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ANNUAL REPORT OF THE INTERNATIONAL PROGRAMS
of the
ASSOCIATION FOR VOLUNTARY STERILIZATION

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PREFACE

This annual report of the Association for Voluntary Sterilization (AVS) is submitted to the Agency for International Development (AID) to fulfill reporting requirements of Cooperative Agreement DPE-0968-A-00-2001-00. This report describes AVS's international activities conducted during the period January 1 to December 31, 1984 and reflects the total international effort by AVS regardless of funding source (AID-central, AID-bilateral, or private).

AVS's international program would not be possible without the collaboration and cooperation of numerous individuals and groups, especially AVS projects and their staff whose work represents AVS's real accomplishments and achievements. Appreciation and gratitude are extended to AID for its continued generous financial assistance; to AVS's Board of Directors, especially the International and Executive Committees, whose interest and guidance are unflagging; and finally, to the professional and support staff at AVS headquarters and regional offices in Dhaka, Tunis, and Bogota.

Special thanks are given to those individuals who participated in the preparation of this report: to Sylvia Vriesendorp, AVS consultant, and Lynn Bakamjian, deputy director of the International Programs Division, who coordinated the initial information compilation and writing process; to AVS staff who contributed information on their activities and programs, especially program staff from New York and the regional offices for the lively examples of the projects they work with; to the Data Processing Department, especially Dana Evans, who methodically tabulated the statistical data; to Josephine Osmani and Ida LoGuidice who cheerfully typed the many drafts of the manuscript; to Meliha Pile who proofed the chapters repeatedly; to Linda Levine who produced the figures and maps; and finally to Pamela Harper for her expert editing, excellent suggestions, and infinite patience.

Terrence Jezowski
New York

ASSOCIATION FOR VOLUNTARY STERILIZATION

The Association for Voluntary Sterilization began in 1943 out of the simple conviction that men and women should have the choice of surgical contraception available to them as a method of family planning. We are a nonprofit membership organization.

In recent years, people have become more aware of how excessive childbearing can endanger the health of women and children and how rapid population growth throughout the world affects all our lives. These concerns have affirmed the continuing need for AVS, whose fundamental aim has been, and remains, to allow people everywhere access to safe and effective voluntary surgical contraception.

From 1943 until 1972, AVS worked only in the United States, taking the lead to insure the right of each individual to choose voluntary sterilization as a method of birth control. In 1972, AVS began its international program. Today we can point to programs in 60 countries in addition to our own, that directly touch the lives of hundreds of thousands of people and indirectly touch millions more.

Education. AVS educates the general public and professionals about voluntary sterilization. We serve as an informational clearinghouse for individuals, medical personnel, professional journals, newspapers, magazines, and psychiatric, social welfare, and legal agencies.

Research. AVS initiates and monitors fact-finding studies on medical, legal, psychological, ethical, socioeconomic, and public health aspects of voluntary sterilization. We support research and evaluation that will help make services safer, more effective, and more widely used.

Services. AVS helps developing countries introduce or expand voluntary sterilization services as an integral part of their health and family planning programs. We support the establishment and operation of clinic services with direct financial subsidies, equipment, training, technical assistance, and educational materials. Our programs complement the work of other family planning organizations and are often administered in collaboration with those agencies.

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CHAPTER 1

EXECUTIVE SUMMARY

For years voluntary surgical contraception (VSC) has steadily grown in popularity and availability. This advance is continuing with favorable developments in all regions of the world. In 1984 surveys revealed that VSC is the most-used contraceptive method among couples in the United States; furthermore, with fears of serious side effects set aside, vasectomy performance rebounded in 1984 to previously high levels. Asian governments continued their forthright commitment to and support for VSC, while struggling with the challenges of making VSC available to the millions who still do not have access. Performance and prevalence grew strongly in Latin America--in some countries VSC is now the most prevalent method--even though governments of the region, as a rule, continue to shy away from open support. Many additional countries, especially in Sub-Saharan Africa, seriously began to introduce voluntary surgical contraception or to consider its introduction. In November 1984 a historic conference on reproductive health, held in Sierra Leone, included VSC as a major topic; a few years earlier most professionals would have considered such an event an impossibility.

Despite VSC's growing popularity, opposition to it also seems to have grown in 1984, and this opposition appears more determined, sophisticated, and extensive. In Colombia, PROFAMILIA, the private family planning association, successfully endured a sustained attack on its VSC program by the Catholic Church. In Brazil certain members of the medical profession challenged the ethical propriety of voluntary surgical contraception. In El Salvador local and international agencies spent considerable energy and effort investigating charges made in the United States press that clients were being systematically coerced to accept VSC. Special inquiries and surveys, program evaluations, and interviews with clients and service providers all failed to substantiate the charges. In some Moslem countries, VSC program development slackened because of the continuing atmosphere of political and religious conservatism. And, in the United States, persistent determined attacks against federal support for abortion and family planning have brought concern and uncertainty to international family planning and VSC programs.

So, 1984 was a mixed year for AVS and its international program. On the one hand, not only are the peoples of the world accepting VSC in increasing numbers, but also many program and technical developments are converging, to improve the quality and availability of VSC services. On the other hand, our optimism and desire to support and guide this movement are tempered by the persistence of opposition to the idea.

It is unlikely that all who oppose making voluntary sterilization available will change their views. Our task is not to debate the question. Rather, we must make every effort to see that the services we support are fully voluntary, safe, and effective; well managed and supervised; and responsive to the needs and concerns of the individual clients and of their communities.

Understandably then, AVS is proud of its 1984 work, not only for the advances in supporting global VSC demand, but also for the considerable accomplishments in promoting compassionate, high-quality, and ethical service to individuals. We therefore report our 1984 work in this summary chapter under two general headings, expanding access and promoting quality. In reality, of course, these two aspects of our work are inseparable.

EXPANDING ACCESS

The purpose of AVS's cooperative agreement with AID is to expand access to VSC, that is, to "carry out a program to increase the number of developing countries in which high-quality voluntary sterilization services are institutionalized and routinely accessible to the majority of the population and to increase the number of developing countries in which voluntary sterilization has become acceptable as a family planning and health measure." The primary tools we use to expand access are grants and technical assistance.

Realizing that our resources are meager in relation to need and that they must be stretched across many countries, we are selective with our grant and technical assistance. We aim to achieve leverage in each country where we work with the grants we award and the technical guidance we give. The following regional reports of grants assistance in 1984 indicate that AVS achieved extensive worldwide coverage which responded to changing priorities.

Regional efforts

By the end of 1984, AVS was supporting active projects in 10 Sub-Saharan Africa countries. In three regionally strategic countries --Kenya, Zaire, and Nigeria--VSC is on the threshold of being integrated into the health-care systems, and AVS is participating with both grants and technical assistance in the development of national programs. In several other countries AVS is collaborating with local counterparts by supporting pilot and demonstration projects that are testing and demonstrating the acceptability and feasibility of VSC. AVS is confident that most of these efforts will succeed and that, within the next decade, VSC will be as available in the health-care systems of Sub-Saharan Africa as it is today in much of Asia and Latin America.

Significantly, all of the countries receiving subagreement assistance for the first time were in Sub-Saharan Africa. Institutions in Burkina Faso, Madagascar, Uganda, and the Comoro Islands received initial grants for new VSC pilot and demonstration projects. Setting the stage for more extensive future assistance, small grants were given for the first time to individuals and institutions in Botswana, Cameroon, Ethiopia, Rwanda, and Somalia.

This expansion of funding activity in Sub-Saharan Africa clearly indicates AVS's commitment to expand access to VSC to more countries. AVS has given Sub-Saharan Africa top priority for two major reasons: because family planning and VSC are least available in this part of the world and because governments and private institutions in other regions are assuming increasing responsibility for VSC services. To support this shift in regional priorities in 1984, AVS added additional staff in New York, to facilitate development of new programs, and began planning for two new offices in 1985: a new regional facility in Nairobi, Kenya, and a country office in Nigeria.

The most significant event in 1984 for AVS in Africa was the Conference on Reproductive Health Management in Sub-Saharan Africa, held in Freetown, Sierra Leone, in November. Sponsored and organized by the World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception, with funding from AVS, this meeting convened over 200 African professionals from 34 countries in the region. The conference, hailed as the "landmark event in the history of family planning in Africa,"* was a turning point for AVS in its involvement in the region. For the first time voluntary surgical contraception was openly discussed and debated by such a regional gathering in Africa; furthermore, the vast majority of the conferees endorsed VSC on health grounds. The conference thus marked the close of one chapter of AVS's work: informing African health professionals about VSC, building trust and a network of relationships with African counterparts, and legitimizing the role of VSC within total health care. At the same time, it marked the start of a new phase in which we will build on pilot and demonstration projects to develop national VSC service-delivery and training programs.

In North Africa and the Middle East, the overall direction for VSC programs is positive, despite difficulties in working in this conservative region. After years of AVS support, the Tunisian VSC program has become institutionalized with government support and funding; as a result, in 1984 AVS began to explore new types of programs in Tunisia, for example, postpartum services to augment the successful interval services. After years of preparatory programming, Morocco embarked on a national service-delivery expansion program in 1984 with AVS support. AVS-funded pilot programs in South and North Yemen slowly built momentum during the year. In the Sudan AVS participated with other donors to help establish the first dedicated family planning and VSC clinic in that country. After years of

official disinterest in Jordan, private-sector professionals from that country invited AVS to explore the development and funding of a pilot service program. Although developments in the region were generally positive, setbacks in Egypt in 1984 reminded us that voluntary surgical contraception is a delicate subject in this part of the world. Despite an extensive commitment of AVS resources in Egypt in recent years, the prospects for official acceptance of VSC remain dim; consequently, AVS in 1984 engaged in a major reassessment of its funding in Egypt.

