress in Morocco. It is likely that the ONPFP will become a more active participant in and spokesman at regional and international forums on population and family planning.

In the next decade, countries in francophone sub-Saharan Africa and the Near East will try to increase technical cooperation among developing countries, and as they do, they will continue to assess and benefit from Tunisia's experience. In the 1970s, Tunisia was at the forefront of the movement to develop strong national family planning programs. In the 1980s, Tunisia will, it is hoped, provide an example of how comprehensive rural outreach programs can be implemented and family planning services integrated into basic health care.

Evaluation Methodology

Because of time constraints, the evaluation team was able to visit only two sites: El Ariana Model Clinic and El Ariana Training Center. The team interviewed Mr. William Gelabert, director of the USAID mission; Mr. Alan Getson, population officer; and Mr. Anwar Bachbaoub. At the ONPFP, the team interviewed Mme. Souad Chater, president and director-general of the Medical Division; Dr. Mrad Daly Rafaat, director of the Medical Division; Dr. Ben Mansour, assistant to Dr. Daly; Mr. Bel Hads Ali Neslb, of the Division of International Cooperation; Mr. Daag Rohamco, the administrator of the El Ariana Clinic; and Mr. Abderrazak Thraya, the director of the Centre de Formation.

Profile of the JHPIEGO Program

In June 1978, a Letter of Agreement was signed by the president and director-general of the Tunisian National Office for Family Planning and Population and JHPIEGO to provide support to the Tunisian National Educational Program to train obstetricians and gynecologists. The objective of this in-country reproductive health training project was to provide a three-week course in endoscopy/laparoscopy for Tunisian ob/gyns and surgeons and for ob/gyns and surgeons from francophone Africa, the Near East, and the Caribbean. The program was to include a one-week didactic program at the Tunisian National Center. The emphasis was to be on the management of fertility and infertility. This program was to be followed by a two-week clinical practicum in endoscopy and laparoscopy in a hospital which performs tubal ligations using the laparoscope.

Between 12 and 16 nurses from centers throughout Tunisia which perform laparoscopies would attend a two-week didactic and practical training program to assist physicians in performing laparoscopy and minilaparotomy. Eighteen nurses from Tunisia and 18 nurses from countries elsewhere in francophone Africa, the Caribbean, and the Near East who assist ob/gyns and surgeons in providing voluntary surgical services would attend a five-day training program in patient counseling and patient care, sterile technique, and maintenance of surgical equipment. They would also acquire practical experience while assisting in laparoscopy and minilaparotomy.

Educational teaching materials would be provided to the Tunisian National Training Center in Tunis. In addition, related educational material would be provided to each trainee.

The clinical training would last two weeks. This would be sufficient time for each physician to complete at least 15 laparoscopic procedures.

Clinical training would be completed at the following centers: Tunis El Ariana Medical Center, Charles Nicolle Hospital, La Marsa Hospital, Le Kef Hospital, Bizerte Hospital, Beja Hospital, Sfax Hospital, Sousse Hospital, Nabeul Hospital, and Monastire Hospital.

As specified in the agreement between the ONPFP and JHPIEGO, a Tunisian technician at KLI would be trained in Pennsylvania in the maintenance of equipment. He would also receive stocks of spare parts. IPAVS, under a separate agreement with the ONPFP, is providing additional spare parts, personnel, and operating costs.

The ONPFP appointed the director of the Medical Division of the ONPFP to be the project director. His primary responsibility will be to administer the training programs and to act as a liaison between ONPFP physicians and nurses. He will be responsible also for all administrative duties, logistics, and reports for the training program.

The National Office of Family Planning and Population is responsible for overall training efforts and for implementation of the program.

A. In-Country Program Development

The objective of the JHPIEGO program was to provide a didactic program and a clinical practicum in fertility management techniques, including laparoscopy. The aim was to train 110 ob/gyns from Tunisia and francophone Africa in six quarterly sessions.

In addition, 34 nurses from Tunisia and 18 nurses from countries elsewhere in francophone Africa, the Caribbean, and the Near East would be trained over a period of one year to assist in endoscopy, laparoscopy, and minilaparotomy. These nurses would also receive instruction in the care and maintenance of surgical equipment.

The sixth and final training session under the current Letter of Agreement was completed in early February 1980. In that period, 51 Tunisian doctors and 49 doctors from countries in francophone Africa, the Near East, and the Caribbean were trained. The foreign trainees came from Benin, Cameroon, Chad, Comoro Islands, Gabon, Ivory Coast, Madagascar, Mali, Mauritius, Morocco, Niger, Rwanda, Senegal, Togo, Upper Volta, Zaire, Haiti, Cyprus, Syria, Turkey, and Yemen.

In 1980, the first amendment to the general Letter of Agreement was duly executed: 40 Tunisians and 40 ob/gyns and surgeons from francophone Africa, the French-speaking Caribbean, and the Near East were trained in the techniques of endoscopy and laparoscopy. The training project lasted one year.

The first two sessions for physicians were held in May and September, 1980. Twelve physicians from Tunisia and 20 physicians from Haiti, Martinique, Madagascar, Senegal, Togo, Zaire, Benin, Mali, Mauritania, and Burundi attended the course.

In September 1980, JHPIEGO and the ONPFP signed an agreement (NTA-33) to train obstetricians, gynecologists, and surgeons who are qualified to learn the techniques of laparoscopy for both diagnostic and therapeutic indications and who are recommended by JHPIEGO for clinical practice at 10 Tunisian Government hospitals following didactic training in infertility at Johns Hopkins.

It is anticipated that a second amendment to Agreement CA-6 will be negotiated so that physicians and nurses in Tunisia, francophone Africa, and the Near East can continue to be trained in reproductive health, and particularly in laparoscopy. Additional negotiations will begin for a JHPIEGO/ONPFP training program in contraceptive techniques, including the insertion of IUDs, for nurses and nurse-midwives in Tunisia, francophone Africa, and the Near East.

B. The JHPIEGO Program in Relation to Postgraduate
Reproductive Health Training for Physicians and Nurses

If the goals specified in the second amendment to Agreement CA-6 are reached, the needs for sterilization specialists will have been met.

The training in laparoscopy should continue for the next 18 months to ensure that there is a sufficient number of trained personnel in Tunisia for 30 clinics. The didactic portion of the curriculum should, however, be modified. There should be less emphasis on rare diseases and rare occurrences in reproductive health. More attention should be given to other health problems. At the same time, JHPIEGO should develop a REHEP program in the medical schools, midwifery schools, and selected nursing schools. JHPIEGO should work more closely with the El Ariana Training Center to develop a didactic program.

C. JHPIEGO's Relationship with
the Ministry of Health and Other Government Agencies

The president and medical director of the ONPFP indicated that the program's relationship with JHPIEGO is more than satisfactory.

Tunisian participation in the program fell short of the projected targets because Tunisians who were candidates for training had difficulty

obtaining a release from their hospital duties. Problems were particularly acute for candidates from rural areas. The Government of Tunisia (GOT) has promised that it will make a more concerted effort to select physicians well in advance of the proposed courses to ensure their release for training.

D. The Program in Relation to Priorities and
Interests of USAID Mission and U.S. Embassy

As stated on page 22 of the GOT/USAID Mid-Term Evaluation, one of the most important objectives was increased acceptance of tubal ligation. JHPIEGO can train health personnel to deliver this service.

The Mid-Term Evaluation recommends increasing the number of hours of required professional school education in family planning. (Four hours are now required.) This goal can be accomplished by developing and implementing REHEP programs.

E. Coordination with Other AID-Funded Population Programs

The team did not have sufficient time to visit the IPAVS/Tunis office; however, it believes that coordination between IPAVS and JHPIEGO is adequate.

The team learned that Dr. Zeinel Abidin Khairullah, an IPAVS consultant, recently made an in-depth evaluation of the clinical aspects of voluntary sterilization. It is expected that this document will be shared with JHPIEGO.

F. Maintenance and Use of Endoscopic Equipment

As of September 1980, JHPIEGO had placed 37 laparoscopes and laproscators in Tunis and in each of the 18 health regions. It has also sent scopes to the three medical schools at the universities of Tunis, Sousse, and Sfax.

The team did not have sufficient time to visit the RAM center. In the El Ariana Model Clinic, the laparoscope and laprocator are well maintained and well used. A sufficient supply of tubal rings is available.

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G. Provision of Other Equipment and Supplies

The El Ariana Model Clinic is modern and seems to have all the necessary equipment and supplies.*

H. Appropriateness of Equipment and Effectiveness of Delivery System

The endoscopic equipment (laparoscope and laprocator) at El Ariana Model Clinic is used appropriately. Initially, physicians were concerned that the laprocator would be too short for effective use with obese patients. This is no longer a concern.

The total number of tubal ligations performed in 1979 at this clinic and the number of cases projected for 1980 may indicate under-utilization of the scopes. The rate of tubal ligation in Tunisia, by laparoscope and minilap, declined slightly after 1975. The decline was attributable to a lack of trained physicians, the discontinuation by the government of payments to doctors for additional fees per case, and internal politics. In 1979, 8,174 tubal ligations were performed. Since the beginning of 1980, there has been an improvement in the rate.

The ONPFP has had no problems in receiving equipment and materials from JHPIEGO. However, the team was unable to locate anyone who knew where the institutional educational packages were located.

I. Technical and Medical Aspects of the Training Program

The consultants recommend that a special retraining course be held for each training team (physician, nurse, anesthetist) at each of the 10 regional training centers. The use of local anesthesia should be emphasized. Instructors should be sent from JHPIEGO/Baltimore to teach the teams how to use local anesthesia. Standard criteria for pre- and postoperative care should be adopted.

* This topic may be addressed more thoroughly in the forthcoming IPAVS report.

J. The Long-Range Effect of U.S.-Based Training

The JHPIEGO trainees are not using their training as effectively as possible, for the following reasons:

- Many trained personnel are being relocated from rural to urban areas.
- Trained personnel are opening private practices.
- At the ONPFP, frequent changes in personnel require periodic management training by JHPIEGO.
- Assistance is needed to implement the proposed REHEP programs, which should be developed in Tunisia. One or more persons from each professional health school in Tunisia should be invited to attend the academic skills course in Baltimore if they have not already done so.

K. Training and Equipping Doctors in Private Practice

The team believes that physicians in private practice in Tunisia need to be trained in family planning methods, and especially in the use of IUDs, and equipped with supplies. At this time, specialists in ob/gyn are required to provide FP services. Private practitioners are, it is reported, not allowed to perform tubal ligations. The Tunisian Government imports ob/gyns from other countries to perform these procedures.

The team did not discuss this issue with the mission and thus cannot comment on the feasibility of providing training through JHPIEGO.

L. JHPIEGO's Role in Supporting and Monitoring the Training Program

The team spent considerable time at El Ariana Model Clinic reviewing the procedures for informed consent to sterilization (see AID Policy Determination No. 70). The consent forms are in French and colloquial Arabic. A social worker, a nurse, and a physician give patients an explanation of sterilization. A waiting period of 48 hours is usually scheduled to allow patients to consider the information. The sterilization program is entirely voluntary.

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M. The Program in Relation to Reproductive Health Training

The training program for Tunisia should be modified to shift the emphasis away from uncommon diseases and reliance on surgical procedures and toward the broader concept of reproductive health which encompasses all family planning methods, including IUD management. The training for the entire region of francophone Africa is being strengthened by this program, which should continue. The team would stress the importance of modifying the didactic portion of the curriculum to better meet the needs of the area.

N. JHPIEGO's Relationship with Schools of Medicine and Nursing

Apparently, JHPIEGO's relationship with schools of medicine and nursing in Tunisia needs to be greatly strengthened. JHPIEGO should institute a REHEP program in all of the medical and midwifery schools and in selected nursing schools.

O. Acceptability of the Program and
Opportunities for the Future

JHPIEGO is a well respected organization in Tunisia. It should continue its activities in the country but gradually decrease the emphasis on endoscopy in reproductive health care training.

Summary of Recommendations

1. Over the next year, JHPIEGO should phase out the training in endoscopy for Tunisian physicians.
2. JHPIEGO should retrain all trainers in Tunisia in the use of local anesthesia.
3. JHPIEGO should discuss standardized criteria for pre- and postoperative care.
4. JHPIEGO should direct future efforts to the development of REHEP programs.
5. JHPIEGO should take advantage of the facilities at El Ariana Training Center and of staff knowledge to develop curricula and educational materials that meet the needs of the area.

6. ONPFP personnel should continue to be sent to Baltimore to improve their skills in management.
7. Where possible, concentrated efforts should be made to train local Tunisians, and not foreign physicians imported by the government.
8. The international component of the training program should be continued in Tunisia on a tuition basis as long as necessary.

REPUBLIQUE TUNISIENNE
OFFICE NATIONAL
DU PLANNING FAMILIAL
ET DE LA POPULATION

Clinique du Planning Familial
19 Rue des jasmins Nouvelle ARIANA
Tél : 233 254

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**CONSENTEMENT POUR UNE INTERVENTION
DE STERILISATION VOLONTAIRE**

Je Soussigné
(nom du médecin ou de la Sage femme ou de l'assistante sociale)

Certifie que madame

Adresse

S'est présentée librement à la clinique de l'Ariana pour subir une stérilisation volontaire. j'ai expliqué à la patiente, et elle comprend que :

- 1*) Le procédé de stérilisation est une opération chirurgicale qui comporte les risques habituels.
- 2*) L'opération de stérilisation est en principe Permanente et irréversible .
- 3*) Des techniques de contraception temporaire sont disponibles .

La signature de la patiente ou de son mari au bas de cette page équivaut à une autorisation pour le médecin de la clinique à effectuer l'opération de stérilisation .

Signature du Médecin
de la S.F. ou de L'A.S.

Je soussigné Madame

déclare avoir bien compris les explications fournies ci-dessus, et autorise le médecin de la clinique à effectuer l'opération de stérilisation sus indiquée.

Signature de la patiente

Signature du mari ou du témoin

(obligatoire si la patiente ne sait pas lire)

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رقم الدفتر

المركز

التاريخ

الجمهورية التونسية
الديوان القومي للتنظيم العائلي
والعمران البشري

الموافقة على اجراء عملية التعقيم الاختياري

اني الممضي اسفله

(اسم الطبيب او القابلة او المرشدة)

اشهد ان السيدة

العنوان القار

(الولاية، المعتمدية)

الهاتف

لاجراء عملية التعقيم

تقدمت تلقائيا الى مصلحة التنظيم العائلي ...

وبعد شرح كل ما يتعلق بهاته الطريقة للمرأة اعلمتها ان :

1) عملية ربط القنوات عملية جراحية تخضع الى بعض المضاعفات العادية

2) هذه الطريقة نهائية ولا رجوع فيها اي انه لا يمكن للمرأة انجاب الاطفال بعد هذه العملية

3) ان الطرق الوقية والواقية من الحمل متوفرة للجميع

امضاء المعنية بالامر او زوجها في الاسفل يرخص لطبيب المصلحة باجراء عملية ربط القنوات

امضاء الطبيب

او القابلة او المرشدة

اني الممضية اسفله السيدة

اشهد بانني اطلمت على كل التوضيحات التي ذكرت مسبقا وارخص لطبيب المصلحة باجراء عملية ربط

القنوات التي وقع ذكرها،

امضاء الزوج او الشاهد

(ضروري ان كانت المعنية

بالامر لا تحسن القراءة)

امضاء المرأة التي ستجري عليها العملية

PROGRAMME NATIONAL D'EDUCATION
POUR OBSTETRICIENS ET GYNECOLOGUES
TUNISIE

Rapport d'Evaluation

Pratique Clinique/Phase II

I. Nom du Médecin Formé _____
Etablissement Auquel Affilié _____
Adresse _____

II. Centre de Formation Phase II _____
Dates: Du _____ Au _____
Instructeur _____

III. Nombre d'Interventions Effectuées Pendant la Formation Clinique/Phase II

<u>Occlusions Tubaires</u>	<u>Autres</u>
Electrocoagulation _____	Coelioscopie Diagnostique _____
Anneau en Silastic _____	Dispositif Intrautérin _____
Mini-Laparotomie _____	_____

IV. Evaluation Clinique par l'Instructeur

En vous basant sur votre observation, veuillez évaluer l'habileté du médecin dans son utilisation compétente et intelligente du coelioscope:

(Basse)----- (Haute)
1 2 3 4 5
(Encerclez le chiffre qui convient)

A votre avis, ce participant est-il capable d'effectuer des interventions coelioscopiques sans supervision?

Oui: Commentaires _____

Non: Commentaires _____

Sinon, quelles sont vos recommandations? _____

V. Signature de l'Instructeur ayant Fourni la Pratique Clinique

_____ Date _____

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Part Three
OBSERVATIONS, CONCLUSIONS, AND RECOMMENDATIONS

I. OVERVIEW OF ACTIVITIES: STRENGTHS AND WEAKNESSES

I. OVERVIEW OF ACTIVITIES: STRENGTHS AND WEAKNESSES

After completing its overseas visits, the evaluation team reached a consensus on JHPIEGO's programming and support activities. The team recognized that although it would have to visit each training site to get a complete picture of JHPIEGO's operations, it could make a reasonable assessment by reviewing the program documents and field reports, and by making inquiries at JHPIEGO's headquarters in Baltimore.

General Observations

The team's general observations on JHPIEGO's work are given below.

1. JHPIEGO must take the credit for selecting appropriate subgrantees to be overseas project directors. These professionals have uniformly been excellent trainers and project administrators. In addition, they seem to be in sufficiently authoritative positions that they can politically influence initiatives in family planning and reproductive health, particularly in their own locale.
2. By virtue of its institutional base and its association with the highly respected Johns Hopkins University, JHPIEGO has been able to initiate programs in countries where, politically, family planning, and particularly voluntary sterilization, are highly suspect. In such countries as Brazil, Somalia, Sudan, Turkey, and Burma, JHPIEGO has established an effective foothold, and has thus been able to conduct programs that complement the activities of other USAID agencies and that often stimulate national governments to conduct follow-up programs.
3. The organization's name and reputation seem to lend it credibility and, as a result, training in voluntary sterilization, which often leads to service programs, particularly in Catholic and Muslim countries, seems to be accepted more readily.
4. The programs in laparoscopy, infertility, and sterilization reversal all enhance the image of JHPIEGO as an academic program, and not as a service delivery agency that is sponsored by the U.S. Government and that emphasizes voluntary sterilization and the distribution of contraceptives.

5. JHPIEGO's decision to move away from stateside training and toward national and regional training is appropriate and more cost-effective, and it will result in better use of trainees' time. By combining didactic and practical training at a single site, often in a country with similar language and customs, JHPIEGO can more closely simulate actual field conditions for trainees.
6. The "international university to university approach" to training often crosses political barriers, permitting ministers, deans of medical institutions, and heads of departments to become involved in activities. Under other conditions, in some countries such involvement would be considered inappropriate or politically unwise.

Programming and Training

In almost all developing countries (except perhaps parts of Africa), a sizable number of international activities have been conducted. JHPIEGO often has a head start on other private voluntary agencies in programming. In fact, the uniqueness of its programs is compensation for the often high costs incurred in all international training programs. JHPIEGO's programs reflect consideration of health and demographics. In the initial phase of training, an effort is often made to win over the political leadership, to help government officials to understand the importance of health programs and the necessity of training in reproductive health. JHPIEGO has been particularly successful in conducting health training and information programs, and it should be encouraged to continue its work in the few geographic areas that still require such programs.

Until recently, the emphasis was on training in advanced techniques of fertility management and training in the use of endoscopic equipment for diagnostic and therapeutic purposes. In the second phase of training, efforts appear to be geared toward clinicians who are responsible for teaching other health professionals, including surgeons, administrators, and academicians (and often a combination of the three). JHPIEGO has been successful in conducting this second-phase activity. Measurements of success must be viewed in terms of the number of activities in the country. JHPIEGO's track record appears to be reasonable, but it is difficult to assess because few follow-up evaluations are made onsite.

The emphasis on regional and national training is welcome. In the past, JHPIEGO was accused of taking an "ivory tower" approach because so much training was done in the States. It now appears that there is little reason to continue the advanced technique course in Baltimore because trainees cannot receive practical training until they have received clinical

training elsewhere. Final courses in this category should be designated for specific countries or regions and given in languages other than English.

There is, however, ample reason to continue providing administrative and academic training in the United States. This training is relatively new and it must be viewed as a primary activity. JHPIEGO certainly has the professional staff and consultants it needs for a successful program. The selection of trainees and follow-up in the field are important issues and should not be ignored.

The authors recognize that a U.S. Government-funded agency has a responsibility to provide mechanisms to control fertility, particularly in areas where the prevalence of sexually-transmitted diseases is high, obstetrical care is poor, and infertility rates are as high as 30 percent. But they recognize also the necessity of training medical personnel in the technique for reversal of tubal occlusion. Such training should be an adjunct of voluntary sterilization programs. Training in infertility and microsurgery has merit, both programmatically and politically. The curricula for both infertility and microsurgery are comprehensive; however, some may consider the course in microsurgery to be limited because it cannot provide practical training.

On a limited basis, some training in microsurgery may be moved overseas (training is already going on in Colombia). JHPIEGO should consider supplementing its didactic sessions and animal work with visits to a stateside program where large numbers of microsurgery cases are performed. An additional week to observe new techniques performed by noted microsurgeons would be particularly beneficial. It might be possible to bring a consultant in microsurgery to a regional site. This would provide an opportunity for additional, necessary training.

All the training courses have merit, but the courses in infertility, microsurgery, and academic skills are limited in their study of demographics and contraceptive technology. JHPIEGO should not lose sight of its responsibility to incorporate such information in each training cycle.

The recent decision to delete the trainee's report on fertility in each trainee's country (a requirement in the short course) is inappropriate. The team recommends that trainees prepare such reports in their own countries before they begin their training.

National and Regional Training Centers

JHPIEGO has successfully developed a large number of national and regional training centers. This development activity is perhaps the most emphasized component of JHPIEGO's programs.

A good training staff is available, but, given the heavy emphasis on training in laparoscopy and use of the laproscator, the long-range effectiveness of the training may be diminished. This observation was made at each field site that was visited. In some cases, institutions are loath to say how many minilaps have been performed because this training component is not mentioned in the subgrant proposal.

It appears that some excellent attempts have been made to incorporate certain aspects of voluntary sterilization in the programs or services offered at each training center the team visited. The directive (PD 70) on informed consent is stressed at each training center.

Incidentally, each subgrantee is aware that it is AID policy to deny funding for activities related to abortion. However, given the prevalence in many countries of sepsis from abortion, with its consequences of high rates of infertility and maternal mortality and morbidity, lectures and presentations on the treatment of this condition are necessary. No training course is complete without them. The authors understand that USAID has ruled that the thorough presentation of such information is permissible as it is a recognized part of all ob/gyn curricula.

Equipment

The controversy over the merits of the various technologies for voluntary sterilization programs cannot be resolved here. There is no doubt that the laparoscope has been a most significant tool, stimulating an interest among the generally conservative population of physicians in the entire realm of family planning activities. There is also little question that where minilaparotomy and even vasectomy have been emphasized in national efforts, they have been at least as successful as laparoscopy. Clearly, USAID cannot provide equipment to every distant hospital and each primary care health center. Yet it is these facilities that provide the bulk of reproductive health services in third world countries. Although there is a need to provide training in endoscopic technology, that component need not be included in every program proposal. Each proposal must be judged in light of the needs of each country. The approach to achieving each country's goals should be realistic. Above all, the organization implementing the proposed activities should not be an external, U.S.-based agency.

Laparoscopic equipment is needed for diagnostic and training purposes at most major teaching centers. At centers where the caseload is heavy and where minilaparotomy is not usually performed, training and services could be provided by the next level (often the provincial hospital). However, in no case should training in endoscopy be promoted exclusively. Each training cycle should include a sizable didactical and practical component in minilaparotomy and vasectomy.

The often-heard phrase that vasectomy cannot be accepted in certain countries is, in many cases, not true. Often, all that is needed is a committed and dynamic person who is willing to provide such a service. The controversy that results when vasectomies are performed is the very thing that helps to stimulate awareness among consumers. Thus, in each training cycle, each graduate should receive, in addition to endoscopic equipment, a minilap/vasectomy kit.

Very often, well trained and motivated persons are transferred from an institution that has a laparoscope, even though no trained replacement is available, and are sent to join an institution that has no such equipment. The minilap/vasectomy kit could be particularly useful to persons in this situation.

Under no circumstances should agreements be made to distribute a certain prefixed number of laparoscopes or laproscators. This equipment should be provided only after the needs of each case are considered.. The provider should also recognize that the least complex and most cost-effective technology is needed at the district and primary health levels.

II. RECOMMENDATIONS FOR FIELD OPERATIONS

II. RECOMMENDATIONS FOR FIELD OPERATIONS

An objective of every evaluation is to identify those areas of activity which, although functional, might be modified to further enhance efficient management and to ensure programmatic output. Accordingly, the team offers the following recommendations for improving field operations.

Training

Training for nurses and paraprofessionals is not given high priority. Where included, it appears to be a supplement to voluntary sterilization services and training for surgeons. Although JHPIEGO's program for training nurses in the United States was probably wisely discontinued, though it was never evaluated formally, many opportunities exist for improving the skills of graduate nurses in LDCs. JHPIEGO particularly has an advantage over other organizations because of its association with Johns Hopkins. A coordinator of nursing education should be designated to work closely with the three AID-funded training grantees (Development Associates, University of North Carolina, and University of Hawaii) so that their expertise in training nurses in LDCs will be used to full advantage.

Unilateral Programming Abroad

The evaluation team observed that each subgrantee criticized unilateral programming. Apparently, none of the subgrantees plays an active role in the project development process. JHPIEGO staff pride themselves on their ability to write effective program documents at the conclusion of field visits. The team suggests that proposal writing be done in the field in collaboration with the potential subgrantee and that the USAID population officer, other AID-funded population agencies, and appropriate LDC government officials be invited to contribute their ideas. During this exercise, the collaborators should agree on the process for selecting trainees, and on the need to review the entire curriculum. It should be agreed in advance that JHPIEGO will provide technical assistance, and that there will be a built-in component to evaluate the program in measurable terms and to guide the grantee in assessing his own performance.

Program Monitoring

JHPIEGO's programs, which represent a significant investment of dollars and effort, continue to expand. It is unrealistic to think that the Baltimore staff alone can effectively monitor programs and offer assistance. The

evaluation team strongly opposes expansion of the bureaucracy, but it recommends that a regional office be established in Latin America and Asia. An effective regional office could provide the necessary technical assistance and "trouble-shoot" in the field. This would leave central staff free to concentrate on the development of training modules, of curricula, of specialty training, and of support services unique to the Johns Hopkins affiliate.

Equipment and Spare Parts

No endoscopic training should be provided unless there is a sufficient supply of laproscopators or tubal-ring converted laparoscopes and spare parts. The maintenance center appears to be functioning quite smoothly; however, no spare parts, particularly for laproscopators, seem to be available. A variety of spare parts should be sent immediately to all JHPIEGO training institutes and a careful survey should be made to identify equipment that requires frequent service and replacement parts. A report that describes difficulties with the equipment should be prepared also. The information should be shared with AID and the manufacturer. Attention should be given to the grantee's instructions for shipping equipment.

Funding

Until recently, it was almost impossible to receive grantee funds on time, and some individuals had to make personal contributions to the program so that it would not collapse. The disbursement process has been modified; however, pure-cost reimbursement is not appropriate in most training efforts where up-front costs are very high and interim costs quite low. A minimum three-month advance should be provided, and the grantee should be allowed to continue to use some advanced monies if the regular reports are completed to satisfaction and if sites are visited only when necessary. The use of funds should be strictly limited to activities designed to meet the objectives specified in the grant proposal.

Where appropriate, a portion of each grant should be set aside to:

- translate materials;
- develop technical materials designed to meet the specific needs of each country;
- develop and distribute printed materials; and
- produce appropriate slides and simple audiovisual aids.

A meeting of all training-site directors should be scheduled as soon as possible. The meeting would have implications for regional training, and would be useful for two reasons: the directors could share creative education and training approaches and participants' suggestions might lead to modifications of programs. It might be wise to schedule a visit to an additional training facility en route home. If there is more than one regional site in a given area, there may be more opportunity to discuss and exchange ideas and to share resources. Provision for the meeting should be built into the grant.

III. RECOMMENDATIONS FOR OPERATIONS IN BALTIMORE

III. RECOMMENDATIONS FOR OPERATIONS IN BALTIMORE

Training

It appears that JHPIEGO has placed great emphasis on the development of second-generation training programs in microsurgery, administration, and academic skills. The curriculum appears to be well conceived. However, a number of graduates, particularly those who have completed the administrative and academic skills course, have commented that some personnel lack clinical expertise. After seven years of training physicians, JHPIEGO is well aware that, in third world countries, a "pure" medical doctor-administrator is interested in new technology and often has a private practice of his own. The evaluators suggest combining administrative and clinical studies to enhance course content and discussion sessions.

Perhaps the most consistent complaint of the trainee is his complete dissociation from JHPIEGO once he has completed the daily didactic sessions. The Baltimore-Washington area offers a wealth of opportunities for trainees. Students should have opportunities to visit local Planned Parenthood clinics, the World Bank, the Smithsonian Institution. They should be able to take advantage of facilities on the main campus of Johns Hopkins University or at the School of Public Health. As those who have worked or traveled abroad would confirm, a stimulus is needed to promote and maintain interest. Trainees should not be expected to be content with a series of daily lectures. Learning must go beyond textbook study. Faculty could perhaps do more to ensure that trainees take full advantage of the available resources while they are in the U.S. For example, many trainees have expressed a desire to observe surgery. It should be possible for trainees to observe or take part in activities at the university and at the medical center in which they are interested and from which they could benefit.

Use of Staff

Despite the new emphasis on overseas training and the significant sum of money allocated to this activity, it appears that most JHPIEGO staff (45 persons) are significantly involved in activities in the U.S. The evaluation team believes these persons' efforts should be concentrated on overseas activities. JHPIEGO should consider the following:

- Appoint a team to review and follow up subgrantee reports. This should be done two to four times a year.*

*

Some of these approaches have already been developed; however, more information must be shared and more responsibility must be delegated to ensure efficient monitoring and programming.

- Design and use a common program development form so that JHPIEGO and prospective subgrantees can compare different programs and review suggested budgets in light of often similar goals.
- Preschedule field visits, allowing sufficient time for a full review of the subgrantee's activities. Too often JHPIEGO staff travel for the sole purpose of presenting a few lectures during a given training cycle and neglect concentrated follow-up work with the subgrantee.
- Careful consideration should be given to the establishment of regional offices in Asia and Latin America. A program developer, an IEC specialist, a secretary, and a part-time medical/technical consultant who is well respected and proficient in all aspects of reproductive health should be recruited for these offices. Their work would supplement the work of staff in Baltimore.

IEC

JHPIEGO should make every effort to establish a complete information, education, and communication (IEC) program. It is inappropriate to use a standard set of training materials in each country and each region. There is available a wealth of materials, including films and slides, in English and in other languages, which could probably be adapted for use in a particular setting. At least one full-time person would be needed to review these materials. A checklist of available resources and a brief summary of each item should be sent to all graduate-trainees each year to increase their knowledge and to enhance their teaching potential. The team cannot overstate the importance of an IEC effort, particularly since the JHPIEGO grant is intended to be used for education and training. The U.S.-based specialists could better respond to the needs of each country if staff were trained in IEC and deployed in the field.

The team recommends that journal articles and books written by trainees be collected and shared. Some of the material could be excerpted and published in the JHPIEGO newsletter. These tasks could be functions of an expanded IEC division.

Program Monitoring

The History and Evaluation Unit has been responsible for monitoring programs. To date, it has used questionnaires to evaluate programs. This approach may have been adequate in the early years, when training took place

in the U.S., but its usefulness has been questioned recently. The questionnaire is viewed now as more of a tool for research than a tool for evaluation. Each field project should be evaluated yearly. It is necessary to measure more than the number of days for training or the number of laproscopators distributed. By following up a program in a country, JHPIEGO can make a more meaningful appraisal of costs and benefits and modify its training curriculum and educational materials to fit the needs of trainees in actual field situations. Provision for on-site follow-ups can be written into the original subgrantee agreement.

The International Council

The evaluation team strongly recommends that the International Council meet at least once each year. Its objective should be implementation of agreed-upon recommendations. Given the JHPIEGO mandate, the council should include trainers and physicians as well as experts in curriculum development, professional training for nurses, evaluation, and development of educational material. There has been some follow-up and minutes of meetings have been distributed, but there has been no further communication with members of the council. Copies of all approved programs should be sent to appropriate members of the council for their comments. A system to implement and follow up the recommendations of the council should be developed. Members should be informed regularly of the status of activities.

IV. COST-EFFICIENCY OF THE PROGRAM

IV. COST-EFFICIENCY OF THE PROGRAM

It is apparent that JHPIEGO programs have had an impact in the countries the evaluators visited. In a few countries, this impact has been significant and has led to modifications in national programming.

The trainees who completed the follow-up questionnaires have indicated that early training in Baltimore apparently stimulated increased activity in education, training, and service delivery in their respective countries. This multiplier effect cannot be adequately measured with questionnaires. Further assessment in-country is needed.

In 1979, almost 80 percent of total grant dollars was for equipment and training (a good mix while the emphasis was on training in endoscopic sterilization). It appears that there will be a major shift, with more dollars being allocated to training and education. It is gratifying to observe this trend toward increased use of these funds abroad.

The dollar ratio was greater than 2:1 in 1979, and it should be exceeded in the coming years. It is worth noting that the overhead to Johns Hopkins University is quite low compared to the benefits JHPIEGO derives from its affiliation with this internationally recognized university. Other resources of the university should be further integrated into the JHPIEGO operation.

The question of funding should be directed to the grantee. Apparently, monies have been used to implement effective programs and to obtain equipment. To realistically project needs, JHPIEGO should analyze each country's needs for training and equipment in light of priorities. This exercise would be useful in establishing a programmatic approach to budgeting. Should funding at the level requested not be granted, activities which do not yield desired results should be modified or dropped in favor of higher-priority initiatives. The Evaluation Unit should be requested to evaluate such activities and to help determine what action should be taken.

V. PROPOSED ACTIVITIES FOR THE FUTURE

V. PROPOSED ACTIVITIES FOR THE FUTURE

JHPIEGO has established an international reputation and has a firm base. It has been quite successful in fostering internationally-based training for physicians in reproductive health and in providing endoscopic equipment to universities and major care facilities around the world. JHPIEGO appears to be committed to expanding its activities. Voluntary sterilization would be an important but minor component of JHPIEGO programs.

The evaluation team suggests that JHPIEGO consider carefully the following activities which, the team feels, may lead the organization in a new direction.

1. University curricula should be modified to incorporate all aspects of reproductive health. This is a worthwhile objective, but it will be difficult to fulfill. In some countries, each university functions autonomously. Often, the dean or the head of a department is the only person who can push for real change, but he may do so at cost to himself, and lose his position for political reasons. The team suggests a country-by-country (or regional) approach. Deans and the heads of ob/gyn departments would gather at a national conference to review curricula and clerkships. They would meet as separate committees to try to implement necessary changes. Funds should be provided for a follow-up meeting to assess changes that have occurred and to deal openly with constraints. But it is hoped that the process would lead to regular and sustained meetings that are not supported financially by JHPIEGO.
2. JHPIEGO must not lose sight of its unique role as a provider of demographic information and contraceptive technology, which are important components of reproductive health programs. These didactic components should be incorporated into the curricula of all JHPIEGO-funded courses in the U.S. and abroad. Some selected programs would also benefit from the addition of training materials on human sexuality.
3. Nurse education and training should be strongly emphasized. In many LDCs even graduate nurses are held in low esteem. If JHPIEGO could establish a relationship between a national council of nursing schools, the curriculum in reproductive health could be improved and the status of women nurses enhanced (they would be raised to the professional ranks).
4. In some countries it may be desirable to involve private physicians in training. JHPIEGO should coordinate this activity with the medical societies in the various countries.

These organizations could benefit from a relationship with JHPIEGO and become actively involved in monitoring and reporting on post-training activities.

5. Regional and national training should be continued and expanded to include both didactic and practical training. Clinical sessions must not be limited solely to endoscopy. They should include training in IUD insertion, minilaparotomy and vasectomy, and discussions of other aspects of reproductive health.
6. JHPIEGO's programs in selected areas (e.g., academic skills, administration, microsurgery, and infertility) are important and should be continued. A natural component of advanced training in infertility is training in the diagnostic use of laparoscopes, which can be useful tools in health programs, in Africa especially. Infertility training might be expanded to incorporate training in the treatment of sexually-transmitted diseases. A mini-course that includes appropriate aspects of fertility and infertility could be taught effectively in the field in a number of less developed countries.
7. New training models should be designed. One approach might be "university-to-university immersion" in reproductive health training. The various regional training centers should be urged strongly to share information and techniques.
8. JHPIEGO should become a resource center, making available information and educational materials on reproductive health. A library of inexpensive material should be assembled for JHPIEGO graduates and AID-funded programs that need and use materials that have a positive impact on the target population.
9. JHPIEGO should fund not only training activities but also demonstration service projects, particularly in countries where other agencies cannot fully function. In particular, training programs in Africa and India should be emphasized.
10. At the International Council meeting, a full day should be devoted to a discussion of new directions for JHPIEGO. The best way to determine field needs is to assemble JHPIEGO staff and LDC professionals for discussion.

Appendix M

MEMORANDUM ON FOREIGN TRIP REPORT
(MOH, Colombia, April 21 - May 3, 1980)

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
CENTER FOR DISEASE CONTROL

DATE: June 24, 1980

William H. Foege, M.D.
Director, Center for Disease Control
Through: Philip S. Brachman, M.D.
Director, Bureau of Epidemiology (BE) *PSB*

Mark Speckhard, M.D.; Mark W. Oberle, M.D., M.P.H.
Program Evaluation Branch (PEB), Family Planning Evaluation Division (FPED)

Foreign Trip Report (AID/RSSA): Ministry of Health, Colombia, April 21-
May 3, 1980

SUMMARY

- I. PLACES, DATES, AND PURPOSE OF TRAVEL
- II. PRINCIPAL CONTACTS
- III. OBSERVATIONS AND RECOMMENDATIONS
 - A. Background
 - B. Sterilization Reporting
 - C. Factors Which Influence Reporting of Sterilizations
 - D. Factors Which Influence Performance of Sterilizations
- IV. SUMMARY OF RECOMMENDATIONS
 - A. Surveillance/Supervision
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- V. ADDENDUM

TABLES 1-4

FIGURES 1-4

ATTACHMENTS 1, 2

SUMMARY

At the request of the Colombian Ministry of Health (MOH), USAID/Colombia and AID/Washington, Drs. Mark Oberle and Mark Speckhard of CDC/BE/FPED/PEB, visited Colombia April 21-May 3, 1980, to evaluate surveillance of the MOH sterilization program. In May 1979 the Colombian Ministry of Health (MOH) initiated a training program for minilap and endoscopic sterilizations with the assistance of the Johns Hopkins Program for International Education and Gynecology and Obstetrics (JHPIEGO) and the United States Agency for International Development (USAID). With the onset of the program, the Division Materno-Infantil (DMI) of the MOH requested that regional hospitals report female sterilization procedures on reporting forms prepared for this program. During the first 7 months of the program, 351 reports of sterilization were received. The MOH perceived that either relatively few procedures were being performed or there was substantial unreporting. To evaluate the surveillance system, Drs. Oberle and Speckhard visited the DMI in Bogota, the DMI Regional Coordinators in 5 Regions, and 10 Regional Hospitals in northern and southern Colombia.

Seven of the Regional Hospitals estimated that they had performed a total of 486 sterilization procedures during the first quarter of 1980. However,

these 7 hospitals had officially reported only 99 (20%) of these procedures. This suggests that there is substantial under-reporting of sterilization procedures, although it would take a more extensive study to define precisely the level of under-reporting. The MOH had noted that on the basis of procedures reported to them, 52% of sterilizations were being done by endoscopy. On the basis of estimates obtained at these 7 regional hospitals, 9% of sterilizations in these hospitals were accomplished by endoscopy. One cannot generalize this percentage to the entire program, but it appears that endoscopy makes up a much smaller proportion of total sterilizations than that suggested by the reports to the MOH.

Evaluation of the surveillance system revealed a number of factors which influence reporting of sterilizations. We believe the success and effectiveness of the surveillance system depends on active supervision at the regional level, most appropriately by the DMI Regional Coordinator. Currently, the MOH requires hospitals to submit sterilization reports directly to the central DMI office to reduce lag time. We recommend that this procedure be amended so that hospitals send sterilization reports through the DMI Regional Coordinator to allow him to monitor and actively manage the sterilization program in his region. We developed a checklist to assist the DMI Regional Coordinator in reviewing hospital sterilization programs (included as Attachment 1 to this report). We found that the need to report all sterilizations is not widely known. The reporting requirement was generally thought to refer to endoscopic procedures only. The MOH should clarify reporting requirements to each hospital so that each knows all sterilization procedures are to be reported. A sterilization monitor who is in the best position to tabulate all the surgical sterilizing procedures should be appointed in each hospital.

The current reporting form for female sterilization contains detailed questions about the person receiving sterilization and about the procedure. The information gathered permits the MOH to evaluate the characteristics of the population receiving sterilization as well as the procedures utilized. To increase the effectiveness of this form, we recommend that it be precoded and that the form be changed to clarify the choices for type of sterilizing procedure and include source of payment. While the information on the sterilization reporting form is of marked interest to the MOH, the length of the form will likely be a deterrent to completion and contribute to under-reporting. We recommend an additional precoded form be used providing a simple line-listing of patient name, age, parity, and type of procedure. We have provided an example of such a form. At present, sterilization reporting is requested from each regional hospital where a laparoscopist has been trained and laparoscopic equipment has been installed. In order to more fully assess the current status of sterilization in MOH hospitals and to provide a baseline for measuring the effect of sterilization programs, surveillance should be extended to all MOH hospitals with a physician and operating room to include regional, university, and the local hospitals.

In evaluating the surveillance system for the MOH sterilization program, we encountered a great deal of information about the sterilization program itself. This information concerning factors which influence performance of sterilizations, may be useful to the policy-makers in AID and the Colombian MOH and is included in our report along with related recommendations.

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I. PLACES, DATES, AND PURPOSE OF TRAVEL

At the request of the Colombian Ministry of Health (MOH), USAID/Colombia, AID/POP/LA, and AID/POP/FPSD, Drs. Mark Oberle and Mark Speckhard of CDC/FPED/PEB visited Colombia April 21-May 3, 1980, to evaluate surveillance of the MOH sterilization program. In May 1979 the MOH initiated a training program in endoscopic and minilap sterilizations for MOH physicians in regional hospitals. At the same time, the MOH requested regional hospitals to report sterilizations. After several months into the program, the MOH was concerned because few reports of sterilizations had been received. In response to this concern, Dr. Mark Oberle visited Colombia October 28-November 1, 1979, to review sterilization surveillance and assess the need for more extensive evaluation. The MOH reported, as of November 1, teams had been trained for 47 regional hospitals, but only 114 reports of sterilizations had been received from 8 regional hospitals. Under-reporting was clearly a problem, and Dr. Oberle identified the need for improving sterilization surveillance (See CDC/RSSA report for Colombia dated December 12, 1979).

In February 1980, Dr. Jorge Michelsen, Vice-Minister of Health, Dr. Oscar Henao, Chief of Population Dynamics in the Division Maternal-Infantil (DMI), and Dr. Luis Ponton, Chief, Office of International Health, Colombia, visited CDC to review ways in which CDC could provide technical assistance to the Colombian MOH. Subsequently, the MOH requested AID to send Drs. Oberle and Speckhard from the FPED at CDC to Colombia to evaluate the sterilization program surveillance system for the MOH. The MOH requested that at this stage in the sterilization program, the focus of the evaluation should be on the effectiveness of the reporting system rather than on morbidity and mortality associated with sterilization.

To evaluate the surveillance system, Drs. Oberle and Speckhard visited the DMI in the MOH in Bogota, the DMI Regional Coordinators in 5 geopolitical regions (departments), and 10 regional hospitals in northern and southern Colombia. This travel was in accordance with the Resource Support Services Agreement (RSSA) with the Office of Population, AID, and CDC/BE/FPED. Dr. Oberle remained in Colombia from May 3 through May 23 to join 3 staff members of AID in an evaluation of health sector loans 069 and 075 and Nutrition Loan 514-0220. This evaluation will be reported separately.

II. PRINCIPAL CONTACTS

A. Colombia Ministry of Health (MOH)

1. Dr. Jorge Michelsen, Vice-Minister of Health
2. Dr. Luis Daza, Chief, Division Materno-Infantil (DMI)
3. Dr. Oscar Henao, Chief, Population Dynamics Section, DMI
4. Dr. Jairo Barragan, Population Dynamics Section, DMI
5. Dr. Luis Ponton, Office of International Health

B. Agency for International Development (USAID/Colombia)

1. Mr. Jerry Martin, Director, USAID/Colombia
2. Mr. Marvin Cernik, Population Officer
3. Mr. Arturo Posada, Assistant Population Officer

- C. Asociacion Pro-Bienestar de la Familia Colombiana (PROFAMILIA)
 - 1. Dr. Miguel Trias, Director, PROFAMILIA, Colombia
 - 2. Dr. Eduardo Rodriguez, Director, Pilot Clinic, Bogota

- D. Department of Huila, Office of Public Health
 - 1. Dr. Rufius Macias Alvira, Chief of Service
 - 2. Dr. Guillermo Gomez, Chief of Medical Services
 - 3. Dr. Jaime Rodriguez, DMI Regional Coordinator, DMI
 - 4. Marta Cecilia Narvaez, DMI Regional Nurse

- E. Regional Hospital, Neiva
 - 1. Dr. Armando Arevalo, Medical Coordinator
 - 2. Dr. Alberto Moreno, Chief of Obstetrics and Gynecology
 - 3. Dr. Ricardo Lievano, Laparoscopist
 - 4. Geneveva Parra, Laparoscopy Nurse
 - 5. Ana Garces, Nursing Supervisor, Outpatient Department

- F. Regional Hospital, La Plata
 - 1. Dr. Victor Manuel Bonilla, Laparoscopist

- G. Regional Hospital, Garzon
 - 1. Dr. Heladio Vargas Motta, Laparoscopist
 - 2. Rocio Cortez, Laparoscopy Nurse

- H. Regional Hospital, Pitalito
 - 1. Maria Ruth Hoyos, Laparoscopy Nurse

- I. Department of Cordoba, Office of Public Health
 - 1. Dr. Ricardo Becharra, DMI Regional Coordinator
 - 2. Fabiola Vuelvas, DMI Regional Nurse

- J. Regional Hospital, Monteria
 - 1. Dr. Eduardo Flores, Medical Coordinator
 - 2. Dr. Julio Zapateiro, Laparoscopist

- K. Regional Hospital, Cerete
 - 1. Dr. Alfredo Spa, Medical Director
 - 2. Dr. Daniel Fajardo, Director, DMI Services
 - 3. Dr. Cristobal Petro, Laparoscopist

- L. Department of Sucre, Office of Public Health
 - 1. Dr. Juan Escobar, DMI Regional Coordinator

- M. Regional Hospital, Sincelejo
 - 1. Dr. Francisco Vergara, Laparoscopist
 - 2. Maria Lucy Hernandez, Laparoscopy Nurse
 - 3. Gladys Alvarez, Chief Nurse

- N. Department of Bolivar, Office of Public Health
 - 1. Dr. Rafael Polo, DMI Regional Coordinator
 - 2. Dr. Maximo Arenas Caballero, Epidemiologist
 - 3. Sara de Marin, DMI Regional Chief Nurse

- O. Clinica Rafael Colvo, Cartagena
 - 1. Dr. Vespeciano Zapata, Laparoscopist
 - 2. Nellie Valiente, Laparoscopy Nurse
 - 3. Ana Duenas, Chief Surgical Nurse

- P. Regional Hospital, Carmen de Bolivar
 - 1. Ana de Yepes, Laparoscopy Nurse

- Q. Department of Atlantico, Office of Public Health
 - 1. Dr. Rafael Perez, DMI Regional Coordinator

- R. Regional Hospital, Barranquilla
 - 1. Dr. Jose A. Rosillo, Laparoscopist

III. OBSERVATIONS AND RECOMMENDATIONS

A. Background

In May 1979 the Colombian Ministry of Health (MOH) initiated a training program for minilap and endoscopic sterilizations. Throughout this report the term sterilization will refer to female sterilization. The training program was developed and implemented by the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO). JHPIEGO arranged for staff of the PROFAMILIA to provide the training to MOH physicians and nurses under the direction of JHPIEGO. The training program is funded by the USAID through the Office of Population (DS/POP). In addition, AID has funded endoscopic equipment for each trainee.

In the initial phase of the program, which is scheduled for completion by July 31, 1980, a physician from each of the 108 Regional Hospitals in Colombia is being trained in laparoscopy, and a nurse from each of the hospitals is being trained in the function and maintenance of laparoscopic equipment. The physician and nurse are usually trained simultaneously as a team.

As of May 1, 1980, 85 physicians and 79 nurses from MOH Regional Hospitals had been trained in laparoscopy, and 73 hospitals had received laparoscopic equipment. With the onset of the program, the MOH DMI requested that Regional Hospitals report female sterilization procedures to the DMI on standard forms. A maternal risk assessment form was also requested for each patient to document the need for sterilization. During the first 7 months of the program, from May through November 1979, 351 reports of sterilization were received by the DMI. Late reporting substantially increased the numbers reported for these months (Table 1). The numbers currently available for the first quarter of 1980 will also be revised upward on the basis of late reporting. We were unable to obtain estimates of populations in the catchment areas served by each hospital either from the hospital or the MOH.

For our evaluation, we asked the MOH to assist us in setting up an itinerary which would allow us to visit as many Regional Hospitals as possible in weeks. We emphasized our interest in hospitals that had submitted few or no reports

but indicated that we also wanted to visit hospitals that had been reporting regularly in order to evaluate surveillance in both types of facilities. We interviewed Chiefs of DMI services, laparoscopists, and laparoscopy nurses in 4 regional hospitals in southern Colombia and 6 regional hospitals in northern Colombia. The MOH advised each of the 10 regional hospitals and 5 DMI Regional Coordinators of our impending visit. We visited with the DMI Regional Coordinators in each of the regions (departments), and a staff member of the Central DMI Office or the region accompanied us on our visits to each regional hospital.

B. Sterilization Reporting

To assess the numbers of sterilization procedures performed, we asked personnel at each regional hospital the numbers of sterilizations performed by type of procedure from January-March 1980. None of the hospitals had a tabulation of sterilizations performed, and deriving the numbers from source documents would have required more time than we could allocate while maintaining our schedule of 10 regional hospitals. However, in 7 of the 10 regional hospitals, personnel were able to estimate the number of endoscopic and total sterilizations performed from January-March 1980 (Table 2). These hospitals are not a random sample nor do we know that they are representative of the 73 regional hospitals with operational programs. The seven hospitals had reported a total of 99 sterilizations for the months of January-March 1980 to the MOH, for an average of 14.1 reports per hospital. The MOH received a total of 816 sterilization reports for January-March 1980 for an average of 11.2 reports for each of the 73 operational programs. This suggests that the surveillance in the 7 hospitals did not differ substantially from the national average.

In the first quarter of 1980 these 7 hospitals officially reported to the DMI only 20% (99) of the 486 procedures estimated to have been performed. There is substantial under-reporting of sterilization procedures, although it would take a more extensive study to define precisely the level of under-reporting. Our data does suggest that sterilizations are performed more extensively in MOH hospitals than had been appreciated.

The MOH had noted that on the basis of procedures reported to them, 52% of sterilizations were being done by endoscopy. On the basis of estimates obtained at these 7 regional hospitals, 9% of sterilizations in these hospitals were accomplished by endoscopy. One cannot apply this percentage with confidence to the entire program, but it appears that endoscopy makes up a much smaller proportion of the total sterilizations than that suggested by the reports to the MOH.

C. Factors Which Influence Reporting of Sterilizations

We believe that the success and improved effectiveness of the surveillance system depends on active surveillance and supervision at the regional level, most appropriately from the DMI Regional Coordinator. Currently, the MOH procedure requires hospitals to submit sterilization reports directly to the MOH (DMI) to reduce lag time. Recommendation: Hospitals should send sterilization reports through the DMI Regional Coordinator to allow him to monitor and actively manage the sterilization programs in his region.

We have developed a checklist (Attachment 1) to assist the DMI Regional Coordinator in reviewing a hospital sterilization program. The questions provide a guide to major areas which should be covered and serve as a personal reminder to the supervisor of problem areas and projected solutions for use when he next reviews the hospital program. The checklist is designed as a management tool and not as a basis for a report.

1. One can expect a degree of under-reporting in any surveillance system. Although a monetary incentive could increase reporting, we would not recommend this, since it would be costly and would likely constitute an unacceptable precedent.
2. The need to report all sterilizations is not widely known. The reporting requirement was generally thought to refer only to endoscopic procedures. The MOH prefers the program title, "Programa Endoscopia Pelvica" because it carries no negative connotations. Recommendation: Clarify MOH reporting requirements to each hospital so that each knows all sterilization procedures are to be reported.
3. No one in the current surveillance system at the hospital level has ready access to information about all sterilization procedures. Hospital personnel estimated that most sterilization procedures currently performed in MOH hospitals are postpartum sterilizations through a periumbilical incision or sterilizations at cesarean section. Neither the Family Planning Clinic nor the laparoscopy nurse may be aware of these procedures. Recommendation: A sterilization monitor who is in the best position to tabulate all the surgical sterilizing procedures should be appointed in each hospital. The DMI Regional Coordinator, in consultation with the hospital staff, may be able to identify the person best able to accomplish this reporting procedure. Such a person should be recommended to the hospital administration for appointment as sterilization monitor with responsibility for completing the sterilization surveillance forms. In many facilities the operating room supervisor may be the one most aware of all surgical sterilizing procedures performed in the hospital.
4. We asked personnel at the 10 hospitals we visited if they noted any problems in completing the reporting forms. The only problem encountered was a single instance in which a hospital staff member felt there had not been sufficient training in completing the form. Recommendation: The DMI Regional Coordinator should review the sterilization reporting form in detail with the person responsible for reporting. Review of the reporting procedure is included on the checklist and should be addressed through visits by the DMI Regional Coordinator to assure that any problems are resolved.