The continued presence of an AVS regional office in Tunis underscores not only our commitment to VSC program development in the region, but also the importance of a responsive field presence that carefully nurtures the special needs of the Arabic-speaking world. In 1984 the World Federation, in collaboration with its affiliate the Regional Arab Federation, published the first Arabic medical textbook on family planning, including VSC. In 1985 AVS's Tunisia office will work with the World Federation to mobilize for a major regional meeting in 1986 of Arabic-speaking professionals to address VSC program development.

In contrast to Africa and the Middle East, AVS's work in Asia is long-standing and in most countries has progressed considerably beyond the introductory stage. VSC has been well accepted in Asia, and many governments include it in their national health and family planning programs. In the 1970s and early 1980s AVS contributed directly to this institutionalization of VSC by using AID central funds to support training, equipment, renovation of facilities, service delivery, and technical assistance. In 1984 AVS continued to distribute central funds for these kinds of capital-intensive activities in several countries, notably Bangladesh, Indonesia, the Philippines, and Nepal. As in past years, AVS also used bilateral USAID-Mission funds to support similar undertakings, such as the extensive service-delivery network of the Bangladesh Association for Voluntary Sterilization; BAVS activities have been funded with bilateral monies since 1981. In 1985 AVS hopes to use USAID-Mission funds in Indonesia for a nation-wide project to equip government health facilities for voluntary surgical contraception.

With government, bilateral, and multilateral donors increasingly paying the bill for service delivery, AVS is, in turn, devoting proportionately less of its AID central funds to Asia. This reduction in central funding emphatically does not carry with it any diminution of our overall effort in the region, which, if anything, has become more intensive and specific. In 1984 we continued to redirect our grants and technical assistance to the more specialized aspects of VSC programs, to address needs not covered by government programs, and to develop projects and activities designed to improve the quality of VSC services. Thus, in 1984 we developed new vasectomy programs, especially in Indonesia, the Philippines, and Thailand. We worked with our counterparts throughout the region to further develop client

counseling policies and programs. We funded VSC client follow-up surveys in Bangladesh and Indonesia, in order to better understand clients' satisfaction with services and their reasons for choosing VSC. We continued or started a number of activities to further strengthen medical quality: promoting proper local anesthesia, developing national VSC medical and service-delivery guidelines, and planning for pilot data-collection and surveillance systems for complications. Despite funding reductions, our Asian involvement is more specialized and sophisticated, addressing needs that are on the cutting edge of VSC program development and expansion, and providing lessons and models for programs in other regions as they achieve maturity.

Finally, in Latin America AVS pursued in 1984 a mix of strategies commensurate with the uneven acceptance and development of VSC services among the nations of the region. In Central America, where governments have been reluctant or unable to support VSC, AVS has for several years supported the provision of VSC services through IPPF-affiliated, nongovernmental family planning associations. In 1984 AVS intensified its long-term effort to shift the major burden of funding to governments themselves, or to USAID Missions, especially in view of the fact that VSC is well accepted and demanded by Central Americans. (In both El Salvador and Guatemala, for example, survey data collected in earlier years and analyzed in 1984 revealed that VSC is the most prevalent contraceptive method among married couples.) By the end of 1984, AVS staff had begun negotiating with counterparts and USAID Missions in Guatemala, El Salvador, and Honduras to progressively reduce the commitment of AVS's central funds to these countries. Thus, in Central America AVS is following a course similar to that taken in Asia: reducing the commitment of central funds to the region but intensifying efforts to provide technical assistance and improve the quality of services.

AVS's most extensive programs in the region in 1984 were in Mexico and Brazil, two countries which demand a heavy commitment of AVS's central funds and staff time because of the absence of bilateral USAID programs for population. In both countries the expansion of VSC programs is relatively new but rapid. (AVS began working in both countries in the mid-1970s with privately funded demonstration programs whose success opened the doors for use of AID central funds.) In both of these large and strategically important countries, AVS support plays a critical role by maintaining the momentum for service expansion while serving as a catalyst for the improvement of medical quality. In 1984 AVS consolidated networks of individual service projects in both countries--through the Associacao Brasileira de Entidades de Planejamento Familiar (ABEPPF) in Brazil and the Federacion Mexicana de Asociaciones Privadas de Planificacion Familiar (FEMAP) in Mexico--to foster local institutional development and responsibility, and to enhance AVS's ability to support even more service outlets. AVS worked through Promocao de Paternidade

Responsavel (PROPATER) in Brazil and various institutions in Mexico, including the Ministry of Health, to improve the acceptability and availability of vasectomy.

While voluntary surgical contraception is well on its way to being institutionalized in much of Latin America, program development is still in its infancy in a number of countries, especially in South America. In Bolivia, Paraguay, Peru, and Ecuador, AVS worked successfully in 1984 to introduce small service-delivery projects. Introducing and desensitizing VSC in these countries is a major challenge for AVS's regional office in Bogota. The considerable differences in VSC acceptance throughout the region will test AVS's flexibility and sensitivity to local needs and conditions. AVS intends to recruit more program staff in both New York and Bogota to meet the challenges that this varied region poses.

Summary of grants assistance

Table 1.1 summarizes some of the inputs and outputs of AVS's grants-assistance program. A comprehensive review and analysis of the program is provided in the first part of Chapter 2.

In 1984 AVS obligated a total of 164 grants for over \$9.6 million in funds from various sources. Ninety-seven of these grants were subagreements for substantive, extended-duration projects, having long-range goals and programmed objectives; 67 were small grants (i.e., under \$7,500) for limited assistance intended either to open doors for more extensive programs at a later time, or to satisfy a very specific small need in an ongoing VSC program. In terms of funding activity, the 1984 obligations reflect a significant increase over 1983 (119 grants including 83 subagreements and 36 small grants were obligated in 1983).

Not only did funding activity increase in 1984, but it reached more countries, including several receiving AVS assistance for the first time. A total of 38 countries received major subagreement assistance in 1984, as compared to 34 countries in 1983.

PROMOTING QUALITY

The growing popularity of voluntary surgical contraception would be unthinkable if, first, VSC did not fulfill an important need in the lives of individuals and if, second, VSC services were poorly offered and provided. Indeed, there is mounting, incontrovertible evidence that satisfied VSC clients are the most powerful and important champions of VSC. AVS is committed to the highest-quality service for each client. This is the only ethical approach to our work. It happens also to be the sine qua non for succeeding in our work.

TABLE 1.1: Highlights of AVS's International Program Accomplishments, 1983 and 1984

| | <u>1983^a</u> | <u>1984^b</u> |
|---|-------------------------|-------------------------|
| <u>Awards</u> | | |
| - Number of subagreements awarded | 83 | 97 |
| *Dollars allocated for subagreement awards | \$9,716,246 | \$9,381,590 |
| *Number of countries receiving subagreements | 34 | 38 |
| - Number of small grants | 36 | 67 |
| *Dollars awarded for small grants | \$79,005 | \$270,383 |
| *Number of countries receiving small grants | 24 | 31 |
| <u>Services</u> | | |
| - Number of service facilities in operation supported by AVS ^c | 652 | 685 |
| - Estimated number of voluntary surgical contraception procedures performed | 228,575 | 270,428 |
| | <u>1983</u> | <u>1984</u> |
| Male | 54,324 | 66,382 |
| Female | 174,251 | 204,046 |
| <u>Training</u> | | |
| - Training facilities in operation ^c | 19 | 20 |
| - Number of physicians reported trained ^c | 75 | 816 |
| - Number of health-support staff reported trained ^c | 3,307 | 1,243 |
| <u>Equipment</u> | | |
| - Number of major equipment items provided | 716 | 590 |
| - Dollars obligated for equipment & commodities | \$760,938 | \$432,116 |
| - Number of repair and maintenance (RAM) centers ever supported by AVS ^c | 13 | 14 |
| - Number of RAM centers currently funded by AVS | 8 | 6 |

TABLE 1.1: Highlights of AVS's International Program
Accomplishments, 1983 and 1984 (continued)

| <u>Professional Leadership and Education</u> | <u>1983</u> | <u>1984</u> |
|--|-------------|-------------|
| - Number of AVS-supported national leadership groups (i.e., national associations for voluntary sterilization) | 10 | 10 |
| - Number of international conferences supported ^c | 2 | 1 |
| - Number of national or regional professional meetings supported ^c | 7 | 12 |

Notes

^a 1983 totals reported here are final figures and may differ from the estimates given in the 1983 annual report.

^b 1984 totals are preliminary counts, estimates, or projections.

^c Totals for these indicators are derived from a special in-house survey of program outputs conducted in March and April of 1985.

AVS addresses quality in three ways: safeguarding and strengthening voluntarism, monitoring and improving medical quality, and encouraging better program management. Our 1984 work in these areas is summarized below, with a more extensive discussion in Chapter 4.

Voluntarism

In addition to strictly monitoring formal informed-consent requirements in service projects, AVS in 1984 supported special surveys of clients to determine not only their satisfaction with VSC services, but also their knowledge, understanding, and motivations for requesting VSC. The surveys are being conducted in AVS-funded service programs in five developing countries: Bangladesh, Colombia, El Salvador, Indonesia, and Tunisia. With the exception of Colombia, all the surveys were begun in 1984. Preliminary results are remarkably consistent and reassuring:

- o The decision to undergo sterilization is usually a long-term, systematic one, involving discussions with spouses, friends, and relatives, and, often, other acceptors. Most clients mention "self," "friends," or "family" as the most influential persons in their decisions.
- o The overwhelming majority of clients know of, and many have used, other contraceptive methods before requesting VSC.
- o Nearly all clients choose VSC because they want to limit the size of their families, not because of incentives or pressure.
- o Although the majority in each survey have indicated that they understand the permanence of VSC, a small but significant number have said they did not understand.