5. The current reporting form contains detailed questions about the person receiving sterilization and about the procedure (Figure 1). The information gathered on this form is of great interest to the MOH, permitting evaluation of the characteristics of the population receiving sterilization as well as the procedures utilized. However, a few changes may allow more complete assessment of pertinent data and more efficient processing. Recommendation: Change the current reporting form for sterilizations as follows:

- a) Clarify choices for type of sterilizing procedure.
- b) Include source of payment.
- c) Precode all items.

Item 25 on the sterilization form (Figure 1) lists 4 approaches to sterilization. The first, minilaparotomy, is a term commonly applied to sterilization through a small suprapubic incision, a procedure which has received recent widespread popularity. However, in Colombia we found many physicians applied the term minilaparotomy to the commonly used postpartum sterilization through a periumbilical incision. In order to distinguish these 2 approaches on the reporting form, we recommend that alternatives be labelled "interval minilaparotomy" and "postpartum periumbilical" (Figure 2)

The second term in Item 25, laparotomy, is generally used to refer to a surgical procedure through a large or standard abdominal incision. However, physicians in Colombia have used this term to refer to sterilizations performed at cesarean section, since cesarean section is not listed separately on the form. Consequently, to distinguish the 2 procedures, we recommend that both "laparotomy" and "cesarean section" be listed on the form (Figure 2).

The source of payment is an additional characteristic of the population receiving sterilization which can be helpful in determining the type of population served. We recommend that an additional item be included on the reporting form entitled, "source of payment," listing alternatives such as "MOH," "Social Security," "PROFAMILIA," "Private," etc., (Figure 2). It should be noted that PROFAMILIA is already tabulating its procedures performed in MOH facilities. Although reports of these procedures are not being duplicated at the moment in the MOH surveillance system, the option of reporting PROFAMILIA procedures would allow the MOH to estimate the total number of sterilizations performed in its facilities. The surveillance form should clearly specify whether PROFAMILIA procedures are to be reported or not.

Precoding the form can greatly expedite the tabulation. The MOH already has experience with precoded forms which could be applied to the sterilization reporting form.

6. While the information on the sterilization reporting form is of marked interest to the MOH, the length of the form will likely be a deterrent to completion and contribute to under-reporting.

A maternal risk form to substantiate the need for sterilization is also requested for each patient undergoing sterilization. While these forms provide much useful information, a precoded form providing a simple line-listing will likely give a more complete count of sterilizations performed. Recommendation: Establish a monthly line-listing report of sterilizations from each hospital indicating name of patient (or number), age, parity, type of procedure. The MOH uses a precoded line-listing form to record new users of contraceptives (Figure 3). A similar form could be used to tabulate all female sterilizations (Figure 4).

7. At present, sterilization reporting is requested from each regional hospital where a laparoscopist has been trained and laparoscopic equipment has been installed. However, the MOH training program for sterilization may extend beyond the regional hospitals. In fact, a second phase of the training program is proposed in which 100 additional teams will be trained during the period July 1980 through March 1981. In this phase of the program, 82 MOH physicians will receive training in minilap sterilizations. Of these physicians, 42 will also receive training in endoscopic sterilizations. In addition, 18 teams from the Instituto de Seguros Sociales, Caja Nacional de Prevision, and Caja Distrital will receive training in both minilap and endoscopic sterilizations. USAID/Colombia reports that the Instituto de Seguros Sociales, with 390 hospitals and clinics, provides service to over 600,000 families. The Caja Nacional de Prevision serves government employees throughout the country, and the Caja Distrital serves government employees in Bogota through a system of health clinics. USAID/Colombia estimates that the 3 organizations offer health care to over 1 million families. In order to more fully assess the current status of sterilization in MOH hospitals in Colombia and to provide a baseline for measuring the effect of sterilization programs, surveillance should be extended to all hospitals, regional, university, and local, in the MOH system. Recommendation: All MOH hospitals with a physician and an operating room should be included in the sterilization surveillance system.

D. Factors Which Influence Performance of Sterilizations

In evaluating the surveillance system for the MOH sterilization program, we encountered a great deal of information about the sterilization program itself, which may be useful to policy-makers in AID and the Colombian MOH. We have included this information on factors which influence performance of sterilizations in the present section. Although this information is not central to our focus on surveillance, we have included recommendations regarding performance. Our recommendations, derived from evaluations on site, are not intended to establish policy but rather to assist policy-makers who must make the ultimate decisions about the program.

In each hospital, we attempted to define a prime limiting factor which most directly affected productivity of the program (Table 3). In 3 of the hospitals we considered motivation to be the prime limiting factor, in 2 personnel, in 2 competition, in 1 patient demand, and in 1 gas supply was a temporary limiting factor. Attachment 2 provides a brief sketch of each regional hospital we visited. This is not for comparative purposes but to provide background if one wishes to know the setting for observation in the text.

1. Motivation

In 3 of the hospitals (Table 2, Nos. 1, 9, 10), motivation appeared to be the prime limiting factor. In 2 of the hospitals the first endoscopic procedures were performed just prior to our visit. The hospitals had approximately 1 week's notice of our impending visit, which may have triggered the performance of these endoscopic procedures. A visit by the DMI Regional Coordinator with a checklist in hand might have had the same salutary effect. In Neiva, a number of reasons were given why the program had not been initiated, but motivation appeared to be the prime limiting factor. During our visit to Neiva, we examined the equipment and explained the function of the insufflator volume indicator, which personnel erroneously thought was malfunctioning. Following the explanation, hospital personnel acknowledged that they were ready to begin the sterilization program. A visit by the DMI Regional Coordinator might have accomplished the same, and the prospect of a return visit might strengthen the staff's intention to begin using the endoscopic equipment. As we recommended in the section on surveillance, we strongly encourage the active participation of the DMI Regional Coordinator in the management as well as the surveillance of the sterilization program.

2. Personnel/Training

In one of the hospitals (Table 2, No. 5), the laparoscopist had been trained despite his expressed disinterest in laparoscopy because there was no alternative candidate to send to the training program. It is not surprising that only a few endoscopic procedures have been performed by this laparoscopist. Recommendation: Train only those personnel who are interested. In another hospital (No. 6), the laparoscopy nurse quit shortly after her training, but this loss was not reported to the DMI Regional Coordinator or to the MOH prior to our visit. Periodic visits by the DMI Regional Coordinator should identify such problems promptly.

Several laparoscopists reflected that they wished they had been trained on the type of equipment that had been provided to their hospitals. Many of the hospitals are being supplied with laparoscopes which are a simplified and somewhat smaller version of the laparoscope. Visualization through the laparoscope is reported

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to be less than through the laparoscope. We were advised that because of the better visualization through the laparoscope, it was preferred as a teaching instrument by PROFAMILIA staff. However, the trainee, who will be faced with using a laparocator in his own hospital, should be trained on that same equipment. Recommendation: Train personnel on the equipment that will be used on site.

3. Demand

In one of the hospitals (No. 3), there was a lack of patient demand for sterilization which was attributed to religious influence. Education and time may resolve this factor. During the first quarter of 1980 PROFAMILIA performed 12,118 female sterilizations in Colombia of which 57% were accomplished by endoscopy according to their first quarter report. Table 4 compares PROFAMILIA activity with that of 7 MOH regional hospitals. Note that from site to site there is wide variation in numbers of sterilizations performed as well as percent accomplished by endoscopy in PROFAMILIA centers as well as in MOH regional hospitals. The numbers of PROFAMILIA sterilizations affirm that there is demand for sterilization. Since patients may travel for some distance to a sterilization center the population served by each site is not defined.

4. Equipment/Gas Supply

In one of the hospitals (No. 4), a depleted supply of carbon dioxide resulted in the interruption of a relatively active endoscopic program. Although this was the only case in which we considered gas supply to be a prime limiting factor, several hospitals registered concern over the supply of carbon dioxide. The gas supply for the laparocator is contained in 2 small cylinders which are supplied with the endoscopic equipment. In a telephone conversation with the manufacturer of the equipment, KLI, Inc., reported that each cylinder enclosed a volume of 2.73 liters. These cylinders can be filled to 850 psi, although they are often filled to a much lesser pressure (400-600 psi), especially when local soda drink manufacturers are used as a source of carbon dioxide. When filled to the maximum pressure (850 psi or 58 atmospheres), each cylinder can provide approximately 158 liters of carbon dioxide for insufflation. Six to 8 liters of carbon dioxide is a reasonable estimate of use per endoscopic procedure which accounts for loss during the procedure, and 10 liters per procedure would not be unusual for the recently trained. A small cylinder could thus be expected to provide gas sufficient for approximately 15-25 procedures; fewer if filled to a lower pressure.

KLI staff reported, in a telephone conversation, that a very small amount of carbon dioxide may enter the cylinder in liquid

form during filling. The KLI staff recommended that the cylinder not be filled with liquid carbon dioxide, since it might inadvertently flow into the insufflator and clog the filters. Several hospitals reported that carbon dioxide was not available locally and that turn-around time for refilling the small cylinders was up to a month. Recommendation: Make a large CO₂ gas cylinder available at any site at which CO₂ is not available locally so that the endoscopic program will not be interrupted while the gas supply is being replenished.

Several laparoscopists expressed concern over the relatively sharp tip of the uterine manipulator provided with the laparocator. In one instance a serious complication resulted from perforation. Recommendation: Consider providing a uterine manipulator with a bulbous tip less likely to perforate the uterus.

Although several sites were using a solution of glutaraldehyde to sterilize the plastic portions of the endoscopic equipment, some sites were still using solutions of benzylkonium, which is much less effective. Recommendation: Encourage each site to sterilize endoscopic equipment in a solution of glutaraldehyde and assist each hospital in obtaining the most economical supply.

5. Competition

In 2 of the regional hospitals (No. 7, 8), personnel mentioned that PROFAMILIA meets the patient demand for sterilization and in addition pays the physician. Because of the potential for duplication of services, PROFAMILIA has agreed to terminate its sterilization activities in certain cities when the MOH is capable of providing sterilization services. The effect that this policy-decision will have on the number of sterilizations performed in a region should be closely monitored. Recommendation: A detailed comparison of the number of MOH and PROFAMILIA sterilizations should be made for a representative time period before and after PROFAMILIA withdraws from an area. In selected regions, this evaluation should involve a review of all available surveillance data.

IV. SUMMARY OF RECOMMENDATIONS

A. Surveillance/Supervision

1. Hospitals should send sterilization reports through the DMI Regional Coordinator to allow him to monitor and actively manage the sterilization programs in his region.
2. Clarify MOH reporting requirements to each hospital so that each knows all sterilization procedures are to be reported.
3. A sterilization monitor who is in the best position to tabulate all the surgical sterilizing procedures should be appointed in each hospital.

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4. The DMI Regional Coordinator should review the sterilization reporting form in detail with the person responsible for reporting.
5. Change the current reporting form for sterilizations as follows:
 - a. Clarify choices for type of sterilizing procedure.
 - b. Include source of payment.
 - c. Precode all items.
6. For ease in reporting, establish a monthly line-listing report of sterilizations from each hospital indicating name of patient (or number), age, parity, type of procedure. This format may be associated with more complete reporting.
7. All MOH hospitals with a physician and an operating room should be included in the sterilization surveillance system.

B. Personnel/Training/Equipment/Program

1. Train only those personnel who are interested.
2. Train personnel on the equipment that will be used on site.
3. Make a large CO₂ gas cylinder available at any site at which CO₂ is not available locally so that the endoscopic program will not be interrupted while the gas supply is being replenished.
4. Consider providing a uterine manipulator with a bulbous tip less likely to perforate the uterus.
5. Encourage each site to sterilize endoscopic equipment in a solution of glutaraldehyde and assist each hospital in obtaining the most economical supply.
6. In a sample of regions in which PROFAMILIA terminates its sterilization services, evaluate the total number of public sector sterilizations accomplished before and after PROFAMILIA's termination.

V. ADDENDUM

On May 2, the evaluation and recommendations were presented to Mr. Marvin Cernik and Mr. Arturo Posada, AID/Colombia; Dr. Luis Daza and Dr. Jairo Barragan, Colombian MOH; and Dr. Miguel Trias and Dr. Eduardo Rodriguez, PROFAMILIA/Colombia, by Drs. Oberle and Speckhard.

On May 15, Mark Speckhard discussed the evaluation and recommendations with Mr. Bill Bair, Mr. Dave Denman, Dr. Andy Wiley, and Mr. Anthony Boni, DS/POP; and Drs. Hugh Davis and Kevin Armstrong, JHPIEGO, in Washington.


Mark Speckhard, M.D. *Ked.*


Mark W. Oberle, M.D., M.P.H.

TABLE 1

Sterilization Report Forms Received
by Ministry of Health, Colombia*

1979

July	59
August	147
September	111
October	226
November	249
December	437

1980

January	268
February	372
March	176

*Data provided by MOH on May 23,
1980.

TABLE 2

Sterilizations in Selected Ministry of Health Hospitals in Colombia
January through March 1980

Regional Hospitals	On Site Estimates of Sterilization				Total Sterilizations Reported to MOH	% Sterilizations Reported to MOH
	Endoscopic	Other	Total Sterilizations	% Endoscopic Sterilizations		
Plata	20	12	32	63	15	47
zon	5	24	29	17	24	83
alito	16	9	25	64	14	56
ere	0	90	90	0	0	0
celejo	1	54	55	2	3	5
men de B.	0	180	180	0	0	0
ranquilla	<u>0</u>	<u>75</u>	<u>75</u>	<u>0</u>	<u>43</u>	<u>57</u>
	42	444	486	9	99	20

TABLE 3

Endoscopic Sterilizations in Selected Ministry of Health Hospitals in Colombia

January through March 1980

<u>Regional Hospital</u>	<u>Equipment</u>	<u>Endoscopic Sterilization by Month from Onset of Hospital Program Through March 1980</u>	<u>Prime Limiting Factor</u>	<u>Recommendation</u>
1.	Fallope-ring Laparoscope - System B	0-0-0-0-0-0-0-0-0-0	Motivation. Demand met by Profamiliar through February 1980. Dr. Daza visited in January and encouraged use of laparoscope. Now have waiting list of patients. Thought insufflation volume indicator malfunctioning but working well and fuction explained during our visit. They plan to begin endoscopic sterilizations soon.	Visits at regular intervals by Department MCH staff with check list and occasional visit by Central Office
2	Laprocator	1-0-2-0-11-9	None now. A faulty gas line connector and fluctuation in electrical power limited program in past but were resolved. An episode of pyosalpinx following an endoscopic sterilization evoked negative response in community but this has abated.	None. The staff is interested, has overcome obstacles, and program is flourishing
3	Laprocator	2-1-2-2	Demand. The local priest is in opposition and "people just are not motivated".	None. Demand may increase in time.
4	Laprocator	0-3-3-4-12-0	Equipment (temporary). CO ₂ supply depleted in March. Only have small cylinder.	Have large cylinder available.
5	Laprocator and Fallope-ring laparoscope - System B	0-0-2-3-0-3-0	Personnel. Trained despite disinterest because no alternative candidate.	Train only those who are interested. Train newly arrived obstetrician who is interested.

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STERILIZATIONS IN MINISTRY OF HEALTH HOSPITALS IN COLOMBIA (Continued)

January through March 1980

<u>Regional Hospital</u>	<u>Equipment</u>	<u>Endoscopic Sterilization by Month from Onset of Hospital Program Through March 1980</u>	<u>Prime Limiting Factor</u>	<u>Recommendation</u>
6	Laprocator	0-0-0-0	Personnel. Nurse quit shortly after training. Did not report loss until our visit.	Regular visits by Department MC staff with check list should identify problem promptly, perhaps in some cases in advance.
7	Laprocator	2-1-2-0-0-0-1	Competition. Profamilia meets patient demand and pays physician.	
8	Laprocator	0-0-0-0	Competition. Profamilia meets patient demand and pays physician	
9	Laprocator	0-0-0-0-0-0-0-0	Motivation. Three procedures done just prior to our visit,	Regular visits by Department MCH staff with check list.
10	Laprocator	0-0-0-0-0-0-0-0-0	Motivation. Three procedures done day of our visit.	Regular visits by Department MCH staff with check list.

TABLE 4

Female Sterilizations in Ministry of Health Hospitals and by
PROFAMILIA in Selected Cities in Colombia
January through March 1980

Cities	Estimated Sterilizations in MOH Regional Hospitals			Sterilizations by PROFAMILIA†			Estimated MOH & PROFAMILIA Sterilizations	
	Total	Endoscopic	Percent Endoscopic	Total	Endoscopic	Percent Endoscopic	Total	Percent MOH
La Plata	32	20	63	0	0	--	32	100
Garzon	29	5	17	0	0	--	29	100
Pitalito	25	16	64	11	9	82	36	69
Cereté	90	0	0	0	0	--	90	100
Sincelejo	55	1	2	284	0	0	339	16
Carmen de Bolívar	180	0	0	85*	0	0	180	NA
Farranquilla	<u>75</u>	<u>0</u>	<u>0</u>	<u>749</u>	<u>749</u>	<u>100</u>	<u>824</u>	<u>9</u>
	486	42	9	1129	758	67	1530	23**

†PROFAMILIA, Informe de Activades de Servicio, Primer Trimestre 1980, Boletín de Evaluación y Estadística No. 17, Bogota, Abril 1980

*Performed in Regional Hospital and included in total for Regional Hospital.

**Carmen de Bolívar is excluded because PROFAMILIA sterilizations performed in MOH hospital.

FIGURE 1

Current Reporting Form for Female Sterilization

MINISTERIO DE SALUD DIRECCION DE ATENCION MEDICA DIVISION MATERNO INFANTIL		NO. HISTORIA CLINICA _____
ESTERILIZACION FEMENINA		
1- SERVICIO SECCIONAL DE SALUD DE _____	2- MUNICIPIO _____	3- HOSPITAL _____
4- APELLIDOS _____	NOMBRE _____	5- EDAD _____
6- DIRECCION _____		
7- Año de nacimiento [][]	8- Zona de Residencia U [] R []	9- Educación: Años de estudio [][]
10- Número de Embarazos [][]	11- Hijos nacidos vivos [][]	12- Hijos vivos actualmente [][]
13- Hijos nacidos muertos [][]	14- Abortos [][]	15- Resultado del último M.V. Embarazo <input type="checkbox"/> Aborto <input type="checkbox"/>
16- Tiempo entre la Terminación del último embarazo y este procedimiento		Menos de 1 hora <input type="checkbox"/> Después de 1 hora hasta la salida del Hospital <input type="checkbox"/> De la salida del Hospital hasta 6 semanas <input type="checkbox"/> 6 semanas o mas <input type="checkbox"/>
17- Razón principal para este procedimiento		Médicas <input type="checkbox"/> Desna de no mas hijos <input type="checkbox"/> Socio-Económicas <input type="checkbox"/> Otras <input type="checkbox"/> Cual: _____
18- Ha estado planificando antes de esta intervención	19- Último Método anticonceptivo usado antes de esta intervención	20- Tiempo de uso del mismo
SI <input type="checkbox"/> NO <input type="checkbox"/> Min-Salud <input type="checkbox"/> Profamilia <input type="checkbox"/> Otros <input type="checkbox"/>	Día <input type="checkbox"/> Anovulatoria <input type="checkbox"/> Otro <input type="checkbox"/> Cual: _____	menos de 3 meses <input type="checkbox"/> de 3 a 12 meses <input type="checkbox"/> de 1 a 2 años <input type="checkbox"/> mas de 2 años <input type="checkbox"/>
21- Exámen Pélvico	22- Infección Pélvica	23- Anestesia
Normal <input type="checkbox"/> Adherencias <input type="checkbox"/> Prolapso <input type="checkbox"/> Fibromas <input type="checkbox"/> Quiste <input type="checkbox"/> Combinación _____ Otro _____	Ninguna <input type="checkbox"/> SI, Aguda <input type="checkbox"/> SI, Crónica <input type="checkbox"/> Cual: _____	Local <input type="checkbox"/> Regional <input type="checkbox"/> General <input type="checkbox"/> Analgesia <input type="checkbox"/> Otra <input type="checkbox"/> Cual: _____
24- Procedimiento Efectuado por	25- Procedimiento Realizado	26- Técnica de Oclusión
Interno <input type="checkbox"/> Médico general <input type="checkbox"/> Residente <input type="checkbox"/> Gineco-Obstetra <input type="checkbox"/> Cirujano general <input type="checkbox"/>	Miniaparotomia <input type="checkbox"/> Laparotomia <input type="checkbox"/> Laparoscopia <input type="checkbox"/> Colpocomia <input type="checkbox"/> _____	Solo Ligadura <input type="checkbox"/> Ligadura y Corte <input type="checkbox"/> Fimbriectomia <input type="checkbox"/> Salpingectomia <input type="checkbox"/> Anillo Tubario <input type="checkbox"/> Clip <input type="checkbox"/> Cauterización <input type="checkbox"/> Otra <input type="checkbox"/> Cual: _____
27- Fecha de la Cirugia [][] / [][] / [][]	28- Nombre del Cirujano _____	
29- Post-Operatorio Inmediato		
HORA	PULSO	T. A. MAX MIN
OBSERVACIONES		
30- Fecha programada primer control [][] / [][] / [][]		
ORIGINAL: MINISTERIO DE SALUD - DIVISION MATERNO - INFANTIL		

FIGURE 2

SUGGESTED CHANGES TO CURRENT STERILIZATION REPORTING FORM
FOR FEMALE STERILIZATION

25. Approach to Sterilization

- Caesarean Section
- Postpartum Periumbilical
- Interval minilaparotomy
- Laparoscopy
- Colpotomy
- Laparotomy

x. Source of Payment

- Ministry of Health
- Social Security
- PROFAMILIA
- Private
- _____

Current Precoded Line-listing Form for Reporting
New Users of Contraceptives

SISTEMA NACIONAL DE SALUD
SUBSISTEMA DE INFORMACION

SIS - 135

PAGINA No.
 1 2

REGISTRO DIARIO DE USUARIAS NUEVAS DE PLANIFICACION FAMILIAR

Seccional _____ Municipio _____

Organismo _____

MES
 12 13
 AÑO
 14 15

No. DE ORDEN	No. HISTORIA CLINICA O NOMBRE ABREVIADO	ZONA DE RESIDENCIA		EDAD EN AÑOS CUMPLIDOS	No. DE HIJOS VIVOS		LEE Y ESCRIBE		DONDE OBTUVO METODO ANTICON. ANTES DE ESTA ATEN.				METODO ADOPTADO EN ESTA ATENCION				ATENIDO POR	
		U	R		18	19	20	21	22	23	24	25	26	27	28	29	30	M.O.
01		1	2				1	2	1	2	3	4	1	2	3	4	1	2
02		1	2				1	2	1	2	3	4	1	2	3	4	1	2
03		1	2				1	2	1	2	3	4	1	2	3	4	1	2
04		1	2				1	2	1	2	3	4	1	2	3	4	1	2
05		1	2				1	2	1	2	3	4	1	2	3	4	1	2
06		1	2				1	2	1	2	3	4	1	2	3	4	1	2
07		1	2				1	2	1	2	3	4	1	2	3	4	1	2
08		1	2				1	2	1	2	3	4	1	2	3	4	1	2
09		1	2				1	2	1	2	3	4	1	2	3	4	1	2
10		1	2				1	2	1	2	3	4	1	2	3	4	1	2
11		1	2				1	2	1	2	3	4	1	2	3	4	1	2
12		1	2				1	2	1	2	3	4	1	2	3	4	1	2
13		1	2				1	2	1	2	3	4	1	2	3	4	1	2
14		1	2				1	2	1	2	3	4	1	2	3	4	1	2

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No. DE ORDEN	No. HISTORIA CLINICA O NOMBRE ABREVIADO	ZONA DE RESIDENCIA		EDAD EN AÑOS CUMPLIDOS		No. DE HIJOS VIVOS		LEE Y ESCRIBE		DONDE OBTUVO METODO ANTICON. ANTES DE ESTA ATEN.				METODO ADOPTADO EN ESTA ATENCIÓN				ATENIDO POR	
		U	R	18	19	20	21	22	SI	NO	23	24	25	26	27	28	M.O.	Perf. Ent.	
15		1	2					1	2	1	2	3	4	1	2	3	4	1	2
16		1	2					1	2	1	2	3	4	1	2	3	4	1	2
17		1	2					1	2	1	2	3	4	1	2	3	4	1	2
18		1	2					1	2	1	2	3	4	1	2	3	4	1	2
19		1	2					1	2	1	2	3	4	1	2	3	4	1	2
20		1	2					1	2	1	2	3	4	1	2	3	4	1	2
21		1	2					1	2	1	2	3	4	1	2	3	4	1	2
22		1	2					1	2	1	2	3	4	1	2	3	4	1	2
23		1	2					1	2	1	2	3	4	1	2	3	4	1	2
24		1	2					1	2	1	2	3	4	1	2	3	4	1	2
25		1	2					1	2	1	2	3	4	1	2	3	4	1	2
26		1	2					1	2	1	2	3	4	1	2	3	4	1	2
27		1	2					1	2	1	2	3	4	1	2	3	4	1	2
28		1	2					1	2	1	2	3	4	1	2	3	4	1	2

FIGURE 4

Suggested Precoded Line-listing Form for
Reporting Female Sterilizations

Pagina No. 1 2 of 3 4 paginas

REGISTRO MENSUAL DE ESTERILIZACION FEMINA

Seccional _____ Municipal _____

Hospital _____ 5 _____ 13 Mes 14 15 Ano 16 17

Fecha	No. de orden	No. Historia clinica o nombre abreviado	Edad en anos cumplidos		No. de hijos vivos	Acceso de esterilizacion						
			22	23		24	25	Cesareo	Post. parto	Mini lap	Laparo scopio	Colpo tomia
18 19	20 21		22	23	24	25	26					
	0 1						1	2	3	4	5	6
	0 2						1	2	3	4	5	6
	0 3						1	2	3	4	5	6
	0 4						1	2	3	4	5	6

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ATTACHMENT 1

Checklist for Division Materno-Infantil Regional Coordinators
When Reviewing Hospital Sterilization Programs
REVIEW OF STERILIZATION PROGRAM

Hospital _____ Date _____ Visited _____

Review report in the hospital of procedures performed and compare with report submitted to Department. The following questions will provide a guide for reviewing the program and a personal reminder of problem areas and projected solutions for use when you next review the hospital program.

Reports

- Is there an adequate supply of report forms?
- Who prepares the forms? Any problems?
- How many sterilizations are being performed?
- Does this number agree with number reported to Department?
- Are all sterilizations being reported?
- Are all diagnostic endoscopies being reported?

Personnel

- How many physicians perform sterilizations (by specialty)?
- Who has been trained in endoscopy (include date)?
- Have those trained received tutorials?
- Is secondary training of other physicians taking place?
- Is there any problem in lack of trained personnel?

Equipment

- What type of endoscopy equipment is installed (include date)?
- Where is the equipment stored?
- Is there need for more equipment?
- What type of gas is used?
- Where is supply of gas obtained?
- Is there any problem in obtaining supply of gas?
- Is there a large cylinder at the hospital?
- How is equipment sterilized? Any problem?
- Any maintenance problems?
- Any electric power problems?

Program

- What is the current demand for sterilization?
- How do women obtain access into the sterilization program (review each step)?
- Are there any obstacles to access?
- What hours are sterilization services provided?
- What is the cost of sterilization to the patient?
- Is transportation a problem for patients?
- How long do patients stay in the hospital for sterilization?
- Have there been any notable complications?

Limiting Factors

- What factors currently limit the hospital in providing sterilizations?

RESOLUTION

- What can be done to resolve factors that currently limit providing sterilizations?
- What is the first step which should be taken?
- When can one reasonably expect this first step to be accomplished?

ATTACHMENT 2

Background Sketch of 10 Regional Hospitals Visited

I. REGIONAL HOSPITAL, NEIVA - 150 BEDS

This hospital has 2 obstetrician-gynecologists who perform sterilizations. Dr. Ricardo Lievano completed his training in laparoscopy in May 1979, and a laparocator was installed at the hospital in that same month. There is current unmet demand for sterilization. However, no endoscopic sterilizations have been done during the 11 months that the program has been in place. Only an occasional sterilization of any type has been done during the first 3 months of 1980, and only 2 have been reported.

Limiting Factor

1. Through February 1980 the demand for sterilization has been met by PROFAMILIA. At least one of the MOH obstetricians does sterilizations for PROFAMILIA at night. In January 1980, Dr. Luis Daza, Chief of the Division of Maternal and Child Health and Population Dynamics for the MOH visited the hospital and strongly encouraged utilization of the laparoscopic equipment. Dr. Lievano reported that since February they have identified unmet demand for sterilization, and there is a current waiting list of 10 patients.
2. Laparoscopic procedures had not been initiated because the volume gauge on the insufflator was thought to be malfunctioning. During our visit the equipment was examined and noted to be working well; the function of the volume indicator was explained to the laparoscopy nurse and anesthesiologist.
3. Air conditioning for the surgical suite had not been functioning in recent months, and hospital personnel reported that elective procedures are referred to Bogota. After discussion, Dr. Lievano noted that they did intend to begin endoscopic sterilizations soon without air conditioning since the procedures are short.

II. REGIONAL HOSPITAL, LA PLATA

Dr. Victor Bonilla completed his endoscopic training in September 1979, and a laparocator was installed in October 1979. This hospital is the sole source of sterilizations in the area, and there is current unmet demand for sterilization. Hospital personnel estimated 32 sterilizations were performed in the past 3 months, of which 15 were reported to the MOH. Twenty endoscopic sterilizations have been performed in the 6 months that the endoscopic program has been in effect. The number of endoscopic procedures show a marked increase in the last 2 months. Personnel at La Plata showed marked interest in the program, have demonstrated an ability to overcome obstacles, and are developing an effective program.

Limiting Factors

1. A faulty connector in the gas line was repaired.
2. Fluctuation in electrical power was resolved with a voltage regulator.
3. Pyosalpingitis developed in one woman following an endoscopic sterilization procedure and evoked a negative reaction in the community, but this was temporary and has now abated.

COMMENT: Personnel suggested that there be training during the PIEGO course in completing the MOH report form.

III. REGIONAL HOSPITAL, GARZON - 80 BEDS

Dr. Heladio Motta completed his training in December 1979; the laparocator had been installed in October 1979. There is limited demand both on religious grounds and because "people just are not motivated to be sterilized." The hospital is currently meeting the demand for sterilization. Personnel estimated there were 29 sterilization procedures accomplished in the last 3 months. There were 7 endoscopic sterilizations in the 4 months since the program has been in effect.

Limiting Factors

None.

COMMENTS: The laparoscopist has found the laparocator is too short for use in obese women. He noted that he had been trained using an insufflator with a volume indicator and regretted the lack of a volume indicator on his laparocator equipment. However, he felt that with experience, he could compensate for the lack of the volume indicator.

IV. REGIONAL HOSPITAL, PITALITO - 84 BEDS

Dr. Reinaldo Rojas completed his training in September 1979, and a laparocator was installed in October 1979. Demand for sterilization is moderate, and the hospital has no problem in meeting the demand. Personnel estimated 25 sterilizations were accomplished in the last 3 months, of which 14 were reported to the MOH. Sixteen endoscopic sterilizations have been accomplished in the 9 months that the program has been in effect.

Limiting Factors

1. Supply of gas depleted in March and took one month to refill small cylinders. Do not have large cylinder.

V. REGIONAL HOSPITAL, MONTERIA - 302 BEDS

Dr. Julio Zapateiro completed his training in June 1979, and a laparocator was installed in September 1979. The hospital does not meet the demand for

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sterilization; there are currently 13 patients on the waiting list. Personnel were not able to estimate total sterilizations performed in the past 3 months. Eight endoscopic sterilizations have been performed in the 7 months since the program began.

Limiting Factors

1. The laparoscopist was sent for training because there was no other candidate, even though he expressed disinterest in the program. Both a laparocator and a system B laparoscope are available. A new obstetrician interested in endoscopy, has arrived in the community and would be a good candidate for training.

VI. REGIONAL HOSPITAL, CERETE - 150 BEDS

Dr. Cristobal Petro completed his training in November 1979, and a laparocator was installed in December 1979. There is much demand for sterilization in the community, but demand cannot be met because of lack of hospital beds and surgical time. Even with the use of the endoscope, there may not be enough operating room time to meet the demand, but it would be markedly improved. Personnel estimated 90 sterilizations were accomplished in the last 3 months. No endoscopic sterilizations have been performed in the 4 months that the program has been in place.

Limiting Factor

1. The laparoscopy nurse quit shortly after completing her training, and the loss was not reported until our visit.

VII. REGIONAL HOSPITAL, SINCELEJO - 162 BEDS

Dr. Francisco Vergara completed his training in May 1979, and a laparocator was installed in September 1979. PROFAMILIA is able to meet the large demand for sterilization and pays physicians for the procedure. Personnel estimated 55 sterilizations were accomplished in the past 3 months. Six endoscopic sterilizations have been performed in the 7 months that the program has been in effect.

Limiting Factor

1. PROFAMILIA is able to meet the demand for sterilization and pays the physician.

COMMENTS: Personnel felt that if PROFAMILIA discontinued sterilizations the regional hospital could not meet the demand unless it increased its gynecologic coverage over the present 2 hours a day. In addition, operating room time is limited. Demand might decline somewhat since PROFAMILIA is free to the patient whereas the regional hospital charges the patient 600 pesos (\$U.S. 13.00).

Part Four
APPENDICES

Appendix A
SCOPE OF WORK FOR JHPIEGO EVALUATION

JHPIEGO Evaluation

Although JHPIEGO has not had a formal A.I.D. Evaluation since that of Drs. Moulding and Burnhill in October 1976*, an A.I.D. Management Audit was initiated in September 1977 and was not concluded until May of 1979. This Management Audit** looked into many aspects of JHPIEGO's United States and overseas operations for the period 1974 through 1977. The 15 recommendations arising from this Management Audit were finally all closed out in September 1980 on the basis of a new Cooperative Agreement*** just concluded between A.I.D. and JHPIEGO.

In addition to an evaluation of present JHPIEGO activities, A.I.D. hopes the Evaluation Team will also offer suggestions and/or recommendations for new JHPIEGO directions or new future activities where this appears useful as a new five-year JHPIEGO Project is about to be put together for A.I.D. overall review and approval. The long duration of the Management Audit, and the extensive examination and documentation it entailed, has provided A.I.D. an in-depth picture of day-to-day JHPIEGO operations and procedures. Therefore, it is not necessary for this Evaluation Team to focus on the details of JHPIEGO operations.

In general, A.I.D. would like the Evaluation Team to describe, briefly discuss and evaluate most of the aspects of the JHPIEGO program listed below under: I. Baltimore-Based Activities; and, II. Overseas Programs.

I. Baltimore-Based Activities

A. Table of Organization

How effectively do the various central JHPIEGO components carry out planning, internal coordination, communication with field programs and ongoing monitoring and reporting of field programs.

B. Baltimore Training Programs

How appropriate for LDCs are the subjects, the faculty, the educational methods and materials, the foreign language courses and the qualifications of the course participants.

C. JHPIEGO Relationships

1. JHPIEGO Relationships with Johns Hopkins University

- a. Comments on JHU-JHPIEGO Relationship: its advantages and disadvantages to JHPIEGO, to Johns Hopkins University and to A.I.D.
- b. Suggestions for future developments in the JHPIEGO relationship with JHU School of Hygiene and Public Health.

* Attachment 1

** Attachment 2

*** Attachment 3

2. JHPIEGO Relationship with Other Agencies:

Comment on the JHPIEGO's relationship to other JHPIEGO donors, to other A.I.D. Grantee agencies, and to non-A.I.D. funded Family Health and Family Planning Agencies.

D. JHPIEGO Selection and Use of Consultants

How appropriate does this appear to be?

E. The JHPIEGO International Advisory Council

How valuable does the role of this Council appear to be? How appropriate is its present composition? Suggestions for future changes in its role, if any.

F. The JHPIEGO Equipment Committee

How valuable does its present role appear to be? What changes, if any, would you suggest in its role in the future?

G. Present General Assessment of JHPIEGO and Future Suggestions in Regard To:

1. Funding
2. Staffing
3. Space
4. Equipment and commodities
5. Training Priorities
6. Overall Management

II. For Overseas Programs

A. In-Country Program Development

How long has the process taken and how is it progressing.

B. The JHPIEGO Program in Relation to Post-Graduate Reproductive Health Training Needs In-Country for Physicians and for Nurses

Is it meeting these needs? What additional steps appear necessary, if any?

C. JHPIEGO Relationship to and/or Coordination with the Ministry of Health and/or Related Government Bodies

Is it satisfactory?

D. JHPIEGO's Program in Relation to Priorities or Interests of the USAID Mission and/or the U.S. Embassy

How appropriate is it?

E. JHPIEGO's Coordination with Other A.I.D.-funded Population-Related Programs In-Country

Is coordination occurring where this appears important? What additional coordination, if any, might be beneficial to programs?

F. Maintenance and Utilization of JHPIEGO-Provided Endoscopic Equipment In-Country

1. How well is such maintenance handled in-country? If such maintenance handled in-country by JHPIEGO or by another A.I.D. Grantee? Does the supply of spare parts seem adequate? Are enough falope rings available? Suggestions, if any, for improvement in maintenance.

2. How effectively does the endoscopic equipment provided by JHPIEGO appear to be used? Are underused instruments being reassigned? Do there appear to be enough instruments available for qualified trainees? Suggestions, if any, for assigning equipment.

G. The Desirability and/or Feasibility of JHPIEGO Providing Program Equipment and Supplies other than Endoscopic Equipment, Medical Kits and Training Supplies

Are supplies generally sufficient for JHPIEGO trainers to effectively use their skills and equipment? What additional items, if any, could JHPIEGO usefully and easily provide?

H. Appropriateness of Equipment Being Provided and Effectiveness of JHPIEGO's System for Delivering Equipment

1. How appropriate does the endoscopic equipment delivered by JHPIEGO appear to be? Is it being put to effective use? What modifications of the equipment, if any, could or should be made?

2. How well does JHPIEGO's method for delivering equipment appear to work? What suggestions, if any, are there for improvement?

I. Technical/Medical Aspects of the JHPIEGO In-Country Training Program; Including Suggestions and Rationale for Desired Changes, if any, and How Best to Effect Such Changes

1. Do the techniques being taught appear appropriate? Are there additional techniques that should be taught? Additional subjects covered? Do trainees appear to receive enough clinical practice? Are there additional training aids or methods which could usefully be made part of the training program?

2. How could suggested changes, if any, be most readily made part of the training program?

J. The Long Range Effect of JHPIEGO U.S.-Based Training

How effectively do JHPIEGO trainees appear to be utilizing their training in meeting in-country reproductive health needs?

K. The Possibilities and Desirabilities of JHPIEGO Supporting and Encouraging Training and Equipping of Doctors in Private Practice

1. Does this appear to be an in-country need? If so, what seems to be the size of the need? Does such training seem feasible?
2. If there is a need and it appears feasible to meet it, what might be suggested means or agencies for effecting this in-country?

L. JHPIEGO's Role in Ongoing Support and Monitoring of the In-Country Training Program

1. How effectively is this being done?
2. Do JHPIEGO procedures for monitoring compliance with A.I.D. guidelines on abortion (AID Policy Determination No. 56) and voluntary sterilization (AID Policy Determination No. 70) appear adequate?
3. Suggestions, if any, for changes in policies and procedures for 1 and 2.

M. The JHPIEGO In-Country Program in Relation to Reproductive Health Training Needs and Priorities of that Geographic Region

Is the in-country program helping to meet regional training needs? If so, how is this being done and what appears to be the result? If not, would it be useful and/or feasible to do so?

N. JHPIEGO in Relation to Schools of Medicine and Nursing In-Country

What appears to be the present relationship, if any? Does an increasing future relationship appear feasible and desirable? If so, in what ways?

O. JHPIEGO's Present Acceptability and Future Opportunity In-Country

How do you assess this?

Appendix B
SCHEDULE FOR EVALUATION

Appendix B
SCHEDULE FOR EVALUATION

<u>Monday, October 27, 1980</u>	CONFERENCE ROOM 216 RPE
9:15 a.m. - 10:30 a.m.	Review of JHPIEGO Evaluation Plan and Worksopce DS/POP/TI, Andrew T. Wiley, M.D.
10:30 a.m. - 10:45 a.m.	JHPIEGO in Relation to Other Training Division Activities DS/POP/TI, Barbara Kennedy, Rn.N., CNM
10:45 a.m. - 11:15 a.m.	JHPIEGO in Relation to Office of Population Priorities DS/POP/DIR, Joe Speidel, M.D. DS/POP/DIR, Patricia Baldi, R.N.
11:15 a.m. - 11:30 a.m.	JHPIEGO in Relation to AID Policies and Objectives DAA/DS/HRD, Steve Joseph, M.D.
11:30 a.m. - 12:30 p.m.	Review of JHPIEGO Documents Originating Documents, 1973, 1974 AID Evaluation (Drs. Moulding and Burnhill), 1976 AID Audit Report, 1979 JHPIEGO Response to Audit, 1979 New Cooperative Agreement, 1980
12:30 p.m. - 1:30 p.m.	Lunch
1:30 p.m. - 3:00 p.m.	General Briefing Representatives of: Training Division Family Planning Services Division Commodity Branch Grants Branch Research Division Regional Divisions Contract (Grants) Office Regional Bureaus DSB Program Office

3:00 p.m. - 4:00 p.m.

History and Present Status of
AID/JHPIEGO Relationship
DS/POP/TI, Andrew T. Wiley,
Project Officer

4:00 p.m. - 5:00 p.m.

Review of Evaluation Plan and
Logistics: Questions and Answers
DS/POP/TI, Andrew T. Wiley
APHA, Barry Carlin
APHA, Judy Simmons

Tuesday, October 28, 1980

8:30 a.m. - 9:30 a.m.

Overview of JHPIEGO

Room 852

Dr. Ronald T. Burkman, Director
Ms. Charlotte Ellis, Assistant
to President
Dr. Ronald H. Magarick, Director,
Program Division
Dr. Andrew T. Wiley, AID/Washington

9:30 a.m.

Briefings by Regional
Development Officers

Room 855

9:30 a.m. - 10:30 a.m.

Africa

Mr. Wilbur Wallace,
Regional Development Officer
Dr. Douglas Huber,
Regional Development Officer
Ms. Connie Husman,
Program Development Officer

10:45 a.m. - 11:45 a.m.

Asia

Dr. Kasturi Rajadhyaksha,
Regional Development Officer
Ms. Connie Husman
Dr. Ronald Magarick

11:45 a.m. - 12:45 p.m.

Latin America

Dr. Hugh Davis,
Regional Development Officer
Mr. Kevin Armstrong, Assistant
Regional Development Officer
Ms. Laura Altobelli,
Program Development Officer

12:45 p.m. - 1:45 p.m.

Lunch

Dr. Ronald Burkman
Dr. Ronald Magarick

2:00 p.m. - 3:15 p.m.

Program and Operations Support Division

Dr. Ronald Magarick
Ms. Ann R. Wurzberger,
Program Coordinator
Ms. Joyce Ohl, Grants Officer
Ms. Marie Mitchell,
Assistant Grants Officer

History and Evaluation

Ms. Franca Barton,
Senior Research Assistant
Dr. Margaret Bright, Director,
History and Evaluation

4:15 p.m. - 5:00 p.m.

Resource Management

Mr. John Blouse, Director,
Resource Management
Ms. Charlotte Ellis

Wednesday, October 29, 1980

9:00 a.m. - 10:00 a.m.

Equipment Unit

Dr. Ronald Burkman
Mr. Chung Oh,
Assistant Equipment Manager

10:00 a.m. - 10:45 a.m.

JHPIEGO Educational Center Program

Dr. John Lesinski, Director,
Educational Center

10:45 a.m. - 11:00 a.m.

JHPIEGO Film:
"Techniques of Laparoscopy"

11:15 a.m. - 12:00 p.m.

Educational Resources

Dr. Ronald Magarick
Ms. Nancy Brown,
Administrative Assistant
Ms. Laura Altobelli

12:00 p.m. - 1:30 p.m.

Lunch with Trainees

Mr. Kevin Armstrong
Ms. Laura Altobelli

1:30 p.m. - 2:30 p.m.

Ad Hoc Meetings

2:30 p.m. - 3:30 p.m.

Closing Discussions

Dr. Ronald Burkman
Ms. Charlotte Ellis
Dr. Ronald Magarick
Dr. Theodore M. King,
President, JHPIEGO
Dr. Andrew Wiley

Appendix C
MATERIALS FOR EVALUATION
(By Division)

Appendix C

MATERIALS FOR EVALUATION
(By Division)

Assistant to President

JHPIEGO Organization Chart

Members of the Board of Directors

Members of the International Council

Programs and Minutes of Meetings of the International Council, 1979 and 1980

Program Support

"Educational and Training Programs for Reproductive Health"

"JHPIEGO Programs for Reproductive Health"

"Sources of Educational Materials in Reproductive Health and Family Planning
for the Training of Medical Students and Graduate Physicians"

"Sources of Research Funds in Reproductive Health"

JHPIEGO Project Development Process

List of Visitors to JHPIEGO

JHPIEGO Forms Package for In-Country Programs (English)

List of JHPIEGO Publications

Grants Support

In-Country Subagreement and Amendment Summary Sheet

Equipment (2 Tables)

Status of Equipment Shipped Since Inception

Status of Equipment Shipped FY 1980

Training Center

Samples of Course Schedules

Samples of Course Handouts

List of Lectures (each course)

List of Educational Materials (each course)

Educational Materials

List of Materials Distributed to Training Center Participants

List of Materials Contained in Educational Packages

Educational Resources: Summary Sheet

Equipment Manuals: Laprocator and A & B

Draft of Key Biscayne Proceedings

RDO/Latin America

Report of Activities in JHPIEGO Latin Region, FY 1980

Colombian National Surgical Training Proposal (NCA-30)

CPAIMEC Second-Year Proposal

Reproductive Health Educational Program Resume

RDO/Africa

Copy of Moroccan Proposal

Copy of Tunisia Proposal

Regional Summary for African Region, FY 1980

Tunisian Participant List (Updated)

RDO/N.E./Asia

Status Report of FY 1980 and Plans for FY 1981 in Asia and the Middle East

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Proposals From:

Philippines (First Year and Continuation Program)

Thailand

Indonesia

Turkey

Al Azhar, Egypt

Alexandria, Egypt

Sudan

Malaysia

Program Reports:

Philippines (Annual and Quarterly)

Al Azhar (First Didactic Course)

Address and Phone Numbers and Contact List for Cairo, Alexandria;
Philippines; and Thailand

RDO/Africa/Asia

Egyptian Trip Report:

"Modern Contraceptives," by D. H. Huber; presented at
May 1980 Seminar, KCMC, Tanzania

Summary of Tanzania, Kenya, Nigeria, and Pakistan

History and Evaluation

First Clinicians Survey Questionnaire

Second Clinicians Survey Questionnaire

Administrators Survey Questionnaire

FY 1979 History and Evaluation Annual Report Appendix

Proposed History and Evaluation Activity Report

Appendix D

SCHEDULES AND DOCUMENTS FOR
DISCUSSIONS OF HEALTH ISSUES AND SURGICAL TECHNIQUES

ADVANCES IN REPRODUCTIVE HEALTH

Countries Represented

Monday,

8:30 - 9:00

WELCOME

Dr. Theodore M. King

9:00 - 10:15

Orientation

Dr. John S. Lesinski

10:15 - 10:30

Coffee Break

10:30 - 12:00

Administrative Briefings

Travel Arrangements

Educational Materials

12:00 - 1:45

Lunch

1:45 - 2:00

Visit to Personnel Office for ID Badges

2:00 - 3:00

Tour of the Dept. Ob/Gyn

3:00 - 5:00

Pre-Test

Tuesday,

8:00 - 10:00

The Silhouette of a Physician,
Researcher and Teacher

Moderator:

Speakers:

10:00 - 10:30

Coffee Break

10:30 - 12:00

Reproductive Health and Reproductive
Medicine - Recent Trends

12:00 - 1:00

Lunch

1:00 - 2:00

Genetics and Reproduction

2:00 - 2:30

Coffee Break

2:30 - 3:30

Physical and Chemical ENvironment
and Reproduction

3:30 - 4:30

Social Environment and Reproduction

Wednesday,

8:30 - 10:00

High Risk Concept in Reproductive
Health Care

10:00 - 10:30

Coffee Break

10:30 - 12:00

Role of the Gynecologic and Obstetrical
Pathology in Clinical Research

12:00 - 1:30

Lunch

1:30 - 4:00

Individual Course Objectives:
Overview
Particular Interests
Decision-Making Matrix
Action Plans-Program Development
Study Assignment: The Four Part Lesson
Plan.

2:30 - 3:00

Coffee Break

3:00 - 4:00

Continuation

4:00 - 5:00

Visit to Visa Service Office

Thursday,

8:00 - 11:30

Curriculum Instruction Model
Values Assessment and Goal Setting
Curriculum Development
Instructional Implementation
Outcome Assessment
Evaluation of Instruction

10:00 - 10:30

Coffee Break

11:30 - 12:00

Review of JHPIEGO Programs Room

12:00 - 1:00

Lunch With JHPIEGO Staff
Hampton House 9th Floor

1:30 - 4:00

Students presentations on physicians
education and research in reproductive
health.

2:30 - 3:00

Coffee Break

3:00 - 4:00

Continuation

Friday,

8:00 - 10:00

Lecture Skills
Organization of contents
Pacing and Interaction
Summary and Supplement
The Four-Part Lesson

10:00 - 10:30

Coffee Break

10:30 - 12:00

Continuation

12:00 - 1:30

Lunch

1:30 - 2:30

Teaching Skills Laboratory
Rating Lectures & Presentations
Questioning Skills & Exercises
Procedures for Participant's Demonstratic
Selection of Topics

Demonstrations

- (1) for participants
- (2) for AV preparation practicum
- (3) for research protocols

2:30 - 3:00

Coffee Break

3:00 - 4:00

Assignment: Background reading on
selected topics Due:

Monday,

8:00 - 12:00

Sources of Data
Vital Statistics
Samples
Special Studies
Definition of terms
Problems of Measurement

10:00 - 10:30

Coffee Break

10:30 - 12:00

Continuation

12:00 - 1:30

Lunch

1:30 - 2:30

Measurement of outcomes of Reproduction
and Disease
Important Variables in Assessing Outcome
Incidence, Prevalence, Mortality,
Adjustments

2:30 - 3:00

Coffee Break

3:00 - 4:00

Continuation

Tuesday,

8:00 - 12:00

Indices of Health
Morbidity and Mortality Ratios
Standardized Rates
Life Tables

10:00 - 10:30

Coffee Break

12:00 - 1:30

Lunch

1:30 - 2:30

Descriptive epidemiology - clues to
etiology
Time, place and person
Examples in infectious disease,
reproduction

2:30 - 3:00

Coffee Break

3:00 - 4:00

Continuation

Wednesday,

8:00 - 12:00

Inferences from Categorical Data
Binomial Distribution
 X_2

10:00 - 10:30

Coffee Break

12:00 - 1:30

Lunch

1:30 - 2:30

Analytic Studies
Case-control - use in congenital
malformations
Cohort
Criteria for cause and effect

~~2:30~~ - 3:00

Coffee Break

3:00 - 4:00

Continuation

Thursday,

8:00 - 12:00

Inference from Measurement Data
Parameters of Populations
Comparisons of Means for independent
paired data

10:00 - 10:30

Coffee Break

10:30 - 12:00

Continuation

12:00 - 1:30

Lunch

1:30 - 2:30

Experimental Designs
Drug Evaluation
Surgical Methods

2:30 - 3:00

Coffee Break

3:00 - 4:00

Continuation

Friday,

8:00 - 12:00

Confidence Intervals
Estimate of Sample Size
Two Types of Errors
Association between Variables

10:00 - 10:30

Coffee Break

12:00 - 1:00

Review of POPULATION INFORMATION
PROGRAMS

1:00 - 2:00

Lunch With POPINFORMATION Staff
Hampton House 9th Floor

2:00 - 3:00

Screening for Detection of Risk Factors
or Early Disease
Sensitivity
Specificity
Reliability
Screening in field of Obstetrics and
Gynecology

3:00 - 3:15

Coffee Break

3:15 - 4:15

Continuation

Monday,

8:00 - 12:00

Reading Research Critically

10:00 - 10:30

Coffee Break

10:30 - 12:00

Continuation

12:00 - 1:30

Lunch with Dr. King and Faculty
Room 393 Hampton House

1:30 - 4:00

Practical Exercises in Research
(Clinical and Laboratory)

Tuesday,

8:00 - 12:00

Writing a Research Proposal

Assignment: Write purpose, Rationale
and Objectives of a Research Proposal
Due:

NOTE: Must be on acetate for group
discussion.