The results of all five surveys should be available in 1985 and will be summarized in next year's report. The results will be used to improve programs. For example, if the preliminary findings showing that a small but significant number of clients misunderstand VSC's permanence is confirmed, then AVS will devote even more attention to counseling and information programs.

In 1984 AVS continued to emphasize the development of better counseling components in service programs as a means to safeguard and enhance voluntarism. The World Federation finalized a manual of VSC counseling guidelines, which will be available to service programs worldwide in 1985. In Asia AVS grantees in several countries, including Indonesia, Nepal, Thailand, and Sri Lanka, convened task forces or seminars to develop national counseling policies or guidelines. Pilot counselor-training projects were funded in Indonesia and

Brazil. Program-development work accelerated in all other regions to incorporate or improve counseling programs; this preparatory work will result in numerous action programs for counseling in 1985.

Medical quality

Because of the surgical nature of VSC, service providers must give vigilant attention to assuring medical quality, a difficult and demanding undertaking given the varying conditions and characteristics of health-care delivery in developing countries. In 1982 AVS demonstrated commitment to medical quality by establishing a separate Medical Division staffed by qualified professionals. In the short time of its existence, the Medical Division has made substantial contributions to the medical quality of VSC services in the world in general, and in particular country and local programs.

Through its financial and technical support to the World Federation, AVS contributed to the development of internationally accepted safety guidelines for VSC service provision; these guidelines were distributed worldwide in 1984. Often because of AVS grants, technical assistance, publications, and training, more and more programs in most parts of the world are adopting safer local anesthesia practices for VSC. AVS's increasingly active medical site-visit program has led to the correction of faulty medical practices and to improvements not only in anesthesia, but also in surgical techniques, asepsis, client selection, follow-up care, and medical surveillance. The Medical Division's immediate investigation of reported deaths associated with VSC, as well as its prompt analysis of reported complications, provide quick feedback and recommendations for corrective actions to service providers.

In 1984 AVS funded several specific programs and activities designed to enhance medical quality assurance in service and training programs. A workshop for Central American physicians was held in Guatemala in August to review VSC safety guidelines in the context of regional experience. Throughout the year AVS continued to collaborate with the World Federation to further develop internationally accepted guidelines. In September, for example, the World Federation convened an international task force in Rio de Janeiro to develop training guidelines for VSC, which will be published in 1985. In addition, the Statistics Committee of the World Federation met in London in June to develop a model medical data-collection and analysis protocol that can be adapted in most VSC service settings to monitor morbidity and mortality.

The surest signs of the success of AVS's work in medical quality assurance are those programs which themselves have undertaken self-directed improvement initiatives. In 1984, for example, the Family Planning Association of Nepal organized quality-assessment teams to visit VSC mobile teams and camps. In several countries, including

Brazil, Colombia, Indonesia, and Thailand, medical norms or guidelines were formulated, or were being developed, for use in local or country programs. In several countries AVS counterparts were designing pilot projects to test the medical surveillance data-collection and analysis protocol recommended by the World Federation. If successful, these systems will further enhance the ability of local organizations to monitor and improve services.

Effective program management

As VSC programs around the world mature, expand, and become more complex, the need for sound program management becomes more evident and urgent. In 1984 AVS responded in many ways to help grantees become more effective and efficient managers. In particular, several steps were taken to improve financial management. A financial management checklist designed to identify weaknesses and problems was drafted for use by AVS field staff. Subagreement audit systems were improved. During the year AVS financial staff and consultants provided on-site technical assistance to programs. Working with grantees, AVS developed multiyear financial plans that not only budget all identifiable costs for each year, but also project the sources and means for recovering those costs in ways that lead to increasing self-reliance and cost-effectiveness.

Program evaluation is another area that received increased attention in 1984. Project evaluation plans were made mandatory for all subagreements in 1984. Guidelines for developing such evaluation plans were drafted. Independent evaluators assessed VSC programs funded by AVS in Guatemala and El Salvador. To increase understanding about the dynamics and impact of VSC programs, AVS supported discrete programmatic research and secondary data-analysis projects. For example, a project in Colombia is studying costs of VSC through different service-delivery systems (i.e., static clinics, mobile teams, private doctors).

THE WORLD FEDERATION

The World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception is an indispensable partner of AVS. The two organizations share common goals: expanding access to VSC and promoting quality. If the World Federation did not exist, the programs it carries out would have to be conducted by AVS or other organizations. As it is, the Federation enables the work to be done with greater acceptance and credibility; it offers a legitimate international forum that brings the views, experience, and expertise of the developing world together with those of the developed world. Furthermore, the World Federation focuses especially on the difficult and sometimes elusive contextual needs of VSC programs: developing standards and guidelines, disseminating technical and scientific

information, organizing leadership meetings and expert consultation groups, and developing relationships with other international and professional organizations, such as WHO and UNFPA, whose actions can heavily influence VSC programs. The effect of these activities is enhanced by the Federation's international membership who, by their endorsement, give credibility and legitimacy to the work. Such important activities would simply be less effective if conducted by AVS, an American organization.

The significant accomplishments of the World Federation in 1984 have already been mentioned earlier in this chapter. They include a model protocol for VSC medical surveillance, guidelines for VSC training programs, and, most significantly, the Conference on Reproductive Health Management in Sub-Saharan Africa. In addition, the Federation continued its information dissemination program. Three issues of Communique, each issue dealing with a specialized theme, were produced. During the year the Federation published Safety of Voluntary Surgical Contraception, an authoritative international reference on the subject of VSC quality assurance. Staff members and international experts finalized the manuscript on VSC client-counseling guidelines. The Federation coordinated the publication of an Arabic medical textbook on family planning and VSC. Finally, World Federation representatives actively participated in a number of international meetings, including the Conference on Population in Mexico City. The 1984 activities and accomplishments of the World Federation are more fully reported in Chapter 5.

1985 AND BEYOND

With 1985 AVS will have passed the midpoint in its current cooperative agreement with AID. It is, therefore, an appropriate time for reflection, for looking back and assessing the achievements and issues of the past few years, but especially for looking forward to the future. The assessment of the past and current program will be done in part by AID, which will appoint an independent evaluation team to look at AVS's work in the field and at headquarters. This review will set the stage for future planning and for negotiation with AID of a new five-year cooperative agreement for 1987-1991. In addition, AVS has established a Long-Range Planning Committee of board and staff which will be activated shortly after the AID evaluation.

During the long-range planning process, each AVS division will be asked a fundamental question: What does AVS want to accomplish by the end of 1991, in terms of program results and organizational capacity? Once divisional and organizational goals have been agreed upon, the committee will project the mechanisms and resources needed to achieve the goals. While this long-range planning process was developed independently of AID requirements, AVS intends to use the plan to help develop the proposal to AID for a new five-year cooperative agreement.

While we expect our long-range goals to be more general than specific, our short-range plans for 1985 can now be stated with some degree of concreteness and surety. There are no radical new directions here. The plans discussed below build upon our earlier experiences and upon assessment of needs; all, in one or more ways, contribute to our fundamental goals of expanding access to VSC and promoting quality.

*Protecting and enhancing voluntarism: The client follow-up surveys will be completed in 1985, and the findings analyzed and used to strengthen programmatic safeguards to voluntarism. In May 1985 in Colombo, the World Federation will convene an international leadership symposium to consider issues related to voluntarism from a cross-national perspective. As in the past, AVS will routinely monitor informed-consent provisions in all service projects.

The World Federation's counseling manual will be published and distributed in 1985. Several counseling initiatives will be supported through subagreement assistance, such as counselor-training workshops in Brazil, Nigeria, and Kenya. At regional seminars in Central and South America, project managers will learn about counseling needs assessment, program development, and evaluation. During the summer AVS field staff will be trained to assess counseling needs and to provide technical assistance in counseling. Staff experts from the National Division, the Medical Division, and the World Federation will be deployed in the field to provide first-hand guidance in developing counseling programs.

*Assuring medical quality: The frequency of routine medical site visits will increase. This will be achieved by adding medical staff in regional offices, by using medical consultants as appropriate, and by instructing nonmedical field staff to observe key clinical aspects of service delivery and report their findings to the Medical Division.

Proper training is a key ingredient in assuring medical quality. In certain countries such as India, AVS will concentrate on developing and monitoring "centers of excellence," where standards of quality are established and demonstrated. Regional training centers in Sub-Saharan Africa will remain a high priority in the overall strategy for that region. A professional coordinator for training and new technology will be added to the staff. The World Federation will publish and distribute the report from last year's training-guidelines workshop in Brazil.

During the year AVS will help programs install medical surveillance systems. Using the protocol developed by the World Federation, AVS staff will work in Kenya, the Dominican Republic, Indonesia, Thailand, and other countries to develop pilot VSC medical-surveillance projects.

AVS will continue to encourage and assist grantees to conduct seminars and workshops on medical safety and to develop safety-guidelines for voluntary surgical contraception based on local conditions.

*Expanding access: In measured, deliberate ways, AVS will continue to develop and fund new VSC programs in underserved areas. In particular, new program development will be emphasized in Sub-Saharan Africa, North Africa, the Middle East, and South America. In 1985 AVS will open a regional office for Sub-Saharan Africa in Nairobi, Kenya; recruit a country representative for Nigeria; reassign the workload of the Tunisia regional office to focus more intently on North Africa and the Middle East; and hire additional professional staff to support the South American programs.