10:00 - 10:30

Coffee Break

10:30 - 12:00

Continuation

12:00 1:30

Lunch

1:30 - 2:30

Small Group Processes
Communication Skills Training
Interpersonal Attending
Interpersonal Responding

2:30 - 3:00

Coffee Break

3:00 - 4:00

Identification of Funding Resources

Wednesday, -

8:00 - 12:00	Communication Skills Training Continued Small Group Processes Elicitation of Interaction Provision of Recognition & Praise Acceptance and Extension
10:00 - 10:30	Coffee Break
10:30 - 12:00	Continuation Assignment: 30 minute presentation on selected topic.
<hr/>	
12:00 - 1:30	Lunch
<hr/>	
1:30 - 4:00	Using Audio-Visual Media in Medical Presentation JHH Medical Arts -
2:30 - 3:00	Coffee Break
3:00 - 4:00	Continuation

Thursday,

8:00 - 12:00

Practicum in:
Writing a Research Proposal
Review purpose, rationale, objectives
Develop outline of methodology & evaluation
Assignment: Write methodology
protocols evaluation section

10:00 - 10:30

Coffee Break

10:30 - 12:00

Practicum in Writing a Research Proposal

12:00 - 1:30

Lunch

1:30 - 2:30

Practicum in Audio-Visual Media Preparation

JHU medical Arts Department -

2:30 - 3:00

Coffee Break

3:00 - 4:00

Continuation

Friday, _____

8:00 - 12:00

Round Table Discussion, Part I*

A Clinician: _____
A. Educator _____

10:00 - 10:30

Coffee Break

10:30 - 12:00

Round Table Discussion, Part II*

A. Clinician _____
A. Educator _____

*Participants should prepare information about problems in medical education and research in reproductive health in their Respective Countries

12:00 - 1:30

Lunch

1:30 - 2:30

Practicum In Audio-Visual Media
Preparation

JHU Medical Arts

2:30 - 3:00

Coffee Break

3:00 - 4:00

Continuation

Monday,

8:00 - 12:00

Practicum in Writing a Research Proposal
Individual critiques of Methodology &
evaluation & protocol sections of
proposal

10:00 - 10:30

Coffee Break

10:30 - 12:00

Continuation

12:00 - 1:30

Lunch

1:30 - 2:30

Practical Exercises in Obstetrical
& Gynecologic Research

Proposed Schedule of Faculty-Students
Conference

Presentation of Problems
Problem Analysis
Results
Critical Review

2:30 - 3:00

Coffee Break

3:00 - 4:00

Continuation

Tuesday,

8:00 - 12:00

Future of Fertility Management

10:00 - 10:30

Coffee Break

10:30 - 12:00

Practicum in Writing a Research Proposal

12:00 - 1:30

Lunch

1:30 - 2:30

Teaching Skills Laboratory
Testing & Performance Assessment
Curriculum Revision -- an evaluating
process
Practicum - Assessments for Individuals

2:30 - 3:00

Coffee Break

3:00 - 4:00

Continuation

Wednesday,

8:00 - 12:00

Working with Small Groups
Action Group
Discussion Group
Problem-solving Group

10:00 - 10:30

Coffee Break

10:30 - 12:00

Continuation

12:00 - 1:30

Lunch

1:30 - 2:30

Participant Demonstrations & Critiques

2:30 - 3:00

Coffee Break

3:00 - 4:00

Continuation

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Thursday,

8:00 - 12:00 Participants Demonstrations & Critiques

10:00 - 10:30 Coffee Break

10:30 - 12:00 Continuation

12:00 - 1:30 Lunch

1:30 - 2:30 Participants Demonstrations & Critiques

2:30 - 3:00 Coffee Break

3:00 - 4:30 Continuation

6:30 - 9:30 FAREWELL DINNER

6:00

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Friday, August 1, 1980

9:00 - 10:00

Post-Exam

10:00 - 10:30

Coffee Break

10:30 - 11:30

Course Evaluation

12:00 - 2:00

Lunch

2:00 - 3:00

Preparation of Educational Material
for Mailing

OPEN PROGRAM

SUGGESTIONS: Appointment With Individual
Faculty

177

THE MANAGEMENT OF THE INFERTILE COUPLE

Countries Represented

Monday,

9:00 - 9:30

Welcome

9:30- 10:15

Orientation

10:15- 10:30

Coffee Break

10:30 - 12:00

Administrative Forms Checks

Travel Arrangement

Educational Materials

12:00 - 1:45

Lunch

1:45 - 2:45

Visit to Personnel Office for ID Badges

2:45 - 3:45

Hospital Tour

3:45 - 5:00

Pre-Test

Tuesday,

9:00 - 10:00

Reproductive Health

10:00 - 10:15

Discussion

10:15 - 10:30

Coffee Break

10:30 - 11:30

Genetics Aspects of Reproduction

11:30 - 12:00

Discussion

12:00 - 1:30

Lunch

1:30 - 2:30

Chemical & Physical Environment
& Reproduction

2:30 - 2:40

Discussion

2:40 - 3:00

Coffee Break

3:00 - 4:00

Social Environment & Human Reproduction

4:00 - 5:00

Visit to Visa Service Office

Wednesday,

9:00 - 10:00

High Risk Concept in Perinatal
Care

10:00 - 10:15

Discussion

10:15 - 10:30

Coffee Break

10:30 - 11:30

Maternal and Infant Morbidity-
Recent Trends

11:30 - 12:00

Discussion

12:00 - 2:00

Lunch with JHPIEGO Staff

2:00 - 3:00

The Population Problem-Solutions

3:00 - 3:15

Coffee Break

3:15 - 4:15

Family Planning: Program Organization
Operation and Evaluation

Thursday,

9:00 - 10:00 Health Impact of Family Planning

10:00 - 10:15 Discussion

10:15 - 10:30 Coffee Break

10:30 - 11:30 Nutritional Impact on
Reproduction

11:30 - 12:00 Discussion

12:00 - 2:00 Lunch

2:00 - 3:00 Reproduction in Adolescence

3:00 - 3:15 Coffee Break

3:15 - 4:15 Human Sexuality and Reproduction

Friday,

9:00 - 10:00	Uncommon Problems With Oral Contraceptives
10:00 - 10:15	Discussion
10:15 - 10:30	Coffee Break
10:30 - 11:30	Intra-uterine Contraception--An Update
11:30 - 12:00	Discussion
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12:00 - 2:00	Lunch With Population Information Program Staff
<hr/>	
2:00 - 3:00	Advances in Voluntary Sterilization
3:00 - 3:15	Coffee Break
3:15 - 4:15	Future of Fertility Management

Monday,

9:00 - 10:00

Advances in Reproductive
Endocrinology

10:00 - 10:15

Discussion

10:15 - 10:30

Coffee Break

10:30 - 11:30

Management of the Infertile Couple-
Update

11:30 - 12:00

Discussion

12:00 - 1:30

Lunch

1:30 - 2:30

Sexually Transmitted Diseases

2:30 - 3:00

Coffee Break

3:00 - 4:00

Management of Incomplete Abortions

Tuesday,

9:00 - 10:00

Use of Laparoscopy in
Gynecology

10:00 - 10:15

Discussion

10:15 - 10:30

Coffee Break

10:30 - 11:30

Common Problems of Maintenance
and Performance of Laparoscopic
Equipment

11:30 - 12:00

Discussion

12:00 - 2:00

Lunch

2:00 - 3:00

Priorities in Preventive
Gynecology

3:00 - 3:15

Coffee Break

3:15 - 4:15

Round Table Discussion with
Faculty

185

Wednesday,

9:00 - 10:00

Laparoscopy on Model

10:00 - 12:00

Laparoscopy on Animal

12:00 - 2:00

Lunch

2:00 - 3:00

Sonography Demonstration

3:00 - 3:15

Coffee Break

3:15 - 4:15

Fetal Monitoring Demonstration

Thursday, _____ -

9:00 - 12:00

Audio Visual Reviews

12:00 - 2:00

Lunch

2:00 - 4:00

Free Discussion with Faculty
and JHPIEGO Staff

6:30- 9:30

Farewell Dinner

Friday,

9:00 - 10:00

Post Test

10:00 - 10:15

Coffee Break

10:15 - 11:15

Attitudinal Survey Form "B"

11:15 - 12:00

Institutional Graduation Gift

12:00 - 2:00

Lunch

2:00 - 4:00

Preparation of Educational
Materials for Mailing

ADVANCES IN REPRODUCTIVE HEALTH FOR ADMINISTRATORS
OF FAMILY HEALTH AND FAMILY PLANNING PROGRAMS

COUNTRY REPRESENTED:

Monday,

8:30 - 9:00

WELCOME

9:00 - 10:15

Orientation

10:15 - 10:30

Coffee Break

10:15 - 12:00

Administrative Briefings

Travel Arrangements

Information on Educational Materials

12:00 - 1:45

Lunch

1:45 - 2:00

Visit to Personnel Office for ID Badges

2:00 - 3:00

Tour of the Dept. Ob/Gyn

3:00 - 5:00

Pre-Test

Attitudinal Survey Form "A"

Tuesday,

9:00 - 10:00

Reproductive Health

10:00 - 10:15

Discussion

10:15 - 10:30

Coffee Break

10:30 - 11:30

Genetics and Reproduction

11:30 - 12:00

Review of JHPIEGO Programs

12:00 - 1:00

Lunch With JHPIEGO Staff
Hampton House 9th Floor

2:00 - 3:00

Physical and Chemical Environment
and Reproduction

3:00 - 3:15

Coffee Break

3:15 - 4:15

Visit to Visa Service

Wednesday,

9:00 - 10:00

Use of Pregnancy Testing for Better Health Care

10:00 - 10:15

Discussion

10:15 - 10:30

Coffee Break

10:30 - 11:30

Data Collection & Analysis for Family Health

11:30 - 12:00

Discussion

12:00 - 2:00

Lunch

2:00 - 3:00

Health Impact of Family Planning

3:00 - 3:15

Coffee Break

3:15 - 4:15

Sexually Transmitted Diseases

Thursday, - -

9:00 - 10:00

Priorities in Preventive Gynecology

10:00 - 10:15

Discussion

10:15 - 10:30

Coffee Break

10:30 - 11:30

Organization, Operation, & Evaluation
of Family Planning Problems

11:30 - 12:00

Discussion

12:00 - 2:00

Lunch

2:00 - 3:00

Infant Mortality--Recent Trends

3:00 - 3:15

Coffee Break

3:15 - 4:15

Trends in Maternal Mortality
World Review

Friday,

8:30 - 12:00

Management: An Overview-
The Functions of the Manager

Discussion

Coffee Break

Organizing: The Concepts of Line and
Staff-Authority, Power and Influence

12:00 - 2:00

Lunch

2:00 - 3:00

Nutrition and Reproduction

3:00 - 3:15

Coffee Break

3:15 - 4:15

Food Supply: World Review

Monday,

9:00 - 10:00

Identification of Problems in the
Management of Family Planning Programs

10:00 - 10:15

Discussion

10:15 - 10:30

Coffee Break

10:30 - 11:30

Intrauterine Contraception - An Update

11:30 - 12:00

Discussion

12:00 - 1:00

Uncommon Problems With Oral Contraceptives

1:00 - 2:00

Lunch

2:00 - 3:00

High Risk Concept in Maternal and Child
Health

3:00 - 5:00

Visit to the Family Planning Training
Institute

192

Tuesday,

9:00 - 10:00	Education for Reproductive Health
10:00 - 10:15	Discussion
10:15 - 10:30	Coffee Break
10:30 - 11:30	Information and Communication Systems
11:30 - 12:00	Discussion
12:00 - 1:00	Review of POPULATION INFORMATION Programs
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1:00 - 2:00	Lunch With POPINFORMATION Staff Hampton House 9th Floor
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2:00 - 3:00	Management: Motivation and Productivity Theories X and Y The Need of Hierarchy
3:00 - 3:15	Coffee Break
3:15 - 4:15	Personnel Management Job Design

Wednesday,

9:00 - 10:00 Management: The Planning Process

10:00 - 10:15 Discussion

10:15 - 10:30 Coffee Break

10:30 - 11:30 Management; Committees

11:30 - 12:00 Discussion

12:00 - 1:30 Lunch

1:30 - 3:30 Human Sexuality

3:30 - 3:45 Coffee Break

3:45 - 4:45 Advances in Reproductive Endocrinology

Thursday,

9:00 - 10:00

Management: Problems in the Health
Sector

10:00 - 10:15

Discussion

10:15 - 10:30

Coffee Break

10:30 - 11:30

Values in Decision - Making: An exercise

11:30 - 12:00

Discussion

12:00 - 2:00

Lunch

2:00 - 3:00

Adolescent Health-Teenage Pregnancy

3:00 - 3:15

Coffee Break

3:15 - 4:15

Diagnosis & Management of Infertility

K18

Friday,

9:00 - 10:00

Management: Measuring Effort and Effectiveness

10:00 - 10:15

Discussion

10:15 - 10:30

Coffee Break

10:30 - 11:30

Delegation, Participation in Decision Making, Developing Subordinates

11:30 - 12:00

Discussion

12:00 - 2:00

Lunch

2:00 - 4:00

Assigned readings for preparation of Country Profiles

1969

Monday,

9:00 - 9:30

WELCOME

9:30 - 10:15

Orientation

10:15 - 10:30

Coffee Break

10:30 - 12:00

Administrative Briefings

Travel Arrangements

Information on Educational Materials

12:00 - 1:45

Lunch

1:45 - 2:45

Visit to Personnel Office for ID Badges

2:45 - 3:45

Visit to Visa Services*

3:45 - 4:45

Pre-Test

Attitudinal Survey Form "A"

* Please bring passport and other documents

200

Tuesday,

9:00 - 10:00

Reproductive Health

10:00 - 10:15

Discussion

10:15 - 10:30

Coffee Break

10:30 - 11:30

The World Fertility Survey

11:30 - 12:00

12:00 - 1:00

Lunch With JHPIEGO Staff

2:00 - 3:00

Epidemiology of Infertility

3:00 - 3:15

Coffee Break

3:15 - 4:15

Tubal Physiology and Pathology

Wednesday,

9:00 - 10:00

Advances in Reproductive Endocrinology

10:00 - 10:15

Discussion

10:15 - 10:30

Coffee Break

10:30 - 11:30

Ovulatory Failure-Induction of
Ovulation

11:30 - 12:00

Discussion

12:00 - 2:00

Lunch

2:00 - 3:00

Endometriosis

3:00 - 3:15

Coffee Break

3:15 - 4:15

Cervical and Uterine Factors in
Infertility

Thursday,

9:00 - 10:00

Physiology of Male Reproductive
System

10:00 - 10:15

Discussion

10:15 - 10:30

Coffee Break

10:30 - 12:00

Audio Visual Aids

12:00 - 2:00

Lunch

2:00 - 3:00

Pathology and Management of Male
Infertility

3:00 - 3:15

Coffee Break

3:15 - 4:15

Audio Visual Aids

Cont'd

202

Friday,

8:00 - 9:00

Genetic Implications of Infertility

9:00 - 10:00

Infertility Drugs
Contraceptive Use-Subsequent Infertility

10:00 - 10:15

Discussion

10:15 - 10:30

Coffee Break

10:30 - 11:30

Endoscopy for Infertility Evaluation,
Culdoscopy and Laparoscopy

11:30 - 12:00

Discussion

12:00 - 2:00

Lunch

2:00 - 3:00

Metabolic Disorders and Infertility

3:00 - 3:15

Coffee Break

3:15 - 4:15

Human Sexuality and Infertility

204

Monday,

9:00 - 11:30

Films and Review of:
Salpinpolysis and Salpingoplasty
Tubal Reanastomosis and Uterotubal
Implantation

Coffee Break

12:00 - 1:00

Review of POPINFORM PROGRAMS

1:00 - 2:00

POPINFORM Luncheon With Staff
Hampton House 9th Floor

2:00 - 3:00

The Future of Fertility Management

3:00 - 3:15

Coffee Break

3:15 - 4:15

In Vitro Fertilization

102

Tuesday,

9:00 - 10:00	An Introduction to the Management of the Infertile Couple
10:00 - 10:15	Discussion
10:15 - 10:30	Coffee Break
10:30 - 11:30	Principal Indication for Tubal Surgery
11:30 - 12:00	Discussion
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12:00 - 2:00	Lunch
<hr/>	
2:00 - 3:00	Clinical Practice Arrangements and Institutional Projections (Half group)
3:00 - 3:15	Coffee Break
3:15 - 4:15	Pelvic Inflammatory Disease and Infertility

Wednesday,

7:30 - 11:00

Observation in the Operating Room
for half of the group

The remaining trainees will review
audio-visual aids in Conference Room
393 at Hampton House

12:00 - 2:00

Lunch

11:45 - 4:30

Observation in the Operating Room for
alternate half of the group

The remaining trainees will review
audio-visual aids in Conference Room
393 at Hampton House

4:30 - 5:00

Clinical Practice Arrangements and
Institutional Projections

207

Thursday,

9:00 - 10:00

A. Reversal of Sterilization:
Tubal Anastomosis

B. Uterotubal Implantation

10:00 - 10:15

Discussion

10:15 - 10:30

Coffee Break

10:30 - 12:00

Panel on Surgical and Medical
Management of the Infertile
Couple

12:00 - 2:00

Lunch

2:00 - 3:00

Artificial Insemination by Donors
(AID)

3:00 - 3:15

Coffee Break

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3:15 - 4:15

Endometriosis

6:00 - 9:30

FAREWELL DINNER

208

Friday,

9:00 - 11:00

Post-Test

Attitudinal Survey Form "B"

11:00 - 11:30

Coffee Break

12:00 - 2:00

Lunch

2:00 - 3:00

Course Evaluation

3:00 - 4:00

Preparation of Educational Material
for Mailing

AN INTERNATIONAL PROGRAM FOR THE ASSESSMENT OF TUBAL ANASTOMOSIS
USING MICROSURGICAL TECHNIQUE

Running Head: Assessment of Tubal Anastomosis

ABSTRACT

The present report outlines a microsurgical training program which has established sixteen centers around the world to evaluate the reversibility of sterilization using microsurgical technique. An obstetrician-gynecologist was selected from each developing country where an existing family planning program was responsible for a large number of sterilization procedures. Each course participant attended a two week course in microsurgical techniques and has since returned to establish a Microsurgical Center. Each Microsurgical Center has since been evaluated and is fully operational.

INTRODUCTION

Prior to the early 1970's, tubal reanastomosis after previous sterilization afforded approximately a 50% chance of a successful pregnancy.⁹ With the application of microsurgical techniques, a pregnancy rate of 60% to 70% has been achieved.³ As a result of this improved rate of successful pregnancy, microsurgery has received a widespread interest with respect to its application to all types of tubal surgery.

It has been estimated that voluntary sterilization is the most prevalent method of fertility regulation in use worldwide. Although the number of individuals requiring reversal of prior sterilization is small, any country where voluntary sterilization is widely practiced should have such services available. Toward this end, the Agency for International Development supported the microsurgical training program, described below, to meet this need in less-developed countries. This program has not only provided microsurgical training, but has established a data collection network which will allow a full evaluation of the training methods as well as pregnancy success following tubal reversal. This report describes the training program which has provided 16 gynecologists from 15 countries with the skills and equipment necessary to establish a national center to complement their existing fertility regulation programs.

MATERIALS AND METHODS

A training program in gynecologic microsurgery was held at the Johns Hopkins Hospital for two weeks on three occasions between July 1, 1978 and June 30, 1980. During this interval, 17 participants attended an intensive

microsurgical training course. The cognitive and technical objectives were carefully selected to fulfill the requirements of the terminal performance objective, that is, at a subsequent field evaluation the participant should satisfactorily demonstrate the ability to perform a tubal anastomosis using microsurgical techniques. Furthermore, each participant should maintain active data registry which records the clinical characteristics of the patients, the surgical methods selected to affect reanastomosis, and the eventual outcome (Table 1). Enabling activities were selected and modified from those utilized at other established microsurgical training programs.^{1,5,6,9} Enabling activities to achieve the technical objectives occupied 60 hours of the estimated 100 hours required to gain fundamental skills in microsurgery.²

Participant Selection

Each participant was selected from a university center in a developing country with an existing fertility management program responsible for a large number of voluntary sterilizations. Each participant was an experienced, highly motivated gynecologist with a specific interest in microsurgery. In addition, the participant's centers were institutions recognized as important tertiary care or referral centers for that country. Participant motivation was reflected in no absenteeism for either lectures or laboratory sessions.

Facilities and Equipment

The basic microsurgical instruments (Figure 1), microsuture (#7-10-0 nylon and absorbable sutures) and magnification systems (microscope and loop or hood) were utilized for all the training sessions. The participant

was allowed some freedom in utilizing a variety of magnification systems for anastomosis, although all basic instruction of fundamental microsurgical technique was conducted under the operating microscope with a teaching viewing attachment. Nevertheless, emphasis was placed on the use of the simpler, less expensive systems such as the loop and/or hood.

The faculty consisted of experienced microsurgeons from all surgical specialties. A student faculty ratio of 1:1 was achieved. Lecture and laboratory involvement were in keeping with that previously described.^{1,6,9}

The animal laboratory was staffed by Animal Anesthesiologists. The rat uterus (Sprague-Dawley) and rabbit oviduct (New Zealand White) were the small animal models used during the first week of the course. Domestic swine provided a large animal model with oviducts closely resembling that of the human.⁷ This provided an experience not unlike that encountered in the operating theatre with human oviduct anastomosis.

Enabling Activities

This course consisted of didactic lectures, practical sessions and demonstrations. The didactic lectures, informal roundtable discussions, current publications and audio-visual media assisted the participant in understanding the cognitive objectives summarized in Table 1. The practical laboratory sessions and operating room demonstrations were the major enabling activities designed to enable the participant to attain the technical objectives. Specific training techniques have been described elsewhere.^{1,4,9} Our techniques are not unlike that previously described in that glove suture practice under close supervision was required

by a participant before proceeding with the practice of the techniques of anastomosis using the animal models. The participant was not allowed to proceed to the animal model until full concentration could be devoted to the particular techniques of the uterine or tubal anastomosis. In addition, the participant viewed at least three human tubal anastomosis in the operating theatre. This experience enabled the student to appreciate those technical requirements which could only be demonstrated.

At the completion of the course, each participant was provided with the instruments noted in Figure 1 in order to facilitate the establishment of a microsurgical center in his or her country.

Program Evaluation

Each participant was carefully evaluated during the microsurgical course. The first evaluation was performed by the faculty at the end of the first week of instruction. If a participant had not made sufficient progress, special instruction was directed towards the deficiencies. An in-country site visit was performed by the Program Director to ascertain the expertise of the microsurgeon and to evaluate the data registry.

RESULTS

Sixteen Microsurgical Centers have been established in 15 less-developed countries across the world in universities with existing fertility regulation programs (Figure 2). During the course, each participant satisfactorily demonstrated to three instructors those enabling activities required of a surgeon to successfully perform a tubal anastomosis using microsurgical technique.

At a subsequent field evaluation the participants satisfactorily demonstrated the ability to perform a tubal reanastomosis using microsurgical technique and were found to be maintaining an active data registry, which has fulfilled the terminal performance objectives of this microsurgical training program.

DISCUSSION

The ultimate goals of this training program were two-fold. The basic goal was to provide the participant with a sufficient expertise in microsurgery so that he may return to his country and apply his new techniques to patients with tubal factors requiring microsurgery to enhance or re-establish fertility. Of equal importance was the second objective of establishing a data registry for microsurgical procedures. Thus, participants were provided with the methodology to objectively monitor their experience. As all participants were trained using the same cognitive and technical objectives, some uniformity in technique for this group of surgeons has been attained. This uniformity will allow for the composite evaluation of larger numbers of patients who have undergone tubal reversal using the standardized technique. Thus, the overall number of cases available for statistical analysis of the efficacy of various microsurgical procedures will be increased. The composite data assessing the results of this international microsurgical training program will be the subject of a future report.

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6. Phillips, J.M., Winchester, W.J.: Teaching Microsurgery to Gynecologist (1). Microsurgery, 2: 120, 1979.
7. Rock, J.A., Rosenwaks, Z., Adashi, E.Y., Jones, H.W., Jr., and King, T.M.: Microsurgery for tubal reconstruction following Falope ring sterilization in swine. J. Microsurgery, 1: 61, 1979.
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9. Valle, R.F.: Training for microsurgery in Reversal of Sterilization. J. Sciarra, G. Zatuchni, J. Speidel (Eds.), Harper and Row, New York, 1978.

ACADEMIC SKILLS FOR MEDICAL SCHOOL FACULTY IN REPRODUCTIVE HEALTH

COUNTRIES REPRESENTED:

TABLE

COURSE OBJECTIVES AND ACTIVITIES

Terminal Performance Objective: At a subsequent field evaluation, the participant will satisfactorily demonstrate (1) a tubal reanastomosis using microsurgical technique, (2) the maintenance of an active data registry.

Cognitive Objectives: The participant should demonstrate an understanding of the:

- Normal physiology of the human oviduct.
- Pathophysiology of tubal disease and adhesion formation.
- Selection of patients for tubal reconstructive surgery.
- Adjuvants in tubal surgery
- Different techniques of tubal anastomosis, tubal implantations, salpingolysis and salpingostomy.
- Fundamentals of microsurgical technique.
- Appropriate techniques for the evaluation of surgical results.

Enabling activities (25 lecture hours)

- Formal lectures on each subject.
- Informal roundtable discussions.
- Current publications and textbooks.
- Audio Visual Media.

Technical Objectives: The participants should demonstrate an ability to perform a uterine anastomosis with microsurgical technique using the rat model as well as a tubal anastomosis using the rabbit and swine model.

Enabling activities* (60 laboratory hours)

- Improve visualization with magnification.
- Vaginal packing to elevate the uterus.
- Exploration and care in packing intestines.
- Constant irrigation and gentle suction.
- Meticulous hemostasis and pin point coagulation with minimal electrodesiccation temperatures.
- Gentleness in handling tissue.
- Place fine (#7-10-0) suture into animal oviductal tissue with 4 mm microneedle using atraumatic technique.
- Tie square knots under magnification with precision and speed with microinstruments.
- Remove all necrotic tissue and adhesions.
- View the techniques of human tubal anastomosis in the operating theater.

*Each participant was supplied with microsurgical instruments and a magnification system to enable him to perform microsurgical procedures upon return to his country.

LEGENDS:

Figure 1: Basic Microsurgical Instruments: Jewelers Forceps (#5),
Microscissors and Baraguer needle holder (without lock).

Figure 2: International Microsurgical Centers for Tubal Anastomosis.

FIGURE 1

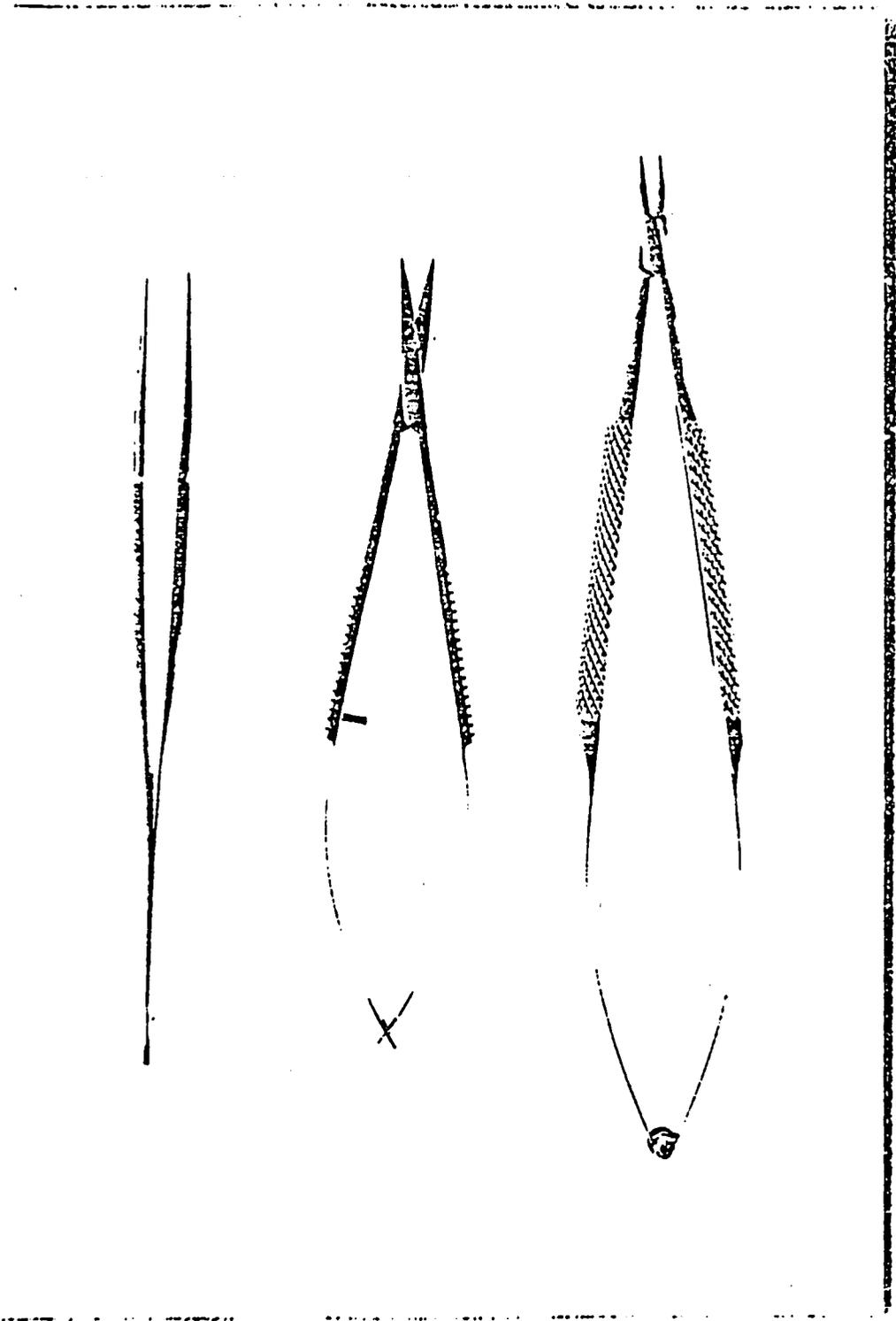
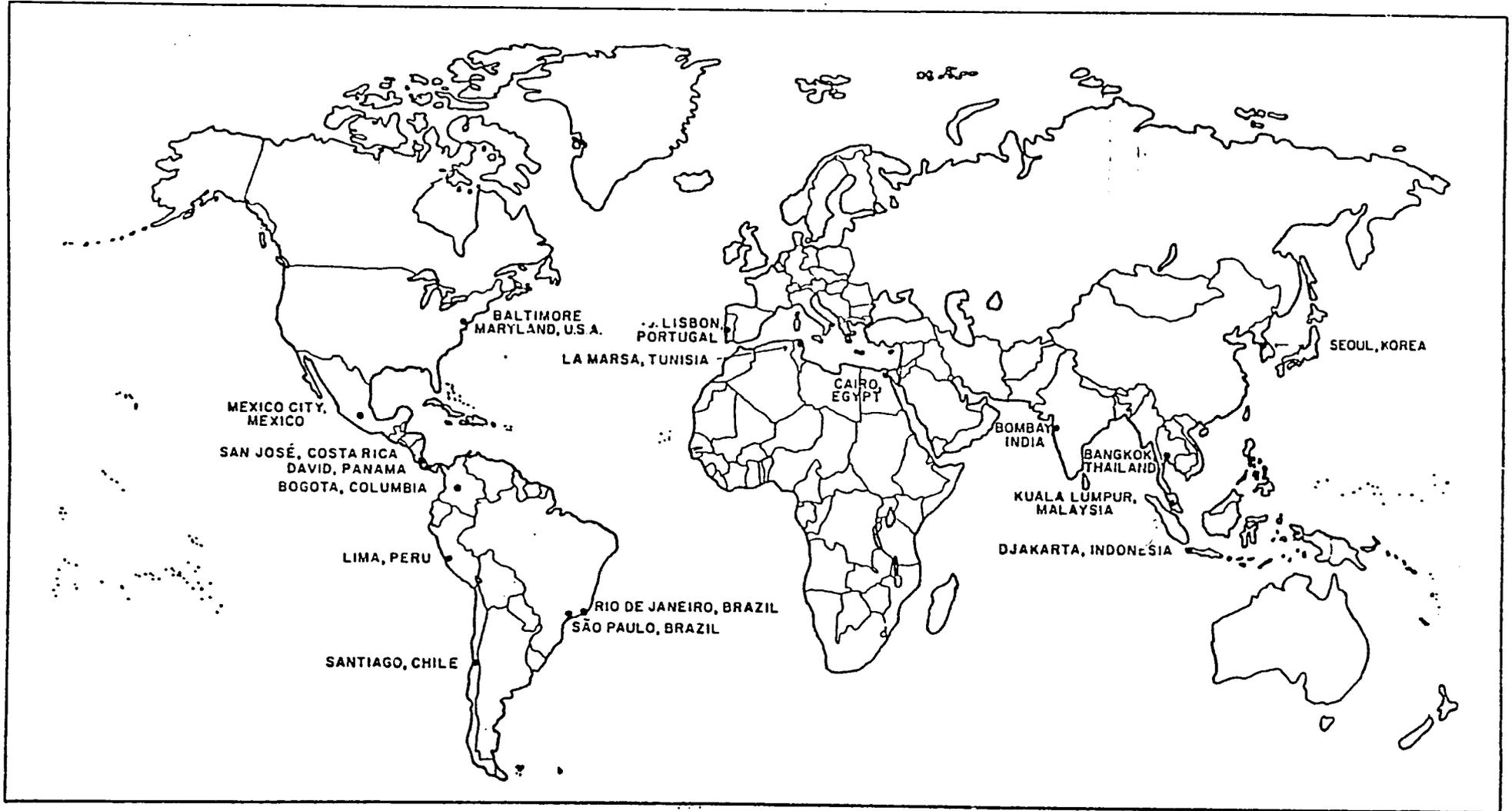


FIGURE 2

MICROSURGICAL CENTERS



22/1

MICROSURGERY

COUNTRIES REPRESENTED:

Monday,

8:30 - 9:00

Welcome

9:00 - 10:00

Reproductive Health

10:00 - 10:15

Coffee Break

10:15 - 11:00

Administrative Briefings

11:00 - 12:30

Hospital Tour, Welch Library

12:30 - 1:30

Lunch

1:30 - 2:00

Lab Conference

2:00 - 4:00

Introduction to Microsurgery
(Traylor Building, Laboratory
Orientation (Distribute Instruments)
Suture, Gloves

224

Tuesday,

8:00 - 9:00 Tubal Physiology and Anatomy
-
9:00 - 9:30 Coffee Break
9:30 - 10:30 Pathology of the Fallopian Tube
10:35 - 11:35 Pelvic Inflammatory Disease and
Infertility
11:35 - 12:30 Microsurgery --An Overview

12:30 - 1:30 Lunch

1:30 - 4:30 Laboratory -Practice suturing
Technique with gloves.
Start rat model (suture of the
rat uterus)

Weck Demonstrations
Davis & Geck (suture)

225

wednesday,

7:30 - 4:30

Operating Room Demonstrations

(Lectures on Technique, instrument care,
draping, instruments and movies)

Lunch

Thursday,

8:00 - 9:00

Selection of Patients for Tubal
Reconstruction

9:00 - 9:15

Coffee

9:15 - 10:15

Techniques of Salpingostomy and
Salpingolysis

10:15 - 11:15

Anastomosis of the Vas Deferens and
Epididymi

11:30 - 12:30

Lunch

12:30 - 4:00

Lectures on Techniques Rabbit-
Tubal Anastomosis

Codman Demonstrations

221

Friday,

9:00 - 9:15

Coffee Break

9:15 - 11:30

Laboratory: Anastomosis with rat
uteri and rabbit fallopian Tube
Swine Model #1

11:30 - 12:30

Lunch

12:30 - 4:00

Swine Anatomy-General Considerations
Laboratory: Continue anastomoses with
rat uteri and rabbit fallopian tube

V. Muller Instrumentation
Ethicon

-

WR

Monday,

8:30 - 9:00 Classification of Adhesive Disease

9:00 - 9:15 Coffee Break

9:15 - 10:15 How to Organize a Research Study

10:15 - 11:15 OMPI-7 Microscope

12:00 - 1:00 Lunch

1:00 - 4:30 Laboratory-Complete animal models with
rabbit tubes and rat uterus, start
domestic swine #2

229

Tuesday,

8:00 - 9:00 Techniques of Uterotubal Implantation

9:00 - 9:15 Coffee Break

9:15 - 10:15 Pathophysiology of Adhesion Formation

10:15 - 12:00 Swine Model #3

12:00 - 1:00 Lunch

1:00 - 5:00 Swine Model #4

Wednesday,

Operating Room Demonstrations
Start Domestic Swine #5 and #6
Review of Microsurgical instruments
and video Tapes
Movie on Uterotubal implantation

Lunch

Thursday,

9:00 - 10:00

Tour of Photography Unit, Johns
Hopkins Hospital
Photographic Session-Pathology
Photography Unit: group pictures.

10:30

Continue Swine Model!#7
Other participants continue with rat
anastomosis

Lunch

232

Friday,

9:00 - 10:00 Introduction to Data Registry and Analysis
Distribution of data forms

10:00 - 10:15 Coffee Break

10:30 - 12:00 Microsurgery Review and Summary
Course Critique by Participants

12:00 - 1:00 Lunch

1:00 - 3:00 Presentation of Diplomas and Instruments

6:00 Farewell Dinner

Monday,

9:00 - 10:00

COFLAC

10:00 - 10:15

Discussion

10:15 - 10:30

Coffee Break

10:30 - 11:30

Advances in Voluntary Sterilization

11:30 - 12:00

Discussion

12:00 - 2:00

Lunch

2:00 - 4:00

Future's Group

Effect of Population Growth on
Social and Economic Development

234

Tuesday,

9:00 - 10:00	Use of Epidemiology in Investigation of the Diseases of Childhood
10:00 - 10:15	Discussion
10:15 - 10:30	Coffee Break
10:30 - 11:30	Acute Infections in Infancy & Childhood
11:30 - 12:00	Discussion
<hr/>	
12:00 - 2:00	Lunch
<hr/>	
2:00 - 3:00	The Future of Fertility Management
3:00 - 3:15	Coffee Break
3:15 - 4:15	Management: Bureaucracy--Characteristics, Advantages and Disadvantages

235

Wednesday,

9:00 - 10:30

Panel on Development of Manpower for
Family Health

Moderator:

Speakers:

10:30 - 11:00

Coffee Break

11:00 - 12:00

Country Profiles

12:00 - 2:00

Lunch

2:00 - 4:00

Country Profiles

Thursday,

9:00 - 12:00

COUNTRY PROFILES

12:00 - 2:00

Lunch

2:00 - 4:00

COUNTRY PROFILES

6:30 - 9:30

FAREWELL DINNER
SABATINO RESTAURANT

6:00

237

Friday,

9:00 - 10:00

Post- Test

10:00 - 10:30

Coffee Break

10:30 - 11:30

Attitudinal Survey -- Form "B"

11:30 - 12:00

Course Evaluation

12:00 - 2:00

Lunch

2:00 - 4:00

Preparation of Educational Material
for Mailing

22

Appendix J

NUMBER OF LAPAROSCOPIC AND MINILAP SYSTEMS
FOR JHPIEGO AND OTHER AID-SUPPORTED PROGRAMS
(As of September 30, 1980)

NUMBER OF LAPAROSCOPIC AND MINI-LAP SYSTEMS
SHIPPED FROM INCEPTION OF PROGRAM

THRU SEPTEMBER 30, 1980
FOR JHPIEGO AND OTHER A.I.D.-SUPPORTED PROGRAMS

	JHPIEGO			U.S.A.I.D.		OTHERS
	System A,B,V&VH,L	System G	I.S.T.P.	System A,B,V,&VH,L	System G	System A,B,V,&VH,L
AFRICA						
Benin	2	1				
Botswana	1	1				
Burundi	2	2				
Cameroon	2	1				1
Ethiopia		3				
Gabon	2	1				
Gambia	2	1				
Ghana	9	11				
Ivory Coast	1					
Kenya	14	4				2
Lesotho	1	2				
Liberia	2	2				
Mali	2	3				
Mauritius		2				
Niger	2					
Nigeria	24	4				
Rwanda	4	1				
Senegal	1	2				2
Sierra Leone	1	1				
Somalia	1	2				
Sudan	17	4				
Tanzania	5	5				

NUMBER OF LAPAROSCOPIC AND MINI-LAP SYSTEMS
SHIPPED FROM INCEPTION OF PROGRAM

THRU SEPTEMBER 30, 1980
FOR JHPIEGO AND OTHER A.I.D.-SUPPORTED PROGRAMS

	JHPIEGO			U.S.A.I.D.		OTHERS
	System A,B,V&VH,L	System G	I.S.T.P.	System A,B,V,&VH,L	System G	System A,B,V,&VH,L
IN AMERICA						
Argentina	1					
Bolivia	5	3				1
Brazil	1					
Canada	1	1				
Chile	4	1				1
Colombia	72	44		2		10
Cuba						1
Costa Rica	24	3				11
Dominican Republic	173	9	3	1		34
Ecuador	6	2	3	3		12
El Salvador	1					
Guatemala						2
Honduras	9	5				
Jamaica	2	5	1	1		10
Mexico	11	3		21	3	10
Nicaragua	1					
Panama	9	3		1		23
Paraguay	1					
Peru	6	5				2
Uruguay	11	3	1			3
Venezuela	13	18	1	14		2
Yugoslavia	26	16		3		105

WFL

NUMBER OF LAPAROSCOPIC AND MINI-LAP SYSTEMS
SHIPPED FROM INCEPTION OF PROGRAM

THRU SEPTEMBER 30, 1980
FOR JHPIEGO AND OTHER A.I.D.-SUPPORTED PROGRAMS

	JHPIEGO			U.S.A.I.D.		OTHERS
	System A,B,V&VH,L	System G	I.S.T.P.	System A,B,V,&VH,L	System G	System A,B,V,&VH,L
AMERICA 'd)						
agua	9	—				
a	10	—1	1	2		1
ay	6	—				
	15	—8	1			3
tts	1					
cia	2					
ad	3	—				2
y	11	—2				
ela	3	—1				
		—				
		—				
		—				
TOTALS	437	133	11	48	3	234
		—				
		—				
		—				
		—				
		—				
		—				
		—				
		—				
		—				
		—				
		—				

10/2

**NUMBER OF LAPAROSCOPIC AND MINI-LAP SYSTEMS
SHIPPED FROM INCEPTION OF PROGRAM**

**THRU SEPTEMBER 30, 1980
FOR JHPIEGO AND OTHER A.I.D.-SUPPORTED PROGRAMS**

	JHPIEGO			U.S.A.I.D.		OTHERS
	System A,B,V&VH,L	System G	I.S.T.P.	System A,B,V,&VH,L	System G	System A,B,V,&VH,L
adash	6					1
		2				1
dia	1					
	93	1	4			5
esia	14	1	1	106		57
	33	6	4	62		
sia	18		2			1
	6	6		40		2
uinea	2	2				
tan	12	9	1	31		59
opines	24	1	3	4		31
anka	6	9				
pore	1					2
n	7		2	1		2
and	93	2	5	2		25
ietnam	1					
TOTALS	317	39	22	246		130

Appendix K
WORLD DISTRIBUTION OF AID-FUNDED LAPAROSCOPES

Appendix L
LIST OF JHPIEGO PUBLICATIONS

JHPIEGO PUBLICATIONS

October 1980

U.S.

1. King, T.M., Stanley, J. Burnett, L.S., Burkman, R.T., Youngs, D.D., Atienza, M.F., and Woodruff, J.D. Continuing Education of Obstetricians and Gynecologists in Fertility Management, Amer. J. Obstet. Gynec. 121: 829, 1975.
2. Rock, J.A., Burkman, R.T., Genadry, R. and King, T.M., An International Program for the Assessment of Tubal Anastomosis by Microsurgical Technique: A Preliminary Report, J. Microsurgery 2: 63, 1980.
3. Burkman, Ronald T., Magarick, Ronald H, Waife, Ronald,(Ed) Surgical Equipment for Reproductive Health, to be published as a monograph, Baltimore, The Johns Hopkins Program for International Education in Gynecology and Obstetrics, November, 1980.
4. Altobelli, L.C., Burkman, R.T., and Clapper, D.J. Laprocator: Preventive Care and Maintenance. The Johns Hopkins Program for International Education in Gynecology and Obstetrics. 1980.
5. Altobelli, L.C., Burkman, R.T., and Clapper, D.J. Advanced Laparoscopic Systems: Preventive Care and Maintenance. The Johns Hopkins Program for International Education in Gynecology and Obstetrics. 1980.
6. Giltrud, N.E. and Husman, C.M. "An Introduction to Reproductive Physiology and Contraceptive Methods: A Programmed Instruction". To be published by the Johns Hopkins Program for International Education in Gynecology and Obstetrics, 1981.
7. Taylor, Howard C. and Magarick, Ronald H., "An International System for the Education of Students of Medicine and Other Health Professionals in Human Reproduction", accepted for publication, International Journal of Gynecology and Obstetrics, 1981.

OVERSEAS (SAMPLING)

1. Magarick, R.H., Burkman, R.T., Lesinski, J.S., "Educational and Training Programs for Reproductive Health", Scientific Exhibition Monograph, IX World Congress of Gynecology and Obstetrics, Japan Society of Obstetrics and Gynecology, Tokyo, 1979.
2. Magarick, Ronald H., "The Physician as Team Leader for Reproductive Health Education", presented at Third Annual Meeting of Egyptian Fertility Control Society, Tanta, Egypt, May, 1979. To be published in Egyptian Journal of Obstetrics and Gynecology, 1980.
3. Magarick, Ronald H., "The Physician's Role in the Integration of Health Education in Family Planning and Maternal and Child Health Services, in Proceedings of Sixth Sudanese Congress of Obstetrics and Gynecology, Khartoum, February, 1979.

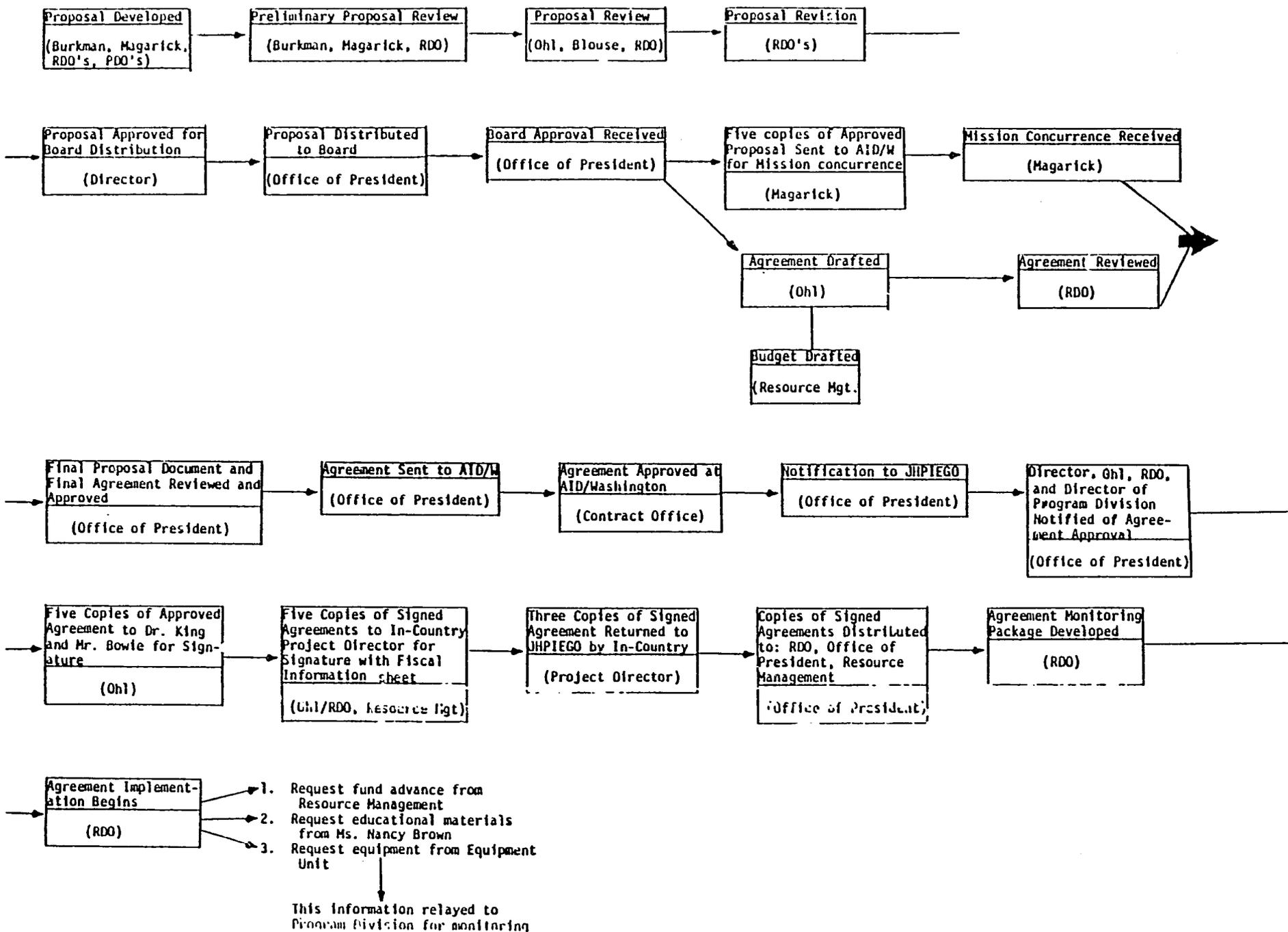
5. Burkman, R.T. (Ed.): Reproductive Health Education in the Developing World, to be published as a monograph. Based on the Proceedings of the International Council Meeting of the Johns Hopkins Program for International Education in Gynecology and Obstetrics, 1981.
6. Oblepias, V. Experience with laparoscopic sterilization in The Philippines. Presented at the 5th Annual Scientific Conference of the Kenya Obstetrical and Gynaecological Society. Nairobi, 1980. To be published in the E. African Medical Journal.
7. King, T.M. Recent Advances in Endometrial Cancer. Presented at the 5th Annual Scientific Conference of the Kenya Obstetrical and Gynaecological Society. Nairobi, 1980. To be published in the E. African Medical Journal.
8. Burkman, R.B. The Diagnosis of Intra-Epithelial Neoplasia of the Cervix. Presented at the 5th Annual Scientific Conference of the Kenya Obstetrical and Gynaecological Society. Nairobi, 1980. To be published in the E. African Medical Journal.
9. Dunn, L. Treatment of Cervical Cancer. Presented at the 5th Annual Scientific Conference of the Kenya Obstetrical and Gynaecological Society. Nairobi, 1980. To be published in the E. African Medical Journal.
10. Fathalla, M.F. Current Concepts in Ovarian Neoplasia. Presented at the 5th Annual Scientific Conference of the Kenya Obstetrical and Gynaecological Society. Nairobi, 1980. To be published in the E. African Medical Journal.
11. Suporn, K. Molar Pregnancy - Experience in Thailand. Presented at the 5th Annual Scientific Conference of the Kenya Obstetrical and Gynaecological Society. Nairobi, 1980. To be published in the E. African Medical Journal.
12. Ladipo, O.A. Hepatitis B Surface Antigen in Menstrual Blood and Serum in Nigerians. Presented at the 5th Annual Scientific Conference of the Kenya Obstetrical and Gynaecological Society. Nairobi, 1980. To be published in the E. African Medical Journal.
13. Ladipo, O.A. Plasma FSH, LH Testosterone in Fertile and Infertile Nigerian Men. Presented at the 5th Annual Scientific Conference of the Kenya Obstetrical and Gynaecological Society. Nairobi, 1980. To be published in the E. African Medical Journal.
14. Rock, John and Genadry, Rene. Microcirugia Ginecologica. Proceedings of the First Latin American Course in Microsurgery, February 25 - March 7, 1980. Bogota, Colombia. In press. (ACEP)
15. Huber, D. Contraceptive Methodology. Presented at the 16th Annual Postgraduate Seminar in Obstetrics and Gynecology, Moshi, Tanzania, May 1980. Proceedings to be published as a monograph.

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16. Huber, D. Fertility Pattern After Contraception. Presented at the 16th Annual Postgraduate Seminar in Obstetrics and Gynecology, Moshi, Tanzania, May 1980. Proceedings to be published as a monograph.
17. Kearney K. Female Sterilization. Presented at the 16th Annual Postgraduate Seminar in Obstetrics and Gynecology, Moshi, Tanzania, May 1980. Proceedings to be published as a monograph.
18. Kearney K. Indications and Risks of Induction of Labor. Presented at the 16th Annual Postgraduate Seminar in Obstetrics and Gynecology, Moshi, Tanzania, May 1980. Proceedings to be published as a monograph.
19. El Sahwi, S. Investigation of the Infertile Couple. Presented at the 16th Annual Postgraduate Seminar in Obstetrics and Gynecology, Moshi, Tanzania, May 1980. Proceedings to be published as a monograph.
20. El Sahwi, S. Surgical Treatment of Infertility. Presented at the 16th Annual Postgraduate Seminar in Obstetrics and Gynecology, Moshi, Tanzania, May 1980. Proceedings to be published as a monograph.
21. Huber, D. Health Aspects of Modern Contraceptives. Presented at the Fourth Annual Meeting of the Egyptian Fertility Care Society, Port Said, Egypt, June 1980. To be published in the Egyptian J. Obstet. Gynec.
22. Huber, D. Effects of Contraceptives on Breast Milk. Presented at the Fourth Annual Meeting of the Egyptian Fertility Care Society, Port Said, Egypt, June 1980. To be published in the Egyptian J. Obstet. Gynec.
23. Rock, J. Microsurgery of the Fallopian Tube. Presented at the Fourth Annual Meeting of the Egyptian Fertility Care Society, Port Said, Egypt June 1980. To be published in the Egyptian J. Obstet. Gynec.
24. Burkman, R.B. The Hopkins Experience with the Falope Band Procedure. Presented at the Third International Seminar on Maternal and Perinatal Mortality, Pregnancy Termination and Sterilization, New Delhi, October, 1980. Proceedings to be published by F.I.G.O.
25. Rock, J. Microsurgery of the Fallopian Tube. Presented at the Third International Seminar on Maternal and Perinatal Mortality, Pregnancy Termination and Sterilization, New Delhi, October 1980. Proceedings to be published by F.I.G.O.