*Allocating resources and raising funds: To allow program development in underserved countries, AVS will continue to shift proportionately more central AID funds from Asian and Central American countries to other regions. This shift will not mean a diminution of efforts in Asia and Central America; indeed, AVS's work may be more intensive in those regions as staff members focus on the specialized and sophisticated needs of maturing programs. In any event, AVS will attempt to shift the primary funding burden in Asia and Central America to governments and local institutions or to USAID bilateral funding, which may be channeled through AVS or provided directly to the programs.

AVS will continue to need and raise private funds for its international work. These funds are crucial to working in countries where AID funds cannot be used because of AID prohibitions or political sensitivity. In the past, privately supported programs have opened the doors for eventual large-scale funding with AID monies. Notable examples are Brazil and Mexico, two large and strategic countries.

*Appropriate and new technology: The Medical Division will stress two areas of effort: the introduction of new techniques, and the advancement of inadequately used techniques, like local anesthesia and minilaparotomy. The division will examine the safety and effectiveness of the Chinese method of nonsurgical female sterilization and its acceptability in other places. Staff members will evaluate the effectiveness, acceptability, and safety of the Filshie clip; will consider the introduction of Norplant in selected programs; will collect data on vasectomy techniques in use; and will assess coagulation equipment for possible introduction into vasectomy programs. Most of these efforts will require private funding.

CONCLUSION

The unmet need for VSC is, by even the most conservative estimates and extrapolations, well beyond the resources available to AVS. AID itself recognizes this fact in its cooperative agreement with AVS, which has as its goal the expansion of access by increasing the number of countries where safe VSC services are available. In order for this to happen, AVS must apply and allocate its resources strategically, leveraging funds to produce results that have an impact beyond the local institution and into the future. We believe the work highlighted in this report for 1984, as well as the plans we have for 1985 and beyond, are contributing in both small and large ways to produce this wider impact. Recognizing that so very much remains to be done in achieving universal access to VSC, we are pleased, but not content, with the success of our efforts so far.

We are sobered by the appreciation that there are those who do not agree with our goals. Mindful of this, we will move carefully and deliberately, guided by our fundamental commitment to the individual and our respect for that person's dignity, needs, and problems. Through this commitment and detailed attention to voluntarism and medical quality, the programs we support must survive and grow because the beneficiaries, the countless individuals, perceive them as good and desired.

* D. Wulf, "The Future of Family Planning in Sub-Saharan Africa," International Family Planning Perspectives 11, no. 1, March, 1985, pp. 1-8.

CHAPTER 2

GRANTS ASSISTANCE PROGRAM

The grants assistance program is the major vehicle for conducting AVS's international program and for completing the work intended under its cooperative agreement with AID. This chapter reports on AVS's grants-assistance program from two perspectives. An overview of the number, funding sources, program emphases, and regional distribution of grants awarded in 1984 is presented in Part I. This is followed in Part II by a more in-depth look at the directions and outputs of our grants-assistance program in each of the regions. The regional reports discuss not only the accomplishments of 1984 but directions for 1985 and beyond.

PART I: OVERVIEW OF 1984 GRANTS ASSISTANCE

Number of grants

AVS conducts its grants-assistance program through the award of subagreements and small grants. Subagreements are generally grants for comprehensive programs in excess of \$7,500; they require prior AVS board and AID/W approvals. Small grants, on the other hand, are always less than \$7,500, do not require prior AVS board and AID/W approval, and are generally for more limited purposes. As shown in Table 2.1, a total of 164 grants were made in 1984. Of these, 97 were subagreements and 67 were small grants.

AVS activity, as measured by the number of subagreements obligated in 1984, has increased by more than 15% since 1983, even though the total amount of funds obligated is somewhat lower than in 1983. This reduction in total amount of obligations can be explained by several factors including a reduction in the amount awarded to the World Federation; an increasing number of small-scale seeding activities, especially in Sub-Saharan Africa; and the 18-month program cycle of many major programs, especially in Asia, a characteristic that causes these subagreements to be counted only every other year among the obligations.

Amount and source of funds

More than \$9.65 million were obligated for subagreements and small grants in 1984. AVS provides support to subrecipients through three funding sources: AID central funds, supplementary AID funding from USAID bilateral or AID regional bureau funds, and private funds. A breakdown of the number of grants awarded and amounts by source of funds is provided in Table 2.1. The primary source of funding continues to be AID central funds which in 1984 accounted for 82% of all

| TABLE 2.1: Summary of AVS Obligations for Local Project Funding by Source of Funds, 1984 | | |
|--|------------------|--------------------|
| Type of Funding/ Source of Funding | Number of Awards | Amount |
| Subagreements: | | |
| Central Funds | 87 | \$7,708,020 |
| Bilateral | 1 | 1,485,284 |
| Private | 9 | 188,286 |
| Subtotal | <u>97</u> | <u>\$9,381,590</u> |
| Small Grants: | | |
| Central Funds | 63 | \$ 240,581 |
| Bilateral | 2 | 22,500 |
| Private | 2 | 7,302 |
| Subtotal | <u>67</u> | <u>\$ 270,383</u> |
| TOTAL | 164 | \$9,651,973 |

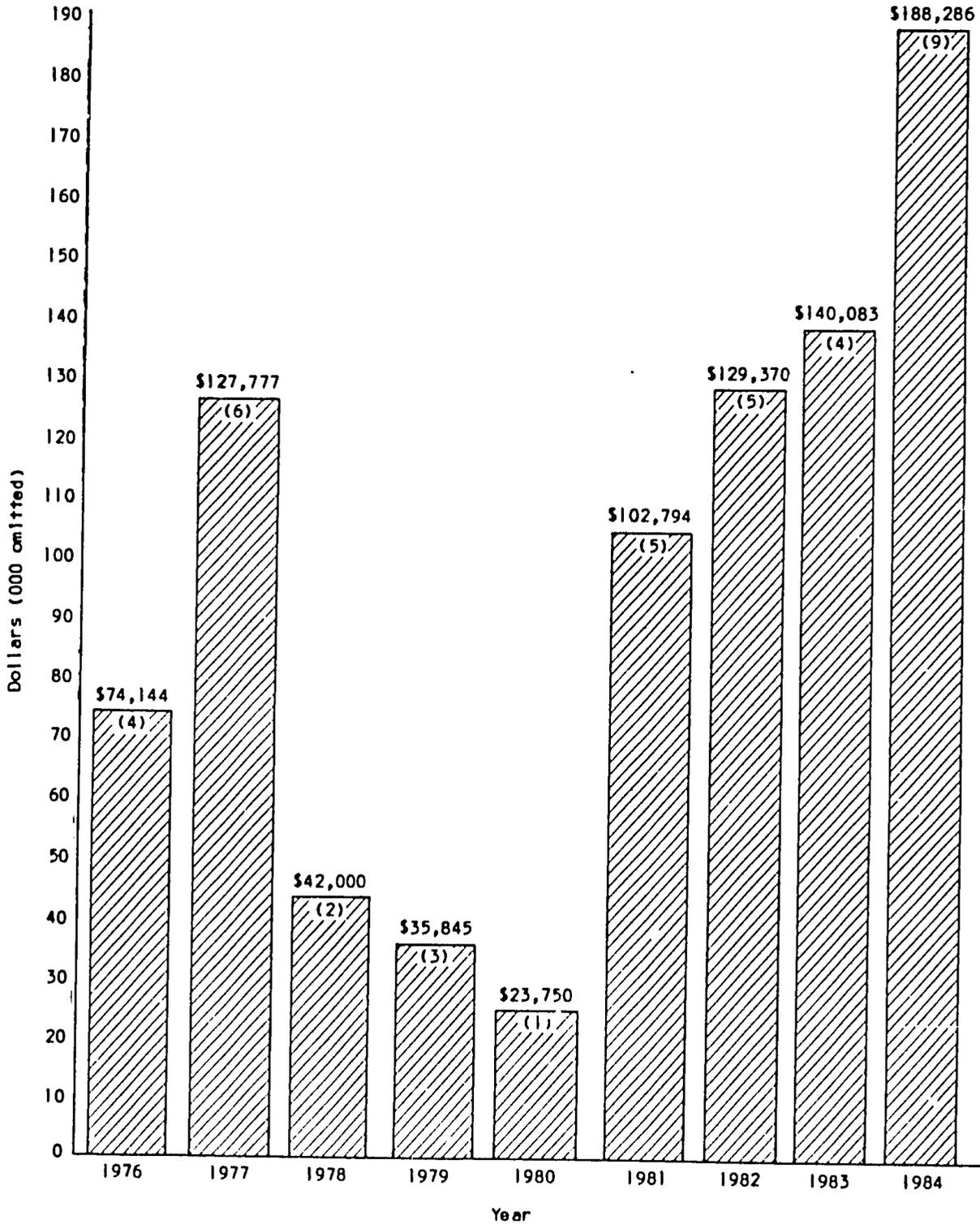
grants assistance. However, AVS is having more and more success increasing the funds available for grants assistance from other sources, as is reported in Chapter 6.

Private funds are used for programs and projects either in countries that are ineligible for public funds, or where VSC is politically sensitive. During 1984, nine subagreements and two small grants were awarded from private funds, for a total of \$195,588 in countries such as South Yemen, Korea, Ethiopia, Benin, Nicaragua, Costa Rica, and Ecuador. The year 1984 saw an increase of 34% in privately funded subagreements over 1983, reaching the highest level ever (see Figure 2.1).

Subagreements by primary emphasis

Subagreements include funds, materials, and technical assistance to public and private institutions in developing countries. The long-range objective of this assistance is to increase access to safe and effective VSC services. Although all subagreements must serve this long-range goal, their short-term objectives may differ, depending on the area of main emphasis.

FIGURE 2.1: Amount and Number of Private Grants Obligated for Subagreements, 1976-1984



Numbers in parentheses are grants obligated.

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AVS therefore classifies subagreements according to these areas of main emphasis: information and education, training, professional education, evaluation or special studies, provision of equipment, repair and maintenance of equipment, support of national leadership groups or leadership development, and local or national service delivery. The classifications are somewhat artificial because many programs, especially the larger ones, serve multiple purposes, a practice that will increase now that AVS has begun to implement the decision made in 1983 to consolidate a number of large programs. Consolidation will streamline and facilitate program execution and administration. In 1984 a number of individual projects were combined into single multiyear programs in Nepal, Bangladesh, and Mexico, and more programs are expected to follow this example in 1985.

Figure 2.3 shows the distribution of funds obligated by primary emphasis. Service delivery is still the major focus of AVS-supported programs, accounting for 72% of all funds obligated. The second largest category (16% of funds obligated) is support of national associations for voluntary sterilization, most of which are in Asia. By supporting national associations, AVS is helping to establish a solid base for institutionalizing VSC service delivery.

Subagreements by region

Table 2.2 compares AVS subagreements by subregions for 1983 and 1984. It illustrates the distribution of programs and funds obligated by region. See "Part II: Regional Perspectives" of this chapter for a discussion of the subagreement awards in each region, and the accompanying tables for lists of subagreements awarded in 1984 in each region.

Small grants

Table 2.1 indicates the number of small grants awarded in 1984 by amount and source of funds. The use of small grants (\$7,500 or less) enables AVS to respond quickly to minor requests for equipment, training, professional education, and evaluation. Of the 67 small grants awarded in 1984, 29 were for equipment, 30 for training and professional education, and 8 for studies and evaluations, for a total of \$270,383. Lists of small grants awarded in 1984 are included in the tables accompanying the regional reports which follow.

FIGURE 2.2: Percentage of Subagreements by Primary Emphasis, 1984

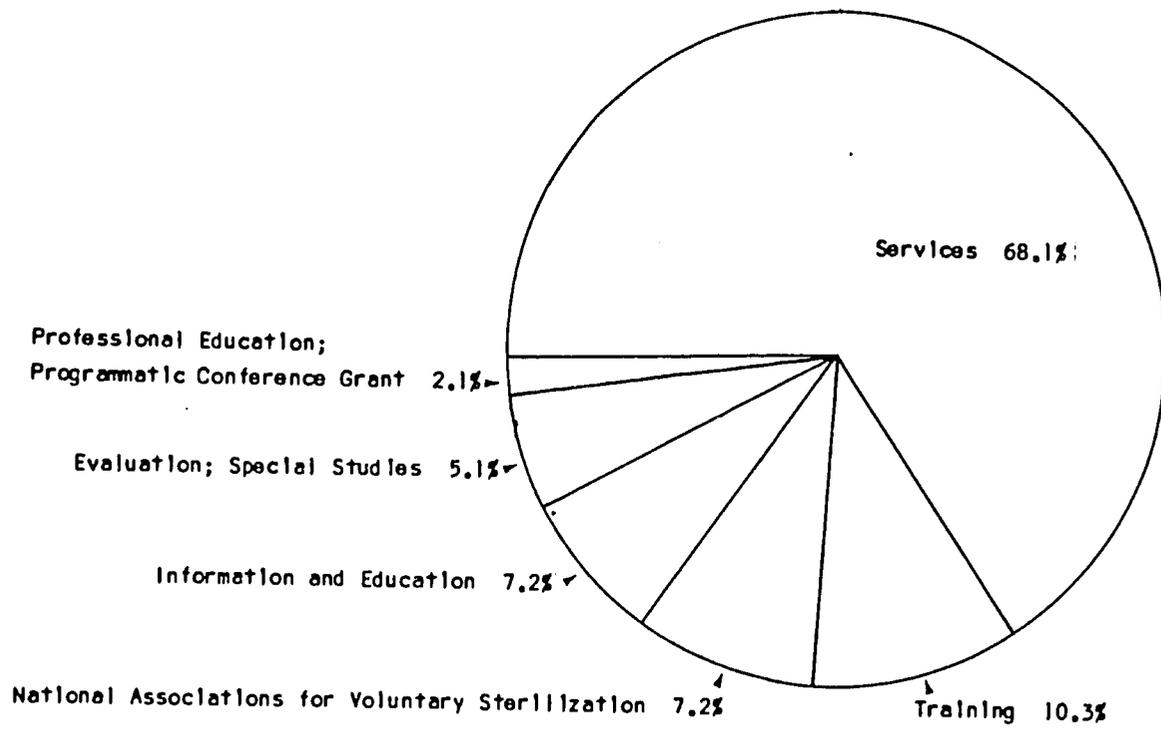
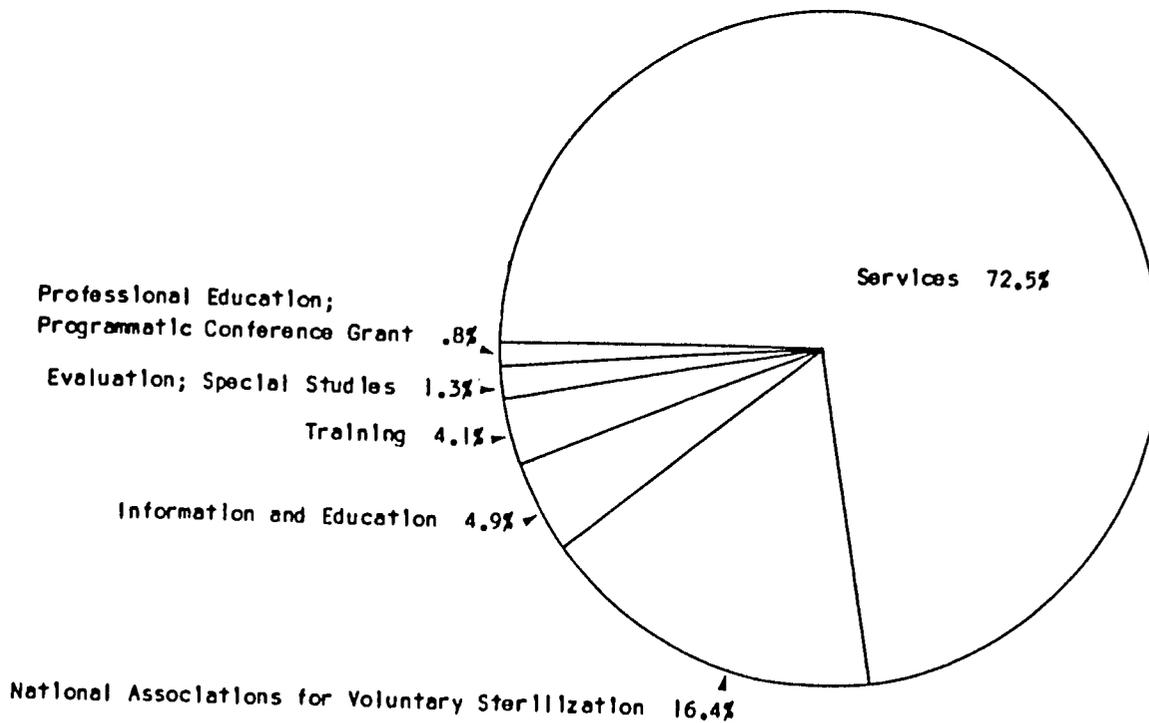


FIGURE 2.3: Percentage of Total Funds Obligated for Subagreements by Primary Emphasis, 1984



| Subregion | 1983 | | | | 1984 | | | |
|------------------------------|--------|-----------|-------------|----------------------|--------|-----------|-------------|----------------------|
| | Number | | Amount | % of Total Obligated | Number | | Amount | % of Total Obligated |
| | Awards | Countries | | | Awards | Countries | | |
| East Asia | 11 | 4 | \$734,068 | 7.6 | 26 | 4 | \$1,660,945 | 17.7 |
| South Asia | 3 | 1 | \$1,717,362 | 17.7 | 8 | 3 | \$2,154,190 | 23.0 |
| Sub-Saharan Africa | 15 | 8 | \$720,207 | 7.4 | 20 | 10 | \$994,331 | 10.6 |
| North Africa and Middle East | 16 | 4 | \$1,136,239 | 11.7 | 12 | 5 | \$769,105 | 8.2 |
| South America | 8 | 3 | \$1,456,858 | 15.0 | 10 | 6 | \$1,297,546 | 13.8 |
| Central America | 19 | 7 | \$2,207,065 | 22.7 | 16 | 6 | \$1,302,962 | 13.9 |
| Caribbean | 8 | 4 | \$790,097 | 8.1 | 3 | 2 | \$363,566 | 3.9 |
| North America | 0 | 0 | \$0 | .0 | 0 | 0 | \$0 | .0 |
| Europe | 2 | 2 | \$32,930 | .3 | 1 | 1 | \$6,025 | .1 |
| World Federation | 1 | 1 | \$921,420 | 9.5 | 1 | 1 | \$832,920 | 8.9 |
| TOTAL | 83 | 34 | \$9,716,246 | 100.0 | 97 | 38 | \$9,381,590 | 100.0 |

NB: This table includes all subagreement obligations, regardless of funding source.