Appendix E
DEVELOPMENT PROCESS FOR JHPIEGO PROJECTS

JHPIEGO PROJECT DEVELOPMENT PROCESS



Appendix E

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Appendix F
SCHEDULE OF JHPIEGO COURSES

JHPIEGO COURSE CALENDAR
U.S. AND IN-COUNTRY COURSE
FISCAL 1981
(October 1, 1980 - September 30, 1981)

<u>COURSE</u>	<u>LOCATION</u>	<u>LANGUAGE</u>	<u>DATES</u>
Physicians	Egypt/Alexandria	-	September 15 - October 3, 1980
Administrators	Johns Hopkins Medical Inst.	English	September 29 - October 17, 1980
Physicians/Nurses	Philippines	-	October 1 - 28, 1980
Physicians	Egypt/ Al-Azhar	-	October 4 - 15, 1980
Nurses	Egypt/Alexandria	-	October 13 - 22, 1980
Nurses	Tunisia	-	October 20 - 25, 1980
Management of Infert.	Johns Hopkins Medical Inst.	Spanish	October 20 - 31, 1980
Microsurgery	Johns Hopkins Medical Inst.	Spanish/English	November 3 - 14, 1980
Physicians/Nurses	Philippines	-	November 3 - 30, 1980
Physicians	Egypt/Alexandria	-	November 15 - December 5, 1980
Administrators	Johns Hopkins Medical Inst.	Portuguese	November 17, December 5, 1980
Physicians (update)	Kenya	-	December 15 - 20, 1980
Physicians/Nurse/ Anesthetist	Brazil	-	Dec. (dates to be determined)
Physicians	Tunisia	French	January 5 - 24, 1981
Physicians/Nurse	Philippines	-	January 5 - 31, 1981
Clinician	Johns Hopkins Medical Inst.	Spanish	January 12 - 23, 1981
Physicians	Egypt/Al-Azhar	-	January 17 - 29, 1981
Nurses	Tunisia	-	February 2 - 7, 1981
Management of Infert.	Johns Hopkins Medical Inst.	French	February 2 - 13, 1981
Physicians/Nurse	Philippines	-	February 2 - 28, 1981
Microsurgery	Colombia	-	February 14 - 20, 1981

<u>COURSE</u>	<u>LOCATION</u>	<u>LANGUAGE</u>	<u>DATE</u>
Physicians/Nurses	Philippines	-	March 2 - 29, 1981
Clinicians	Johns Hopkins Medical Inst.	Spanish	March 9 - 20, 1981
Physicians/Nurses	Philippines	-	April 1 - 28, 1981
Physicians	Tunisia	French	April 6 - 24, 1981
Management of Infert.	Johns Hopkins Medical Inst.	English	April 20 - May 1, 1981
Microsurgery	Johns Hopkins Medical Inst.	*	May 4 - 15, 1981
Academic Skills	Johns Hopkins Medical Inst.	English	May 4 - 29, 1981
Administrators	Johns Hopkins Medical Inst.	Spanish	June 15 - July 3, 1981
Administrators	Johns Hopkins Medical Inst.	French	July 13 - 31, 1981
Clinicians	Johns Hopkins Medical Inst.	*	September 14 - 25, 1981

*Primary course language will be determined at later date

Appendix G
REPORT ON JHPIEGO ACTIVITIES
IN LATIN REGION
(FY 1980)

Report of Activities in JHPIEGO Latin Region FY'80

Hugh J. Davis, M.D.

The Latin Region was responsible for the planning, development, coordination, and implementation of activities in 15 Latin American countries, plus Spain and Portugal during FY'80, covering a total population of 350 million. In addition to trainees from the Latin Region attending English-language courses at Johns Hopkins, there were 4 special courses in Spanish and Portuguese offered during the year for administrators and clinicians in Reproductive Health attended by 96 trainees. A total of 104 trainees from the Latin Region were identified, recruited, and processed during the year via the Johns Hopkins program.

There were 16 clinical practice centers in the Latin Region active during FY'80 in support of both in-country and Johns Hopkins training programs. There were a total of 208 surgical trainees, 10 anesthesia trainees, and 78 nursing trainees programmed through these centers during the year. Of the total of 104 in-country trainees processed, 27 were from the in-country program in Brazil and 77 were from Colombia.

Agreements to renew and formalize collaborative educational activities were concluded with 11 clinical practice centers during FY'80 in the Latin Region. Proposals were developed for the mobilization of 10 new clinical practice centers in Brazil, which will greatly increase training capability in that high priority country.

In-Country Training

Currently major in-country training efforts were activated through the Ministry of Health in Colombia and through the Centro de Pesquisa e Assistencia Integrada a Mulher e a Crianca (CPAIME) in Rio de Janeiro, Brazil. These programs trained surgeons, anesthesia and nursing personnel in relation to

endoscopy and surgical techniques of fertility management. As indicated, support of in-country surgical training activities, ten major surgical centers were identified in Brazil, necessary equipment installed and proposals developed for support of in-country clinical practice training activities. During FY'80, there were 77 institutions in Colombia mobilized with trained personnel and equipment via the Colombia National Program.

Brazil (CPAIMC)

In Brazil through CPAIMC's efforts, JHPIEGO sponsored the training of 27 surgical trainees, 10 anesthesia trainees and 12 nursing trainees, making a total of 49 in-country trainees. This effort was supplemented by the Johns Hopkins program, which trained 44 Brazilians in FY'80.

Colombia (MOH)

Through the Colombian National Program, JHPIEGO accomplished training of surgical and nursing candidates to complete the mobilization of 108 Ministry of Health institutions. The Ministry recruited, selected, supervised, deployed and installed the institutional candidates. With the assistance of PROFAMILIA's eight clinical practice centers, all training was accomplished by the administration of 6-day tutorial clinical-didactic sessions. PROFAMILIA has been receiving support from Johns Hopkins since 1973 and is operating at a level of over 40,000 minilaparotomy and endoscopy procedures per year at the present time, providing ample training opportunities for both JHPIEGO central, in-country and third country program trainees.

At the close of FY'80, 212 USAID laparoscopes, the majority of which had been supplied by JHPIEGO, had been placed in Colombia with expanded maintenance back-up via the Colombian (MOH) National Program supported by JHPIEGO. The Colombian National Program was the biggest JHPIEGO in-country training program in the world operational in FY'80.

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Reproductive Health Education Program

In addition to major surgical training activities in relation to Brazil and Colombia, the Latin Region of JHPIEGO developed and initiated the innovative Reproductive Health Education Program (REHEP) in conjunction with the University of Santa Maria, Rio Grande do Sul, Brazil. This new tuition-based training initiative introduces 40 hours of didactic presentation, 40 hours of clinical management seminars, and 40 hours of clinical tutorial experience for medical and nursing students in Reproductive Health. Via the REHEP initiative, core faculty training and support, educational materials and models, as well as assistance in curriculum development have been supplied.

The design of the REHEP initiative is attracting institutional support for translating this educational innovation into meaningful research and service actions. There has been considerable interest of the part of other donor agencies such as the Association for Voluntary Sterilization, International Fertility Research Program, International Planned Parenthood Federation, Development Associates, Family Planning International Assistance, in supporting institutional expansion of services, organization of research, distribution of commodities and expansion of training activities for paramedical personnel in a coordinated fashion via the key leadership medical institutions in the process of developing REHEP projects.

Proposals are in process to implement the REHEP model at other key medical institutions in Brazil, Colombia, Paraguay, Peru, Ecuador and Chile at this time.

Latin Region Country Status Review

A program review at the close of FY'80 for those Latin Region countries in which JHPIEGO activities were functional during the year showed the following status of activities in process and projected activities for FY'81.

Argentina - Population: 27 million, USAID laparoscopes: 6, Priority: low

and site visited by JHPIEGO consultant from Mexico.

Projected Activities

Limited training activities are planned for FY'81 in support of in-country actions.

Bolivia - Population: 5 million, USAID laparoscopes: 5, Priority: low

Johns Hopkins trainees during FY'80 totaled 1 who was sponsored by the Noyes Foundation.

Projected Activity

Limited in-country training actions are planned for FY'81 due to governmental constraints.

Brazil - Population: 120 million, USAID laparoscopes: 84, Priority: high

Johns Hopkins trainees during FY'80 were 44 while in-country training efforts through CPAIMC produced 49 trainees. CPAIMC surpassed its objectives last year which were (1) to provide didactic and clinical practice for 27 physicians, 9 nurses and 9 anesthetists; (2) to provide field visit training for 25 institutions representing the 27 physicians trained; (3) to establish and manage equipment maintenance activities; (4) to assist with the establishment of in-country clinical training centers. In accomplishment of this last objective, 10 clinical practice centers were activated for Johns Hopkins and CPAIMC programs and are already functioning in the following Brazilian cities: Belem (CPAIM), Belo Horizonte (CEPECS), Fortaleza (SAMEAC), Londrina (CLAM), Ribeirao Preto (Das Clinicas), Rio Claro (CME), Rio de Janeiro (CPAIMC), Rio de Janeiro (Pio XII), Salvador (MCO), Santa Maria (SMIRH).

At the end of FY'80, the Santa Maria REHEP was activated with the intention of training 150 medical and nursing students.

JHPIEGO staff visitors to Brazil included Drs. Ronald Burkman, and John Lesinski for the Brazilian Human Reproduction Society in Londrina, Mr. Kevin Armstrong for programmatic visitation and review, Ms. Laura Altobelli for curriculum and nursing development programs, Mr. Dale Clapper for equipment

and maintenance review status.

Projected Activities

CPAIMC will utilize the 10 existing clinical practice centers in training 36 physicians this year. In addition, CPAIMC will train 18 anesthetists and 18 nursing trainees. JHPIEGO will train an additional 20 Brazilian trainees via Johns Hopkins courses. Four additional REHEP programs are projected for FY'81.

Chile - Population: 11 million, USAID laparoscopes: 35, Priority: low
Johns Hopkins trainees in FY'80 totaled 10.

Projected Activities

REHEP at Hospital Salvador, Santiago, Chile, is in process and expected to be activated in FY'81. Limited Hopkins training support projected. A lecture on in vitro fertilization was delivered at the Eastern University of Chile by Dr. Anibal Acosta a JHPIEGO consultant, in April 1980.

Colombia - Population: 26 million, USAID laparoscopes: 212, Priority - medium

Johns Hopkins trained five trainees from Colombia in FY'80. The major training activity was via the Colombian National Program managed by the Ministry of Health. Surgical training was executed through PROFAMILIA and its affiliated training centers throughout Colombia to complete the required 108 doctor-nurse teams for Colombian institutions.

In-Country

The Colombian National Program mobilized 108 Ministry of Health-affiliated institutions. This was the largest in-country training effort in the world for JHPIEGO. In addition to this successful in-country program, maintenance support activities increased to provide coverage nationally through the Ministry of Health. Six maintenance technicians were trained in-country through the joint cooperation of JHPIEGO and the Ministry of Health. Both Mr. Clapper, JHPIEGO, and Mr. Rivera, Salvadoran MOH Maintenance Center, provided didactic and tutorial assistance in strengthening the Colombian maintenance program on-site in April of 1980.

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The first Latin American microsurgery course was conducted in Bogota, Colombia in February 1980, with JHPIEGO, Ministry of Health, and Military Hospital coordination and assistance. Six trainees included four Colombians, one Peruvian and one Brazilian.

Projected Activities

Projected for FY'81 is further training to support the mobilization of 20 institutions collaborating with the Ministry of Health and training to support mini-laparotomy capability in 100 secondary Ministry institutions. To accomplish this activity, 120 physician-nursing teams will receive training in PROFAMILIA centers nearest the selected institutional candidates. In addition, the second Latin American microsurgery course will be held in Bogota. Six trainees will attend the MOH-JHPIEGO-Military sponsored training in February 1981.

JHPIEGO visitors to Colombia included Dr. Hugh Davis, Head of the Latin Regional Office, for programmatic evaluation and assessment, Mr. Kevin Armstrong, Latin Region, for program review, Ms. Laura Altobelli, Latin Region, for educational assessment of nursing training and curriculum development activities, Mr. Dale Clapper, Equipment Manager, for the training and maintenance review of Colombia. Also, Dr. John Rock and Dr. Rene Genedry from Johns Hopkins provided the faculty for instruction of the first Latin American Microsurgical course in February 1980.

Costa Rica - Population: 2 million, USAID laparoscopes: 24. Priority: low

Johns Hopkins trainees for FY'80 totaled three.

In-country Activities

This year, JHPIEGO sponsored the formation of a laparoscopic equipment maintenance center under the Medical Equipment Section of the Caja Costarricense de Seguro Social which is headed by engineer German Ching. Inventory systems were developed, preventive maintenance schedules implemented, and maintenance storage and workshop facilities activated during FY'80.

Projected Activities

Limited training support actions. Continued support of the Costa Rican maintenance center is planned.

Dominican Republic - Population: 5 million, USAID laparoscopes: 9, Priority: medium.

Johns Hopkins trainees for FY'80 totaled three.

Projected Activities

Limited training support actions in view of active national training capability.

Ecuador - Population: 8 million, USAID laparoscopes: 14, Priority: low

There were no Johns Hopkins trainees for FY'80. The Pan American Health Organization procured, shipped and installed four laparoscopic systems during FY'80.

Projected Activities

Limited training support actions are planned. Dr. Luis Torres of the Obstetrics and Gynecology Hospital in Guayaquil has requested assistance in the organization of a REHEP for medical and nursing students during FY'81.

A JHPIEGO consultancy visit to deliver lectures at a Regional Conference held in Guayaquil, Ecuador was carried out by Dr. Francisco Pardo of the Javeriana University, Bogota, Colombia. This consultancy was sponsored by JHPIEGO in July 1980.

El Salvador - Population: 5 million, USAID laparoscopes: 14, Priority: low

Johns Hopkins trainees for FY'80 totaled two.

Projected Activities

Limited training support actions are projected and continuing support of the MOH maintenance center functions.

Guatemala - Population: 7 million, USAID laparoscopes: 33, Priority: low

Johns Hopkins trainees for FY'80 totaled 4. Total trainees for FY'80 totaled six.

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Projected Activities

Limited training support actions in view of the well developed active in-country capability. Program discussions were held with Dr. Roberto Santiso, Director of APROFAM (the Guatemalan IPPF affiliate), in May 1980 at a conference in New Orleans attended by Dr. Davis. Maintenance activity was discussed with Dr. Aguirre of APROFAM, Administrator, in June of 1980.

Honduras - Population: 3 million, USAID laparoscopes: 18, Priority: low

Johns Hopkins trainees for FY'80 totaled three.

Projected Activities

Limited training support actions in view of active in-country capabilities. JHPIEGO is planning with ASHONPLAFA (the Honduran IPPF affiliate) to activate a clinical practice center for JHPIEGO-trained physicians.

Mexico - Population: 68 million, USAID laparoscopes: 134, Priority: high

Johns Hopkins trainees for FY'80 totaled 11.

Projected Activities

JHPIEGO is planning to sponsor PROFAM seminars in Mexico City, Guadalajara, and Monterrey to stimulate private sector interest in family planning in both reversible and surgical methods. Mobilization of additional in-country training centers via the Ministry of Health, ISSSTE, and other training actions are planned. More Mexican trainees will be programmed for the Johns Hopkins program as requested by USAID/Mexico.

During FY'80, Mexico was visited three times by JHPIEGO staff. The first was by Dr. Ronald Burkman, JHPIEGO Director, who attended an Ob/Gyn conference in Guadalajara. The second visit was a joint visit by Drs. Ronald Burkman and Ronald Magarick (JHPIEGO Program Support Division). The third visit was by Dr. Ronald Magarick in August of 1980 for program development purposes, leading to the PROFAM conference series sponsorship.

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Panama - Population: 2 million, USAID laparoscopes: 14, Priority: low

Johns Hopkins trainees for FY'80 totaled two.

Projected Activities

Limited support of activities in-country via selected institutions and candidates.

Paraguay - Population: 3 million, USAID laparoscopes: 6, Priority: low

There were no Johns Hopkins trainees for FY'80 from Paraguay.

Projected Activities

Limited support of activities in-country via selected institutions and candidates, development of Reproductive Health Education Program in process for the National Maternity Hospital, which is headed by Dr. Miguel Ruoti, Chief of Obstetrics and Gynecology (JHPIEGO fellow 1974).

Peru - Population: 17 million, USAID laparoscopes: 19, Priority: medium

Johns Hopkins trainees for FY'80 totaled five. Total number of trainees for FY'80 totaled six (one microsurgical trainee).

Projected Activities

Support of activities in-country via selected institutions and candidates is projected and the development of Reproductive Health Education Program is in-process at this time. The mobilization of a maintenance center for Peru is projected for FY'81.

Portugal - Population: 10 million, USAID laparoscopes: 4, Priority: low

Johns Hopkins trainees for FY'80 totaled two.

Projected Activities

Limited support of training activities via selected institutions and candidates.

Spain - Population: 38 million, USAID laparoscopes: 2, Priority: low

Johns Hopkins trainees for FY'80 totaled two.

Projected Activities

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Panama - Population: 2 million, USAID laparoscopes: 14, Priority: low

Johns Hopkins trainees for FY'80 totaled two.

Projected Activities

Limited support of activities in-country via selected institutions and candidates.

Paraguay - Population: 3 million, USAID laparoscopes: 6, Priority: low

There were no Johns Hopkins trainees for FY'80 from Paraguay.

Projected Activities

Limited support of activities in-country via selected institutions and candidates, development of Reproductive Health Education Program in process for the National Maternity Hospital, which is headed by Dr. Miguel Ruoti, Chief of Obstetrics and Gynecology (JHPIEGU fellow 1974).

Peru - Population: 17 million, USAID laparoscopes: 19, Priority: medium

Johns Hopkins trainees for FY'80 totaled five. Total number of trainees for FY'80 totaled six (one microsurgical trainee).

Projected Activities

Support of activities in-country via selected institutions and candidates is projected and the development of Reproductive Health Education Program is in-process at this time. The mobilization of a maintenance center for Peru is projected for FY'81.

Portugal - Population: 10 million, USAID laparoscopes: 4, Priority: low

Johns Hopkins trainees for FY'80 totaled two.

Projected Activities

Limited support of training activities via selected institutions and candidates.

Spain - Population: 38 million, USAID laparoscopes: 2, Priority: low

Johns Hopkins trainees for FY'80 totaled two.

Projected Activities

Limited support of in-country activities via selected institutions and

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Uruguay - Population: 3 million, USAID laparoscopes: 11, Priority: low

Johns Hopkins trainees for FY'80 totaled one.

Projected Activities

Limited support of training activities via selected institutions and candidates.

A resume of JHPIEGO training activities in the Latin Region during FY'80 is presented in the following table. Via both in-country and Johns Hopkins training efforts, a total of 284 trainees were processed, representing a substantial proportion of of the total JHPIEGO accomplishment in reproductive health education and training during the year.

JHPIEGO LATIN REGION TRAINING ACTIVITIES

1 October 1979 - 30 September 1980

<u>Country</u>	<u>Clinicians</u>	<u>Microsurgery</u>	<u>Administrators</u>	<u>Academic Skills</u>	<u>Clinical Practice</u>	<u>F V</u>
Argentina	1				1	
Barbados	1				1	
Bolivia	1*				1	
Brazil	17	3	22	2	21	
Chile	3	2	4	1	1	
Colombia	1	5	3		2	
Costa Rica	2	1		1	1	
El Salvador	1		1		1	
Guatemala	3		1		3	
Honduras	3				3	
Mexico	7		3		7	
Panama	1	1			1	
Peru	1	1	4		1	
Portugal	1		1		2	
Spain	2				2	
Uruguay			1			
Venezuela	1				1	

In-Country Projects

	<u>Clinicians</u>	<u>Anesthetists</u>	<u>Nurses</u>	<u>Field Visits</u>
Colombia	77**		64	30
Brazil	27	10	12	20

*Sponsored by Noyes Foundation

**Includes 2 Guatemalan Physicians trained in Colombia

Appendix H
ACTIVITIES REPORT FOR
ASIA AND THE MIDDLE EAST
(FY 1980)

JHPIEGO
ASIA AND THE MIDDLE EAST
ACTIVITIES REPORT
FISCAL YEAR
-1980-

Kasturi Rajadhyaksha, MD.
Regional Development Officer

ASIA: FY 1980

A number of in-country programs developed during the last fiscal year were finalized and implementation began during the fiscal year of 1980. They are Egypt (one at Cairo; one at Alexandria), Malaysia, Pakistan, The Philippines, Sudan, Thailand, Turkey, Indonesia and India. Details on these programs are given elsewhere. It is expected that full implementation of these projects in the years ahead will have a significant impact on the reproductive health of women and families in this region.

In addition to the above educational projects, ten clinical practice agreements were renewed for the second year in this region. These ten clinical practice centers in Asia greatly expand the JHPIEGO capacity for clinical training. Three maintenance center (Philippines, Malaysia, and Sudan) agreements were signed. Of these three maintenance centers, the Philippines center has been functioning and centers in Malaysia and Sudan will begin implementation early next year. Maintenance technicians from the Philippines, Sudan, Malaysia, and Turkey have completed their training.

A major activity pending in the region at the end of this year was the implementation of the India program which was developed in 1978 but due to political conditions existing in the country had failed to receive approval from the Government of India. The endoscopic training in India has been initiated.

Noteworthy, as indicated in other parts of this document, JHPIEGO has received physician-trainees from Burma. This was the first time in ten years that there had been a participation in any AID-sponsored program and JHPIEGO personnel were pleased by the opportunity to work with

physicians from this country.

The program in Pakistan also got underway during the year through UNFPA funding JHPIEGO activities. This was the first UNFPA/JHPIEGO program effort.

The reader will note from review of the specific country activities, that many JHPIEGO faculty and consultants participated in several obstetrical and gynecological congresses in the Asian region during the year, and that many similar activities are planned for the coming year - all of which seem effective means of promoting JHPIEGO's goals of improving reproductive health of women and children

FY 1981

All the in-country programs will have completed one year of training and will be continued in the future. Their impact will become visible.

It is expected that JHPIEGO will develop a working relationship with the People's Republic of China.

Also, in addition to the physician training programs, we plan to concentrate on developing training courses for rural physicians and paramedical personnel which will strengthen the family planning activities in the region. Areas of priority will be given to smaller Middle Eastern and Asian countries like Yemen, Fiji, Papua New Guinea, and other small countries.

PAKISTAN

With the departure of AID from Pakistan, the proposal for the Pakistan National Training Programme in Endoscopy and Reproductive Health was revised and submitted to UNFPA. The project was funded and the six training centers for the first year have begun training physicians and nurses. In 1980 the project is supporting the training of 108 physicians and an equal number of nurses. For the three years of the project, a total of 800 physicians and 800 nurses will be trained in approximately 17 training centers. In addition, a maintenance center is being supported with parts, service equipment, and additional training to service the 116 laparoscopes currently in country (most of which were provided by AID) in addition to the 54 laproscators provided under the current UNFPA project.

AFGHANISTAN: FY 1980 and 1981

No activity is expected due to political conditions.

BANGLADESH: FY 1980

The program that was developed earlier could not be finalized and implemented during the year due to questions raised by the USAID Mission in Dacca. Dr. T.A. Chowdhury, the Program Director, attended the Key Biscayne Conference.

FY 1981

It is expected that JHPIEGO will be assisting AID/Washington and the Government of Bangladesh in planning a program for training physicians and nurses in anesthesia and aseptic techniques during tubal ligations.

BURMA: FY 1980

Four physicians from four institutions attended JHPIEGO courses: two attended the Administrator's course and two attended the English Clinician's course. They all received clinical practice training in Manila, the Philippines. But, installation of laproscopators and field-visits have not been made as both require cabinet decisions.

FY 1981

If possible, plans are to complete the field-visits and send laproscopators to Burma.

CHINA:(Peoples Republic) FY 1980 and 1981

Although to the present there has been no activity in the People's Republic of China, we expect to have some relationship developed during FY 1981. The JHPIEGO Director will visit China in December 1980. Some visitors have also come from China to visit JHPIEGO. And after these exchange of visits, we expect some

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trainees to attend JHPIEGO/Baltimore courses.

INDIA: FY 1980

The JHPIEGO Director participated in the All India Congress of Obstetricians and Gynecologists and presented a paper entitled, "The Johns Hopkins Experience with the Techniques of Laparoscopic Sterilization." Two recently completed JHPIEGO films were shown; one on the technique of laparoscopic sterilization by application of silastic bands, and a second on the maintenance of laparoscopic equipment by clinical personnel. The JHPIEGO Director met with the Ministry of Health and Family Welfare officials regarding implementation of the National Endoscopic Training Program for Physicians. Fifty laproscopators have been sent to the Government of India. Dr. John Rock, a JHPIEGO consultant, visited Bombay for a field visit. Dale Clapper of the JHPIEGO Equipment Unit visited India to discuss maintenance of equipment. One trainee was trained at JHPIEGO for Microsurgery. Visitors to JHPIEGO include: Mrs. Serla Grewal, Additional Secretary of Family Planning, and two other physicians from India.

FY 1981

Efforts will be continued to get an agreement with the Government of India. The JHPIEGO Director and Dr. John Rock will attend the Indian Congress of Ob/Gyn in October 1980, New Delhi.

INDONESIA: FY 1980

After many delays the proposal for training of nurses was finalized and the agreement was signed. The first course began in August 1980. It was attended by fifteen nurses/observers. Dr. Flora Roebuck visited Indonesia for three weeks and assisted with the course. The program was to train trainors in reproductive health care and educational methodology. The program was very

successful and the Indonesians are requesting additional workshops. The total number of visitors to JHPIEGO from Indonesia: four. Consultant visits to Indonesia were two. And the number of trainees who attended courses at JHPIEGO/Baltimore: one.

FY 1981

An infertility training program proposal and additional training workshop proposals will be finalized.

JTI

EGYPT: FY 1980

As anticipated, the agreements for endoscopy training programs were signed with the Al Azhar University, Cairo and the Alexandria University, Alexandria.

A) Al Azhar Training Program -

The objectives of this program are 1. To provide didactic and clinical practice training in modern techniques of endoscopy and fertility management to an estimated thirty physicians from general and provincial hospitals throughout Egypt and six residents from the hospitals affiliated with the Al Azhar University. 2. To provide laproscopators to the trained physicians. The first training course was conducted in August 1980 with ten physicians. Clinical training and provision of laproscopators has proceeded as planned.

FY 1981-

There will be three more courses to complete the number of forty trainees. The second year continuation program will be finalized.