PART II - REGIONAL PERSPECTIVES

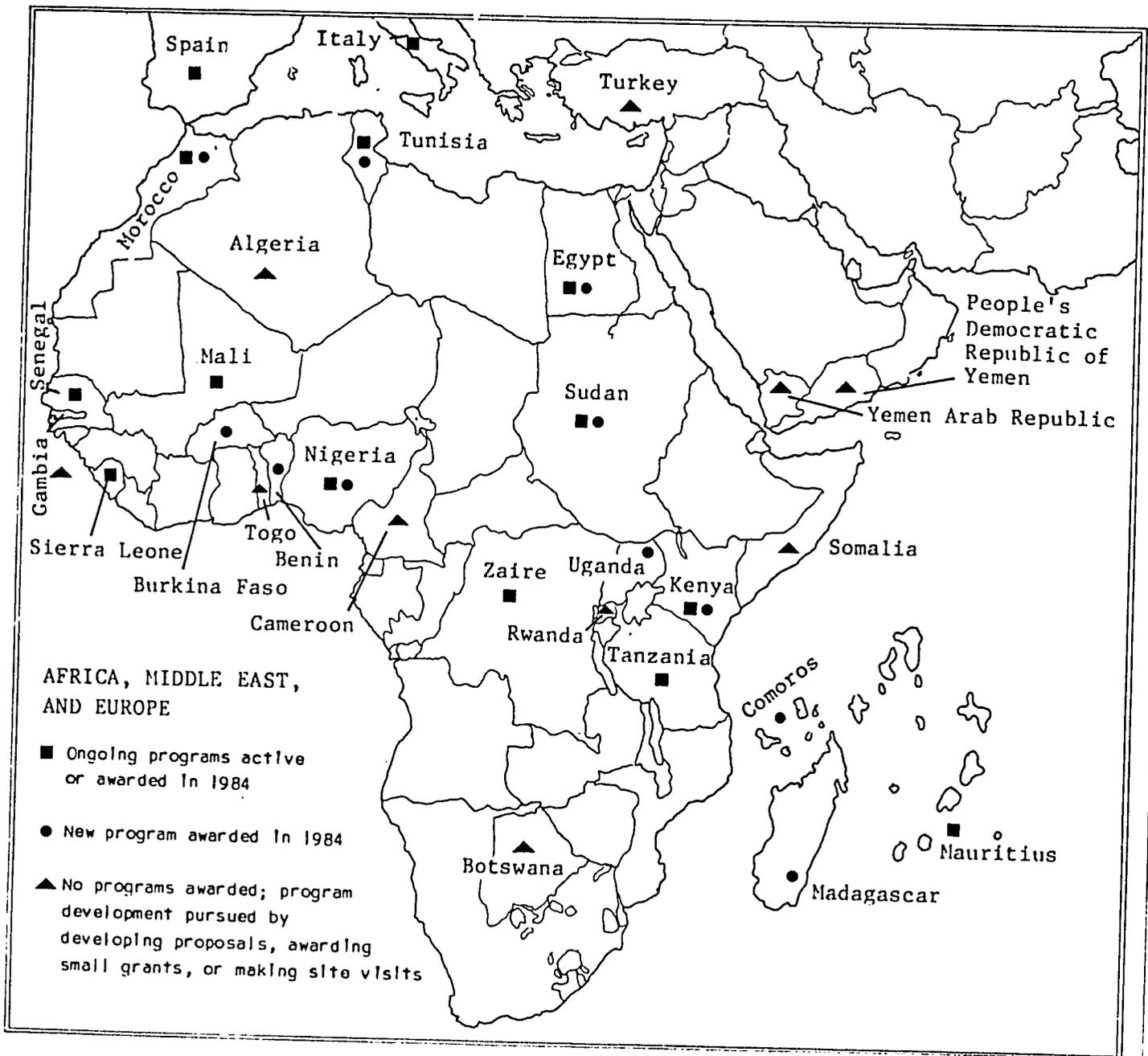
AFRICA AND THE MIDDLE EAST

Summary of regional strategies, issues, and activities

The Africa and Middle East region comprises a vast area of over 60 countries. Although wide variations exist, many of the countries share common circumstances which shape AVS's approach to the region. These include the unavailability of maternal and child health and family planning services for large portions of the population, exacerbated by the lack of trained personnel; legal, religious, and political barriers against family planning in general and VSC in particular; socioeconomic and cultural factors, combined with high infant mortality rates, which encourage large families; and, especially in Equatorial Africa, the high incidence of infertility.

In an effort to respond to these needs, AVS has worked over the past few years to identify opportunities for VSC program development which (1) introduce and demonstrate high-quality and appropriate VSC services, generally within the context of maternal and child health and (2) increase awareness of the health benefits of VSC among health professionals, policymakers, and opinion leaders. This basic strategy encompasses AVS's involvement in most Sub-Saharan Africa and Middle East countries where we work, given that VSC is not yet widely accessible or accepted in the region. In 1984, it appeared as though the strategy had taken hold in several important countries in both sub-regions. In Nigeria, where the change in government led to increased interest in voluntary sterilization among officials, AVS responded with the establishment of several new service programs which are well-placed to serve as models for future government expansion efforts. Government views towards VSC have also changed in Kenya. Statements by both the vice president and the Minister of Health about the need to limit family size and to space births confirm a trend of increasing popular acceptance of family planning, particularly VSC, as evidenced by the waiting lists for VSC at several facilities and the increasing number of requests for AVS assistance.

A promising development which signifies increasing official acceptance of VSC is the award of new subagreements with ministries of health (MOH) in Burkina Faso, Comoro Islands, and Uganda, and initiation of contacts with MOH's in other countries, such as Senegal. Another major new public sector program, which commenced in 1984 and will likely prove to be a regional model for North and Francophone Africa, is the expanded service program located at the Ministry of Health's National Training Center for Reproductive Health in Morocco.



By far the most strategic event in 1984 for AVS in this region was the Conference on Reproductive Health Management in Sub-Saharan Africa held in Sierra Leone in November. AVS worked with the World Federation for two years planning the program and identifying participants. AVS considered the conference to be an appropriate vehicle to increase awareness among leaders about the health rationale for VSC, and to establish a leadership network for future program development; thus, the meeting served as a cornerstone for AVS's strategy in Sub-Saharan Africa. This conference, planned and run by and for Africans, was the culmination of AVS's exploratory efforts of the past few years and will be the launching board for the development of new programs in the future.

In 1984 AVS hired a program manager and grants officer for Sub-Saharan Africa at headquarters. This has enabled staff at both headquarters and the Tunis regional office to intensify contacts and program-development efforts. The increased activity, particularly in Sub-Saharan Africa, necessitates and justifies the establishment of an AVS regional office in 1985 for the management of programs in Sub-Saharan Africa.

SUB-SAHARAN AFRICA

Summary of funds obligated

In 1984 AVS obligated 20 subagreements for a total of \$994,331 in Sub-Saharan Africa. Five of these were awarded in "new" countries: Burkina Faso, Madagascar, Uganda, and the Comoro Islands. By the end of 1984, the number of active programs in the region totaled 29. In addition, 29 small grants were awarded for a total of \$100,463. The number of subagreements has increased by 33%, and the number of countries covered has increased by 25% (see Table 2.2). With more staff assigned to the region, with the prospect of a regional office, and with the follow-up of the Conference on Reproductive Health Management, AVS expects this upward trend to continue in 1985.

Special regional initiatives

The outcomes of the Freetown conference confirmed the path AVS has assumed for programming in Sub-Saharan Africa. The conference participants broadly accepted female sterilization on health grounds, especially among high parity women, and recognized that the demand for tubal ligation far outstrips the region's capacity to provide services. More concern was expressed over the need and means to create and increase VSC services than about the method's cultural acceptability.

Conference participants identified two major programmatic needs: training, and information and education. Training is a special problem because it cannot be conducted without first establishing services, and yet services cannot be established without proper training of providers. AVS has traditionally responded to immediate training needs in Africa by arranging educational opportunities in other regions; however AVS considers regional training capability to be a priority. A first step in this effort is a pilot program, funded in 1984 using private monies, with the Family Planning Association of Kenya (FPAK); this project will provide training to Tanzanian and Ethiopian physicians in minilaparotomy using local anesthesia. Based upon the results of this pilot effort, AVS will evaluate FPAK's capacity to function as a regional training center.

Throughout Sub-Saharan Africa the need for information and education about voluntary sterilization is acute. The lack of I&E materials and expertise is a serious obstacle. AVS's regional office in Tunis has responded to the problem by developing guidelines for model seminars on male and female voluntary sterilization for physicians and other health professionals. The model programs have been distributed in Senegal, Burkina Faso, Mauritius, and Madagascar, as well as in three countries in the Arab Region. An evaluation of the seminars' usefulness and impact was begun at the end of 1984.

At the conclusion of the Conference on Reproductive Health Management, AVS sponsored a Sub-Saharan information and education consultancy. Sixteen participants from 10 countries discussed the needs and problems that arise when organizing information and education programs at the hospital and community levels. The participants underscored the importance of providing sex education to youth, training all categories of field staff in communication, and conducting research to determine the most effective means of communicating with rural and illiterate populations.

Major programs

AVS's major program in Anglophone Sub-Saharan Africa is the subagreement with the Family Planning Association of Kenya (FPAK), which trains physicians and provides services at a number of sites. In 1984, \$121,274 was awarded to FPAK, to continue to insure voluntarism and the highest medical quality in the development of VSC services. This program is a potential model for training and services in the region, particularly for the private sector.

Sierra Leone has an important program, which serves as a model demonstrating how voluntary sterilization can be successfully incorporated into the services of a large public maternity hospital. In 1985 AVS provided funds for the fifth consecutive year, assisting the ministry of health to integrate family planning, including VSC, into

maternity services at the Princess Christian Maternity Hospital in Freetown. In Mauritius a similar project successfully completed the second year of a three-year program.

In Mali and Senegal, where the governments are still reluctant to get involved in VSC activities, private or quasi-public institutions continue to expand service provision, thus demonstrating an existing demand. In Senegal in 1984, AVS provided dedicated space at Abass N'Dao Municipal Hospital to help meet the demand for voluntary sterilization. Collaborating with JHPIEGO, AVS negotiated an agreement to renovate and equip operating space at the University of Dakar Teaching Hospital, which will serve as a regional training center in laparoscopy. In 1984 the director of the Senegalese national family health program asked AVS to help the program include information about voluntary sterilization in their education component. This encouraging breakthrough came after years of AVS staff efforts in Senegal.

In Mali the Malian Association for the Protection and Promotion of the Family (AMPPF), successfully completed its second year of information and education activities; in addition, services were provided at two main hospitals and expanded to another maternity hospital in the capital city.

In Zaire AVS provided technical assistance as well as equipment to two service programs. One of those projects is incorporating VSC into a USAID rural health project. The other is including voluntary sterilization as a component of family planning services in 14 major cities.

Planned initiatives for 1985

*New countries: AVS expects that the Conference on Reproductive Health Management in Sub-Saharan Africa, which was held in Sierra Leone in November 1984, will lead to increased activities in the region. As a result of this meeting, staff have already been invited to visit Somalia, Burundi, Ghana, and Malawi.

*Collaboration with ministries of health: In Mauritius and Senegal AVS has worked successfully with private-sector programs, leading MOH officials to express interest in voluntary sterilization. Negotiations with the ministries began in 1984 and should bear fruit in 1985.

*Information and education: In Nigeria and Kenya AVS is supporting the development of two pilot workshops on counseling and I&E. These projects are expected to serve as the foundation for ongoing training in these topics in the region.

*Service delivery and training: In 1985 AVS will work with the member hospitals of the Protestant Churches Medical Association in Kenya to provide VSC services for rural populations in five provinces. Private funds will be solicited to support basic supplies for VSC services in Ethiopia and Tanzania, and to enable a regional training center in Kenya to train physicians from these two countries in mini-laparotomy.

NORTH AFRICA AND THE MIDDLE EAST

Summary of funds obligated

In 1984, 12 subagreements were obligated for this subregion for a total of \$769,105. This includes support for the National Training Center for Reproductive Health in Morocco in the amount of \$350,480. A project in the People's Democratic Republic of Yemen was funded for \$24,875 from private sources. The majority of programs are in Egypt, representing AVS support to the Egyptian Fertility Care Society and university-based training programs. In addition, 10 small grants were awarded for a total of \$24,556.

Special regional initiatives

The need for information and education, particularly for professionals, about voluntary sterilization is acutely felt throughout the subregion. As in Sub-Saharan Africa, materials are lacking, and expertise is limited. As mentioned earlier, the regional office in Tunis has developed guidelines for seminars on male and female VSC for physicians and other health professionals; they have been distributed in Turkey, Egypt, and North Yemen. An evaluation of the seminars' usefulness and impact was begun at the end of 1984. During the year brochures on family planning and voluntary sterilization were translated for the use of subrecipients in Arabic-speaking countries, where appropriate materials are lacking.

In 1984 AVS awarded a small grant to the Urology Department of the Ain Shams University in Cairo, Egypt, to hold a seminar designed to create awareness among the professional community about the role of the man in family planning and about vasectomy as a form of permanent contraception. It is hoped that this seminar will increase referrals of vasectomy requestors to the university service. If increased demand is demonstrated, AVS will help the university expand its service capability.

In some countries in this subregion, voluntary sterilization faces almost unsurmountable obstacles, primarily for religious and political reasons. In these places AVS's involvement is low key and consists mainly of staying in contact with interested health professionals by providing them small grants for training or attendance at relevant conferences.

Major programs

AVS's most successful involvement in North Africa and the Middle East has been and still is in Tunisia. Because the program is supported by the government, it is a model for other countries and, as such, attracts many visitors from various parts of the subregion. 1984 was the fifth year of a six-year program period, and AVS is gradually decreasing its contributions as the government yearly increases its share of the costs. In 1984 AVS contributed part of the cost of each VSC procedure, up to a ceiling of 7,000 cases. Because 1985 is the last year of the program, AVS may collaborate with the Ministry of Health in a bilateral program to integrate postpartum voluntary sterilization into the ministry's maternal and child health services. As part of this effort, AVS may have to assist in upgrading and renovating facilities since the MOH hospitals have not been involved in VSC service delivery (all services are presently delivered at clinics of the Office National du Planning Familial et de la Population).

AVS has entered the second phase of its involvement in Morocco. During the first phase a national training center was successfully established in Rabat. AVS has now embarked on a five-year effort to support VSC service delivery in 30 training institutions located throughout the country. For this initiative the USAID mission in Morocco has provided \$500,000 in funds.

AVS involvement in Egypt dates back to 1974 and comprises 11 subagreements. In 1984, support was given to the private Egyptian Fertility Care Society (EFCS) and to the autonomous university system, for a total amount of \$336,350. Because of sensitivities surrounding VSC, the programs stress information and education (particularly for provincial-level public authorities and the professional community), service delivery for medical indications, and training of physicians to insure that quality standards remain high.

Despite continued large commitments of AVS resources, the status and political acceptability of VSC have not appreciably improved in Egypt. This necessitates a shift in strategy for AVS. In 1984, steps were taken to further institutionalize VSC training in the medical universities, and this will continue in 1985. AVS is now poised to phase down its support to EFCS for its leadership, training coordination, and education activities. Continuing support beyond 1985, if any, will be for discrete, small projects directly related to VSC.

Planned initiatives for 1985

*New countries: A private-sector organization has requested AVS support to launch a VSC service program in Jordan. This project will mark AVS's first involvement in that country. While Turkey offers significant opportunities, AVS continues to have difficulty obtaining travel approval from the American embassy.

*Training: In Egypt AVS's support of 10 university training programs will conclude, and a formal evaluation will be conducted. This evaluation will help determine what the next step should be. AVS expects to provide assistance for service delivery in a few selected institutions of trainees. In Morocco AVS will follow-up trainees and monitor their success in establishing VSC services in their home institutions; this effort will lay the groundwork for a national public-sector VSC program, a potential model in the region.

*Information and education: As a continuation of its technical assistance effort in information and education, the regional office in Tunis will evaluate the impact of the model seminar guidelines as technical assistance tools. The office will then proceed to the second stage of this effort and begin assisting subrecipients with materials development. This work will be a cooperative effort among regional office staff, New York staff, and specialized consultants.

*Service delivery: In the Sudan five years of support for an information and education program, conducted under the auspices of the Sudan Fertility Control Association, have resulted in the establishment of a model clinic for family planning, which will begin service delivery in 1985. AVS will provide support for voluntary sterilization services; the project should become operational in mid-1985.

*Regional development: In collaboration with the World Federation, AVS will review the work of the Regional Arab Federation for Voluntary Fertility Care during the past two years and will begin planning a regional workshop for Arabic-speaking countries to be held in 1986.

TABLE 2.3

Subagreements Awarded in 1984: Africa and the Middle East

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|---|---------------|--|
| <u>BENIN</u> | | |
| Comite National du Benin pour la Promotion de la Famille BEN-03-IE-1-P | \$19,215 | To initiate an I&E campaign for fertility management. |
| <u>BURKINA FASO</u> | | |
| Ministry of Health BUF-01-SV-1-A | \$80,663 | To incorporate fertility and infer- tility services into maternal-child care in major government hospitals in Ouagadougou and Bobo-Dioulasso. |
| <u>COMORO ISLANDS</u> | | |
| El Maarouf Hospital COI-02-SV-1-A | \$40,364 | To increase availability of infer- tility diagnosis and female VSC services. |
| <u>EGYPT</u> | | |
| Egyptian Fertility Care Society EGY-02-IE-7-A | \$206,103 | For a consolidated program to increase acceptance and availability of reproductive health services. |
| Ain Shams University EGY-12-TR-3-A | \$25,950 | To support a training program for reproductive health and fertility management. |
| Mansoura University EGY-16-TR-4-A | \$9,180 | To provide the final year of support for a training program in reproduc- tive health and fertility management. |
| Alexandria University EGY-17-TR-4-A | \$18,401 | To provide support for its reproduc- tive health and fertility management training program. |
| Port Fouad General Hospital EGY-24-TR-2-A | \$6,188 | To provide the second year of support for a female VSC training program. |
| Banha Faculty of Medicine EGY-25-TR-1-A | \$26,956 | To establish a training program for reproductive health and fertility management. |

TABLE 2.3 - continued

Subagreements Awarded in 1984: Africa and the Middle East

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|--|---------------|--|
| Egypt - cont'd | | |
| Ahmed Maher Hospital EGY-28-SV-1-A | \$20,986 | To meet the demand for VSC services by increasing availability and accessibility. |
| <u>KENYA</u> | | |
| Family Planning Association of Kenya AFR-01-TR-1-P | \$10,000 | To establish an East African regional center for training in minilaparotomy with local anesthesia. |
| Family Planning Association of Kenya KEN-02-SV-3-A | \$121,274 | To provide VSC services at four clinics in the interior; to establish services at the FPAK clinic in Nairobi; to train medical and paramedical personnel in VSC techniques and counseling. |
| Nyeri Provincial General Hospital KEN-05-SV-1-A | \$28,190 | To provide counseling and female VSC services and I&E. |
| Kangaru Clinic and Maternity Hospital KEN-06-SV-1-A | \$32,392 | To establish a female VSC program by providing equipment for the operating and recovery rooms. |
| Pumwani Maternity Hospital KEN-07-SV-1-A | \$69,700 | To expand postpartum services; to develop the capacity to provide interval services. |
| <u>MADAGASCAR</u> | | |
| Andranomadio Lutheran Hospital MAG-02-SV-1-A | \$21,653 | To provide for renovation and equipment for services and for information and education programs. |
| Organisation Sanitaire Tananarivienne Inter-Entreprises MAG-03-SV-1-A | \$35,947 | To expand maternal and child health services through VSC in its polyclinic. |
| Fianakaviana Sambatra MAG-04-IE-1-A | \$21,798 | To expand VSC services and initiate an I&E campaign. |