B) Alexandria Training Program -

The objectives of the program are 1. to provide didactic and clinical training in female reproductive health, with an emphasis on voluntary tubal ligation to thirty Egyptian and ten non-Egyptian physicians through five courses of three week's duration. 2. To provide equipment to the institutions of successful trainees. 3. To provide five one-week courses for a total of 40 Egyptian and non-Egyptian non-physician health personnel to update the knowledge and give instructions in proper sterilization and maintenance of equipment as well as current techniques related to reproductive health. 4. One five day international conference dealing with different aspects of reproductive health will be held at the end of the year.

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AID Evaluation team will visit the Alexandria program in November 1980.

In addition to the endoscopy training programs in Egypt, clinical practice center agreements have been signed with Ain Shams Al Azhar, Alexandria and Assuit Universities.

Trainees attending JHPIEGO/Baltimore courses: 4 trainees from 4 institutions. Visitors coming to JHPIEGO: 2. Consultant visits to Egyptian programs: 4 Equipment sent to the present In-Country Programs: 16 laproscators to Alexandria; 8 laproscators and 1 laparoscope to Al Azhar.

The main concern is delay in the programs receiving funds. As Egypt is an excess currency country, the funds have to be sent through the U.S. Controlier and clearing a check takes months. Efforts are being made to clear this problem.

FY 1981

Completion of the courses and the International Conference will be highlights of 1981. Also, the second year continuation program will be finalized.

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IRAQ

Trainees trained at JHPIEGO from Iraq: four trainees from four institutions.

FY 1981

Dr. Fathalla from Egypt will field visit the country. Dr. Baramki, a JHPIEGO Consultant, had planned to attend a Pan Arab conference but his plans were dropped due to political conditions. Some trainees will be trained and field-visits then arranged, but these future plans will depend upon the political conditions.

KOREA: FY 1980 and 1981

During the year, one trainee was trained in Microsurgery. However, no major activity is planned for the future.

MALAYSIA: FY 1980

The Agreement was signed with the National Family Planning Board, Government of Malaysia, for the Malaysian Reproductive Health and Endoscopic Training Program for Physicians and Nurses. The first didactic course was conducted in August 1980 and was attended by 30 physicians and nurses. Neil Rosenshein represented JHPIEGO. Arrangements are underway to complete the clinical practice training in the Philippines or Seoul (Korea).

One maintenance technician was trained at KLI, Pennsylvania and the Philippines. Total number of consultant visits. 3. The total number of trainees coming to courses at JHPIEGO: 1 trainee from 1 institution. Visitors to JHPIEGO: 1. Equipment to Malaysia: 10 System B's.

FY 1981

Completion of the program, evaluation, and continuation will

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be the anticipated activity for 1981.

NEPAL: FY 1980

JHPIEGO sent a consultant to Nepal this year and it was decided that the women consultants from Nepal should be recruited to attend upcoming JHPIEGO/Baltimore courses.

Trainees to JHPIEGO courses: 2 trainees from 2 institutions

Visitors to JHPIEGO: 2

FY 1981

The JHPIEGO Regional Development Officer will visit Nepal to assess the feasibility of a nurses training program. An additional 6-8 female physicians will be trained in Baltimore.

THE PHILIPPINES: FY 1980

A large number of laparoscopes had been distributed to institutions in the Philippines by AID/Washington and AID sponsored agencies such as IPAAS, JHPIEGO, and Pathfinder. A survey in 1978 revealed that there were 57 laparoscopes in 42 institutions. Out of these 42 institutions, only 9 were actively using the scopes. The reason being that some of the scopes were out of order and trainees had either left the institution or were not in a position to utilize the scope. Therefore, to ensure better utilization of laparoscopes, it was decided that an endoscopic training and repair center program be started at the Mary Johnston Hospital, Manila. Under Dr. Virgilio Obelpias, a past JHPIEGO trainee, the Fertility Care Center, (which he directs), was very well suited for this activity with its separate facility. The agreements for the program were signed in 1980.

The first year objectives of the Endoscopic Training and Repair Center were:

1. To train 55 Philippine physicians and a minimum of 20 international referrals per year in the techniques of laparoscopic sterilization.
2. To follow-up and report on the progress and performance of the Philippine trainees after completion of their training.
3. To establish, equip and operate a repair and maintenance center for donated endoscopic equipment.
4. To establish and maintain a system for identifying, collecting, and re-distributing laparoscopes in need of repair.

The strategy to achieve these objectives was two-fold; -one, to train physicians, -two, repair equipment.

The training consisted of one month courses for physicians who had no experience in laparoscopy and a two-week refresher course

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for physicians with laparoscopic experience. The institutions with inactive scopes were invited to send trainees to the Fertility Care Center at the Mary Johnston Hospital.

Simultaneously, two maintenance technicians were trained by KLI technicians and spare parts were provided to set up a maintenance center. The Mary Johnston Hospital remodelled the second floor of the Fertility Care building as a site for the maintenance center. The maintenance technicians then collected machines needing repair. Thus, the first year objectives were reasonably well accomplished: the anticipated number of trainees did in fact receive the training.

During the second year, the program will train 56 Philippine physicians and 25 Philippine Registered Nurses through eight courses. The program is going according to schedule. Two courses have been completed and the third one is in progress. The maintenance center has been functioning satisfactorily for both year one and two. The center repaired and serviced 43 laparoscopes and allied surgical equipment. Twenty-nine machines have been re-distributed and fourteen are awaiting assignment. The clinical practice center at Mary Johnston Hospital has also been quite active.

In addition to all this activity, there were three consultant visits to the program(s) in the Philippines at the Mary Johnston Hospital, Fertility Care Center. Dr. Oblepias attended the Key Biscayne conference and the JHPIEGO Board of Trustees meeting. The program staff of under Dr. Oblepias visited Nepal to train Nepalese in the use of laproscators.

Some problems were unfortunately encountered during the first year. The budget had to be increased to cover the rising inflation. And there was delay in the program receiving funds in time. JHPIEGO has not always received reporting forms on schedule. Yet, we have worked to solve these logistical problems and have met with success.

FY 1981

Naturally, the program activities will be continued. The program will be visited by the AID Evaluation team in November 1980. Also, Year Three of the Philippines Program, (a proposal with the Mary Johnston Hospital) will be finalized. The training of Drs. Baens and Oblepias in microsurgical tubal ligation is expected to act as a catalyst for the development of a microsurgical center at the University of the Philippines. The University of the Philippines, Ob/Gyn department, is also interested in a "REHEP" program proposal. It is expected that this will be finalized during 1981.

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SRI LANKA: FY 1980

There was no progress in the negotiations during fiscal year 1980, but the Health Minister, Dr. G. JayaSurya visited JHPIEGO. It is expected that Sri Lanka/JHPIEGO cooperation will receive an impetus from his visit.

Trainees to JHPIEGO: 1 Visitors to JHPIEGO: 1 Consultant
visits to Sri Lanka: 1 Equipment sent to Sri Lanka: 1

FY 1981

Projections include training of administrators and to explore the possibility of an in-country program.

PAPUA NEW GUINEA: FY 1980

Two physicians from Papua New Guinea have attended courses at JHPIEGO. They received laproscopators and have been field-visited by a JHPIEGO consultant, Dr. Rowland. This is the first time we have been able to get laproscopators into this country.

FY 1981

Some more trainees will attend Baltimore courses. The R.D.O. will visit the country to explore the possibility of an in-country program for nurses in January 1981. It is expected that a program will be finalized during 1981.

SOLOMON ISLANDS: FY 1980 and 1981

One trainee was trained in accordance with the Philippines program and additional trainees from the Solomon Islands will be trained if requested.

SUDAN: FY 1980

The procedural formalities regarding the 2 in-country programs took longer than expected due to local political conditions. However, the agreements for the Continuing Education In Reproductive Health of Rural Medical Officers and the Equipment Maintenance Center in the medical stores of Sudan were signed in April 1980. A maintenance technician was trained at KLI. Dr. Rajadhyaksha, the Regional Development Officer, visited Khartoum in July for purposes of consultation and implementation of the program. Dr. Salih, a member of the Sudanese Parliament, visited JHPIEGO/Baltimore. The total number of laproscopists in the country of Sudan is 17. Trainees attending JHPIEGO courses: 3 (one trainee sent to the Egyptian program), Consultant visits: 1

FY 1981:

A maintenance center workshop and trainer's workshop will be conducted in November (1980), and the maintenance center will be set up following the workshop. There will be some consultant visits to the program also. They will visit the program during and after the initiation of the workshop. The continuing education program should train rural physicians. Some more trainees, physicians, and nurses may be sent to the Egyptian programs.

SYRIA: FY 1980 and 1981

No major activity occurred in Syria in 1980; however one trainee was trained at JHPIEGO. No major activity is planned for the future.

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THAILAND:

Female sterilization has been popular in Thailand for at least two decades. Approximately 49,000 acceptors were recorded by the National Family Planning Program (NFPP) in 1973. In 1975, the number of female sterilizations was increased to 90,000 and the number increased to 106,816 in 1977. The present trend shows that the demand for female sterilization is higher than the expansion of the service.

In the past, postpartum tubal sterilization was the method of choice. Interval sterilization was just recently emphasized and a number of approaches were used including laparoscopy, culdoscopy, colpotomy, and mini-laparotomy. Though postpartum sterilization still remains the most usable method, interval sterilization offers great accessibility to the majority of rural women who deliver their babies at home.

The two most popular interval methods at present in Thailand are mini-laparotomy and laparoscopy. Each method has its advantages and disadvantages. Minilaparotomy is simple and requires less expensive instruments. However, the operation becomes difficult with patients who have peritubal adhesion or obese patients. Frequently, general anesthesia is required. Laparoscopy, under local anesthesia and neuroleptanalgesia, is considerably simple and safe in well-trained hands. It can be performed in obese patients without difficulty and requires less operative time. But, laparoscopic instruments are expensive and delicate. Tubal electrocoagulation commonly used in laparoscopic tubal sterilization is limited in the provincial hospitals because of these disadvantages.

The female sterilization service will be considerably enlarged if the laparoscopic approach can be added to the service, and with the development of a modified laparoscope - the laprocator, this now seems possible. The laprocator is less expensive and

more simple to care for and to operate. The inexpensive mini-light source can also be used in places where electricity is unstable. Electrical injury can be avoided by using the falope ring to occlude the tube instead of tubal electro-coagulation.

The Thai Government clearly hopes that the level of contraceptive usage of both temporary and permanent methods of family planning increase by 1981 and the proposed project is one method to assist the Government of Thailand in reaching their goal of of 2.1% growth rate (by 1981) as stated in the fourth plan.

FY 1980:

An endoscopy training program started in January 1980. The objectives of the course were to 1) train 60 physicians from provincial hospitals in performing female sterilization by laprocaters 2) assess the effectiveness, safety, and acceptability of female sterilization by the laprocator technique.

In selecting trainees, the following criteria were used:

1. First priority would be given to physicians from large population areas. It should be noted that there were 72 provinces within Thailand, each of which has at least one hospital operated by the Ministry of Public Health. It is anticipated that at the end of two years, at least one physician would be trained in the use of the laprocator from each of the provincial hospitals.

2. Residents- At the completion of their Ob/Gyn residency, residents at Chulalongkorn and Siriraj Hospitals would be permitted to attend the didactic course. These residents would have received laparoscopy training during their residency and a system would then be developed with the Department Chairman at each institution in which the resident would be certified by the Department Chairman and staff of the laprocator training program as being competent in the use of the laprocator.

The training program has functioned according to schedule. A total of 49 physicians and 12 residents attended the didactic program. JHPIEGO was represented by Dr. Burkman. During the year, the trained physicians have received clinical training and field-visits. Second generation trainees are being trained by the trainers.

The logistical problems of sending funds, equipment, and receiving equipment have been worked out. Equipment sent to date: 80 systems. Trainees at JHPIEGO courses: 2
Visitors to JHPIEGO: 1 Consultant visits to Thailand: 1

FY 1981

A two-day conference will be held in March 1981 at the Siriraj Hospital and will be coordinated by Dr. Suporn Koetsawang for all physicians who have been trained in order to review the status of the laparoscopy program, including the number of laparoscopies performed, complications, and how well the laproscators have functioned. The evaluation of the laproscator will be completed.

The program will be visited by the AID evaluation team in November (1980).

A continuation proposal for year two will be finalized. And, some trainees will be trained at the Baltimore center.

767

TURKEY: FY 1980

The endoscopic training program proposal was finalized and the agreement was signed in May. The program is expected to train 30 physicians and 75 nurses during the first year. The first course was held in September for physicians. The course for training nurses to become "trainors" was held prior to the physician's course. Ms. Connie Husman, Program Development Officer, was the consultant for this course. Dr. Theodore King and Dr. Grumbine were consultants for the physician's course.

During 1980, a special course for administrators was arranged at JHPIEGO/Baltimore - and it was attended by 15 administrators from Turkey. This was the first course to be given in Turkish.

Dr. Pelland and Dr. Rowland visited Turkey in May to install equipment at the institution which shall be used as the clinical practice site for training.

Also, a maintenance technician received training at KLI.

Visitors to JHPIEGO: 1

Trainees to JHPIEGO: 19

Consultant visits: 6

Two physicians attended the trainor's workshop in Tunisia.

Equipment shipped: 20 systems.

(Turkey)

FY 1981

Continued implementation of the program is expected and a close monitoring of it is anticipated for 1981.

No major activity is planned in view of the recent political upheaval.

YEMEN: FY 1980

Trainees to JHPEIGO:

FY 1981

It is planned that trainees from Yemen will be recruited during 1981

Appendix I

IN-COUNTRY SUB-AGREEMENT AND AMENDMENT SUMMARY SHEET

10/1

(X Indicates action but date is not easily accessible)

IN-COUNTRY SUB-AGREEMENT & AMENDMENT SUMMARY SHEET

NUMBER	CA-1	CA-2	CA-6	CA-6	CA-7	CA-8
COUNTRY	Korea	Pakistan	Tunisia	Tunisia	Mexico ISSTE	Mexico Vela
AMEND. #/PURPOSE				Amend.# 1 2nd year		
BOARD APPROVAL	12/20/77	12/29/76	5/4/78	X	12/20/77	6/12/78
PROP. TO AID	X	X	X	6/9/80	X	X
AID CONCUR.	X	X	X	6/16/80	X	X
REV. BY PRES. OFC.	X	X	X	X	X	X
AGREE. TO AID	X	X	4/28/78	6/19/80	X	X
AID APPROVAL	X	X	5/22/78	6/25/80	2/14/78 8/18/78	
JHPIEGO SIGN.	N/A	N/A	5/26/78	6/27/80		
AGREE. TO COUNTRY			4/9/79	7/3/80		
COUNTRY SIGN.			6/22/78	7/22/80		
FINAL COPY/AID			N/A	7/22/80		
TERM DATE				6/30/81		
COMMENTS	Closed Out	Closed Out			On Hold	On Hold

10/06/80

(X Indicates action but date is not easily accessible)

NUMBER	CA-9	CA-10	CA-10	CA-10	CA-11	CA-11	CA-11
COUNTRY	India	Kenya	Kenya	Kenya	Nigeria	Nigeria	Nigeria
AMEND. #/PURPOSE			Amend. #1 Extend date	Amend. #2 Extended date/ reall. funds		Amend. #1 Extend date	Amend. #2 Extend date
BOARD APPROVAL	6/12/78	12/20/78	N/A	N/A	12/20/78	N/A	N/A
PROP. TO AID	X	X	X	X	X	X	X
AID CONCUR.	X	X	X	X	X	X	X
REV. BY PRES. OFC.	X	X	X	X	X	X	X
AGREE. TO AID	X	2/16/79	9/4/79	6/9/80	5/23/79	9/4/79	5/27/80
AID APPROVAL	X	3/15/79	9/20/79	6/23/80	X	9/20/79	6/6/80
JHPIEGO SIGN.	N/A	4/16/79	9/28/79	6/27/80	5/30/79	9/28/79	6/18/80
AGREE. TO COUNTRY		X	X	7/9/80	X	X	6/19/80
COUNTRY SIGN.		4/3/79	12/20/79		7/19/79	10/26/79	
FINAL COPY/AID		N/A	N/A		N/A	N/A	
TERM DATE				6/30/81			6/30/81
COMMENTS	Closed Out Equipment Only						

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10/06/80
 (X Indicates action but date is not easily accessible)

NUMBER	CA-13	CA-13	CA-13	CA-14	CA-15	CA-15	CA-15	CA-15*
COUNTRY	Thailand	Thailand	Thailand	Sri Lanka	Philippines	Philippines	Philippines	Philippines
AMEND.##/PURPOSE		Amend.##1 Extend date	Amend.##2 Extend date			Amend.##1 Delete ref. to Prov.	Amend.##2 Extend date	Amend.##3 Add'l Funds
BOARD APPROVAL	9/26/78	N/A	N/A	10/31/78	12/20/78	N/A	N/A	4/15/80
PROP.TO AID	X	X	X	X	X	X	X	X
AID CONCUR.	X	X	X	X	X	X	X	X
REV.BY PRES. OFC.	X	X	X	X	X	X	X	X
AGREE.TO AID	1/8/79	9/4/79	5/27/80	2/28/78	3/1/79	N/A	9/4/79	5/15/80
AID APPROVAL	5/30/79	9/20/79	6/6/80	3/29/79	5/30/79	N/A	9/20/79	5/19/80
JHPIEGO SIGN.	5/31/79	9/28/79	6/18/80		5/31/79	8/28/79	9/28/79 1/10/80	6/9/80
AGREE.TO COUNTRY	X	X	6/24/80	4/9/79	X	X	10/4/79 1/10/80	6/11/80
COUNTRY SIGN.	7/19/79	10/19/79	8/7/80		6/21/79	10/1/79	2/8/80	7/7/80
FINAL COPY/AID	N/A	N/A	9/15/80		N/A	N/A	N/A	N/A
TERM DATE			6/30/81					
COMMENTS				On Hold			First Copy Lost In Mail-Remailed	

*Amendment continued

10/06/80

(X Indicates action but date is not easily accessible)

NUMBER	CA-15	CA-16	CA-16	CA-16	CA-18	CA-18
COUNTRY	Philippines	Colombia	Colombia	Colombia	Egypt/ Alexandria	Egypt/ Alexandria
AMEND. #/PURPOSE	Amend. #4 2nd year		Amend. #1 Extend date	Amend. #2 Chg. Prog/ Add'l Funds		Amend. #1 Extend date adj. workscope reall. funds
BOARD APPROVAL	6/2/80	10/31/78	N/A	4/11/80	12/14/79	N/A
PROP. TO AID	6/6/80	X	X	4/16/80	X	X
AID CONCUR.	6/13/80	X	X	X	X	X
REV. BY PRES. OFC.	X	X	X	X	X	X
AGREE. TO AID	6/2/80	11/17/78	9/4/79	6/2/80	2/15/80	6/5/80
AID APPROVAL	6/9/80	12/14/78	9/20/79	6/23/80	2/27/80	6/23/80
JHPIEGO SIGN.	6/18/80	Spanish English 2/26/79	9/28/79	6/27/80	3/24/80	6/27/80
AGREE. TO COUNTRY	6/24/80	X	X	X	X	7/3/80
COUNTRY SIGN.	7/16/80	Spanish 1/18/79 English 3/7/79	10/16/79		4/12/80	7/16/80
FINAL COPY/AID	7/28/80	N/A	N/A	N/A	N/A	7/28/80
TERM DATE	5/31/81	9/30/80				6/30/81
COMMENTS		Expired	Expired	Expired		

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10/06/80
 (X Indicates action but date is not easily accessible)

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NUMBER	CA-20	CA-20 Revised	CA-20	CA-21	CA-21	CA-22*
COUNTRY	Morocco	Morocco	Morocco	Sudan	Sudan	Turkey
AMEND.#/PURPOSE			Amend.#1 Extend date		Amend.#1 Extend date/ Adj.workscope/ reall. funds	
BOARD APPROVAL	6/4/79	12/14/79	N/A	7/18/79	N/A	7/18/79
PROP. TO AID	X	X	X	X	X	X
AID CONCUR.	X	N/A	X	X	X	X
REV. BY PRES. OFC.	X	X	X	X	X	X
AGREE. TO AID	6/7/79	N/A	6/3/80	X	6/3/80	9/28/79
AID APPROVAL	6/8/79	3/11/80	6/9/80	10/30/79	6/9/80	10/3/79
JHPIEGO SIGN.	7/5/79	4/4/80	6/18/80	11/20/79	6/18/80	11/1/79
AGREE. TO COUNTRY		4/9/80	6/26/80	11/21/79	7/3/80	
COUNTRY SIGN.		5/18/80		4/28/80	7/12/80	
FINAL COPY/AID	N/A	N/A		N/A	8/6/80	
TERM DATE			6/30/81		6/30/81	
COMMENTS	See CA-20 Revised					See CA-22 Revised

*Amendment continued

1/06/80

Indicates action but date is not easily accessible)

NUMBER	CA-22	CA-22	CA-23	CA-23	CA-23	CA-24	CA-24	CA-24
COUNTRY	Turkey Revised	Turkey	Brazil CPAIMC	Brazil CPAIMC	Brazil CPAIMC	Egypt Al Azhar	Egypt Al Azhar	Egypt
AMEND.#//PURPOSE		Amend.#1 Extend date		Amend.#1 Correct date	Amend.#2 Extend date		Amend.#1 Extend date	Amend.#2 Prog.Design/ Reall. funds
BOARD APPROVAL	N/A	N/A	7/18/79	N/A	N/A	7/18/79	N/A	N/A
PROP. TO AID	N/A	X	X	X	X	X	X	N/A
BOARD CONCUR.	N/A	X	X	X	X	X	X	N/A
REV. BY PRES.OFC.	X	X	X	X	X	X	X	9/15/80
FREE TO AID	N/A	5/27/80	9/26/79	N/A	5/27/80	12/5/79	5/27/80	N/A
BOARD APPROVAL	N/A	6/6/80	10/22/79	N/A	6/6/80	12/20/79	6/6/80	N/A
PROJ. SIGN.	3/21/80	6/18/80	10/30/79	1/10/80	6/18/80	1/10/80	6/18/80	
FREE TO COUNTRY	X	6/24/80	X	X	6/18/80	X	6/19/80	
COUNTRY SIGN.	3/28/80	8/12/80	11/6/79	1/21/80	7/11/80	1/26/80	6/23/80	
FINAL COPY/AID	N/A	8/15/80	N/A	N/A	N/A	N/A	7/7/80	
TERM DATE		6/30/81			6/30/81		6/30/81	

COMMENTS

Orig. copies lost
Xeroxed copy only

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(X Indicates action but date is not easily accessible)

NUMBER	CA-25	CA-25	CA-26	CA-27	CA-28	NCA-29
COUNTRY	Malaysia	Malaysia Revised	Bangladesh	Indonesia	Brazil Santa Maria	Somalia
AMEND. #/PURPOSE						
BOARD APPROVAL	7/18/79	N/A	9/11/79	X	12/16/79	5/27/80
PROP. TO AID	X	N/A		6/20/80	X	6/2/80
AID CONCUR.	X	N/A	7/8/80	6/20/80	X	7/16/80
REV. BY THE PRES. OFC.	X	X		7/8/80	X	7/29/80
AGREE. TO AID	11/26/79	N/A		7/29/80	4/8/80	9/15/80
AID APPROVAL	12/28/79	N/A		8/11/80	4/22/80	10/8/80
JHPIEGO SIGN.	1/10/80	4/14/80		8/11/80	5/14/80	10/16/80
AGREE. TO COUNTRY		X		8/18/80	X 2nd mailing 7/17/80	10/16/80
COUNTRY SIGN.		4/11/80		8/22/80	8/7/80	
FINAL COPY/AID	N/A	N/A		10/2/80	N/A	
TERM DATE		3/31/81		6/30/81	6/30/81	
COMMENTS	See CA-25 Revised		On Hold		1st copies lost in mail	Hand carried

10/06/80

(X Indicates action but date is not easily accessible)

NUMBER	UN-1	UN-2	UN-3	UN-4	UN-5	UN-6
COUNTRY	Pakistan	Pakistan	Pakistan	Pakistan	Pakistan	Pakistan
AMEND.//PURPOSE						
BOARD APPROVAL	3/21/79	3/21/79	3/21/79	3/21/79	3/21/79	3/21/79
PROP. TO AID	X	X	X	X	X	X
AID CONCUR.	X	X	X	X	X	X
REV.BY THE PRES. OFC.	X	X	X	X	X	X
AGREE. TO AID	N/A	N/A	N/A	N/A	N/A	N/A
AID APPROVAL	N/A	N/A	N/A	N/A	N/A	N/A
JHPIEGO SIGN.	1/10/80	1/10/80	1/10/80	1/10/80	1/10/80	1/10/80
AGREE. TO COUNTRY	1/17/80	1/17/80	1/17/80	1/17/80	1/17/80	1/17/80
COUNTRY SIGN.	4/5/80	4/5/80	4/5/80	4/5/80	4/5/80	4/5/80
FINAL COPY/AID	N/A	N/A	N/A	N/A	N/A	N/A
TERM DATE	12/30/80	12/30/80	12/30/80	12/30/80	12/30/80	12/30/80
COMMENTS	UNFPA	UNFPA	UNFPA	UNFPA	UNFPA	UNFPA

10/06/80

VIII. REGIONAL HOSPITAL, CARMEN DE BOLIVAR - 80 BEDS

Dr. Nelson Gonzalez completed his training in October 1979, and a laparocator was installed in December 1979. There is moderate demand for sterilization, which is easily met by the regional hospital. The surgeon at the regional hospital does all the PROFAMILIA sterilizations in the hospital by minilap. Personnel estimated that 180 sterilizations were performed in the past 3 months. No endoscopic sterilizations have been accomplished in the 4 months that the program has been in place.

Limiting Factors

1. PROFAMILIA meets the demand for sterilization and pays the physician for the procedure.

IX. MATERNITY HOSPITAL, CARTAGENA - 64 BEDS

Dr. Vespeciano Zapata completed his training in May 1979, and a laparocator was installed in August 1979. There is current moderate demand for sterilization which is being met. Personnel were not able to estimate the total number of sterilizations performed in the last 3 months. Three endoscopic sterilizations were accomplished in the 8 months in which the program has been in effect.

Limiting Factors

1. Motivation appears to be the limiting factor, since no other limiting factors were identified, and the only endoscopic procedures (3) performed were accomplished just prior to our visit.

X. REGIONAL HOSPITAL, BARRANQUILLA - 200 BEDS

Dr. Jose Rosillo completed his training in May 1979, and a laparocator was installed in July 1979. There is current great demand for sterilization which is being met by PROFAMILIA and the regional hospital. Personnel estimated that 75 sterilizations were performed in the past 3 months. Three endoscopic sterilizations were accomplished in the 9 months in which the program has been in place.

Limiting Factors

1. Personnel noted that electric power fluctuations were a problem which has only been recently resolved with a voltage regulator. However, motivation appears to be the prime limiting factor in that the only (3) endoscopic procedures performed were accomplished on the day of our visit.