TABLE 2.3 - continued

Subagreements Awarded in 1984: Africa and the Middle East

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|--|---------------|--|
| <u>MALI</u> | | |
| Malian Association for the Protection and Promotion of the Family MLI-01-SV-2-A | \$48,725 | To provide continued support for educational activities and fertility management services at two major hospitals in Bamako (Gabriel Toure Hospital and Hamdallaye Maternity Hospital). |
| <u>MAURITIUS</u> | | |
| Mauritius Family Planning Association MAU-02-SV-2-A | \$37,535 | To continue the integration of VSC techniques into the range of health services routinely available. |
| <u>MOROCCO</u> | | |
| National Training Center for Reproductive Health MOR-03-SV-1-A | \$350,480 | To provide operational support for the center and five provincial hospitals in order to expand and institutionalize female VSC services |
| <u>NIGERIA</u> | | |
| Military Hospital, Yaba NIR-07-SV-1-A | \$42,596 | For expansion of its female VSC program and for I&E activities for medical personnel and VSC clients. |
| Specialist Hospital, Benin City NIR-08-SV-1-A | \$37,690 | For expansion of its female VSC program and for I&E activities for medical personnel and VSC clients. |
| Iyi Enu Hospital NIR-09-SV-1-A | \$34,259 | For expansion of its female VSC program and for I&E activities for medical personnel and VSC clients. |
| University of Jos Teaching Hospital NIR-10-SV-1-A | \$40,000 | To continue postpartum VSC services and to assist the hospital in developing the capacity to provide interval VSC. |
| Lagos University Teaching Hospital NIR-11-SV-1-A | \$59,742 | To provide female services and to develop model I&E and counseling referral programs. |

TABLE 2.3 - continued

Subagreements Awarded in 1984: Africa and the Middle East

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|---|---------------|---|
| <u>SIERRA LEONE</u> | | |
| Princess Christian Maternity Hospital SIL-01-SV-5-A | \$79,900 | To expand VSC service programs at Princess Christian Maternity Hospital (Freetown) and two provincial hospitals (Bo, Kenema); to extend services to a third provincial hospital (Makeni), Tonga Fields Mining Hospital, and Freetown Military Hospital. |
| <u>SUDAN</u> | | |
| Khartoum North Hospital SUD-03-SV-2-A | \$24,936 | To increase the availability and accessibility of female VSC services. |
| <u>TUNISIA</u> | | |
| Office National du Planning Familial et de la Population TUN-09-EV-1-A | \$20,050 | For a follow-up study of female VSC clients. |
| <u>UGANDA</u> | | |
| Ministry of Health UGA-01-SV-1-A | \$132,688 | To establish fertility management centers in public hospitals in four regions (Entebbe, Kampala, Jinja, and Mbale). |
| <u>YEMEN, PEOPLE'S DEMOCRATIC REPUBLIC OF</u> | | |
| Al Gamhuria Hospital PDY-01-SV-1-P | \$35,000 | For expansion of its male VSC service program. |
| Aboud Teaching Hospital PDY-02-SV-1-P | \$24,875 | To initiate female services at Aboud Teaching Hospital and El Mansourah Maternity Hospital. |

TABLE 2.4

Small Grants Awarded in 1984: Africa and the Middle East

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|--|---------------|---|
| <u>ALGERIA</u> | | |
| Mustapha Hospital S-738-TV | \$407 | For attendance of a staff member at the Second International MCH Conference in Monastir, Tunisia. |
| <u>BOTSWANA</u> | | |
| Ministry of Health S-704-EQ | \$1,800 | For two Ortho-Gynny models. |
| <u>CAMEROON</u> | | |
| Polyclinique Sende S-757-EQ | \$7,470 | For a Laprocator and necessary emergency equipment. |
| <u>EGYPT</u> | | |
| Ain Shams University S-695-PE | \$2,649 | For a vasectomy seminar. |
| Egyptian Fertility Care Society S-740-TV | \$795 | For attendance of a staff member at the Second International MCH Conference in Monastir, Tunisia. |
| Egyptian Fertility Care Society S-743-PE | \$1,020 | For medical journals in EFCS's resource center. |
| <u>ETHIOPIA</u> | | |
| Ministry of Health S-699-EQ-P | \$3,656 | For a Laprocator system for Yekatit 12 Hospital. |
| <u>KENYA</u> | | |
| Family Planning Association of Kenya S-689-EV | \$5,776 | For an evaluative study on the demand for VSC in rural Kenya. |

TABLE 2.4 - continued

Small Grants Awarded in 1984: Africa and the Middle East

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|---|---------------|---|
| Kenya - cont'd | | |
| Chania Clinic S-709-EQ | \$670 | For two films on vasectomy for use in physician training and in client education. |
| Provincial General Hospital, Nyeri S-710-EQ | \$600 | For surgical supplies for its female VSC program. |
| University of Nairobi S-729-TV | \$7,269 | To support 34 Kenyan delegates to the National Conference on Reproductive Health, Nairobi, August 1984. |
| Mkomani Harambee Clinic, Mombasa S-742-EQ | \$2,200 | For sutures. |
| <u>MADAGASCAR</u> | | |
| Anglican Church S-756-EQ | \$3,585 | For audiovisual materials and films. |
| <u>MALI</u> | | |
| Malian Association for the Protection and Promotion of the Family S-702-TR | \$3,927 | For attendance of a staff member at the Fifth Annual Workshop on Family Planning in Africa at Columbia University. |
| Malian Association for the Protection and Promotion of the Family S-703-TR | \$3,927 | For attendance of a cooperating physician at the Fifth Annual Workshop on Family Planning in Africa at Columbia University. |
| <u>MOROCCO</u> | | |
| Faculty of Medicine, Rabat S-739-TV | \$677 | For attendance of a staff member at the Second International MCH Conference in Monastir, Tunisia. |

TABLE 2.4 - continued

Small Grants Awarded in 1984: Africa and the Middle East

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|---|---------------|---|
| <u>NIGERIA</u> | | |
| Port Harcourt University S-696-TV | \$7,250 | For attendance of a staff member at a CEDPA workshop on planning and management of health and family planning service-delivery programs |
| University of Ife S-705-TR | \$3,640 | For attendance of the physician in charge of the comprehensive health center at a workshop on community participation in health and development at the School of Public Health, University of North Carolina. |
| Clinic and Maternity Hospital S-725-EQ | \$580 | For two Minilap Kits. |
| University of Benin Teaching Hospital S-755-M | \$4,030 | For production of visual aids (flip charts, pamphlet, poster, slide set) for use in counseling and client education primarily in Nigeria but also throughout Africa. |
| <u>RWANDA</u> | | |
| Office National de la Population S-706-EQ | \$200 | For a film on minilaparotomy. |
| <u>SENEGAL</u> | | |
| Family Health Project S-690-EQ | \$2,050 | For materials to be used in the training of I&E personnel in the national family planning program. |
| Family Health Project S-707-TR | \$2,500 | For attendance of a staff member at the Fifth Annual Workshop on Family Planning in Africa at Columbia University. |
| Le Dantec Maternity Hospital S-713-EQ | \$300 | For 12 laparoscope bulbs. |

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TABLE 2.4 - continued

Small Grants Awarded in 1984: Africa and the Middle East

| RECIPIENT | AMOUNT | PURPOSE |
|---|---------|---|
| <u>SIERRA LEONE</u> | | |
| Association for Management of Infertility S-693-PE | \$3,600 | For a conference on VSC in MCH services for 24 policymakers. |
| Association for Management of Infertility S-724-TV | \$7,417 | For the Conference on Reproductive Health Management. |
| Association for Management of Infertility S-747-TV | \$7,490 | To support 30 in-country participants to the Conference on Reproductive Health Management. |
| World Federation S-748-PE | \$2,250 | For registration fees for the Conference on Reproductive Health Management. |
| <u>SOMALIA</u> | | |
| Ministry of Health S-688-TV | \$3,500 | For training of two physicians in minilaparotomy. |
| Ministry of Health S-726-EQ | \$1,800 | For audiovisual materials to educate physicians and other medical personnel. |
| <u>TOGO</u> | | |
| Association Togolaise pour le Bien-Etre de la Famille S-700-TR | \$3,928 | For attendance of administrator at the Fifth Annual Workshop on Family Planning in Africa at Columbia University. |
| Association Togolaise pour le Bien-Etre de la Famille S-701-TR | \$3,928 | For attendance of its medical officer at the Fifth Annual Workshop on Family Planning in Africa at Columbia University. |

TABLE 2.4 - continued

Small Grants Awarded in 1984: Africa and the Middle East

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|---|---------------|---|
| <u>YEMEN ARAB REPUBLIC</u> | | |
| Al Thurah Hospital S-689-EQ-V | \$7,000 | For surgical equipment, operating room emergency equipment, and audio-visual materials to upgrade VSC service delivery. |
| Al Thurah Hospital S-718-TR | \$2,500 | For vasectomy training in Sri Lanka. |
| Ministry of Health S-721-EQ | \$2,400 | For 16mm projector and five films. |
| Ministry of Health S-722-EV | \$3,462 | For collection of data from 10 hospitals to study demand for VSC. |
| <u>YEMEN, PEOPLE'S DEMOCRATIC REPUBLIC OF</u> | | |
| Abood Maternity Hospital S-687-EQ-P | \$3,646 | For equipment to introduce minilaparotomy services. |
| <u>ZAIRE</u> | | |
| Basic Rural Health Project S-761-EQ | \$5,000 | For spare parts. |

LATIN AMERICA

Summary of regional strategies and issues

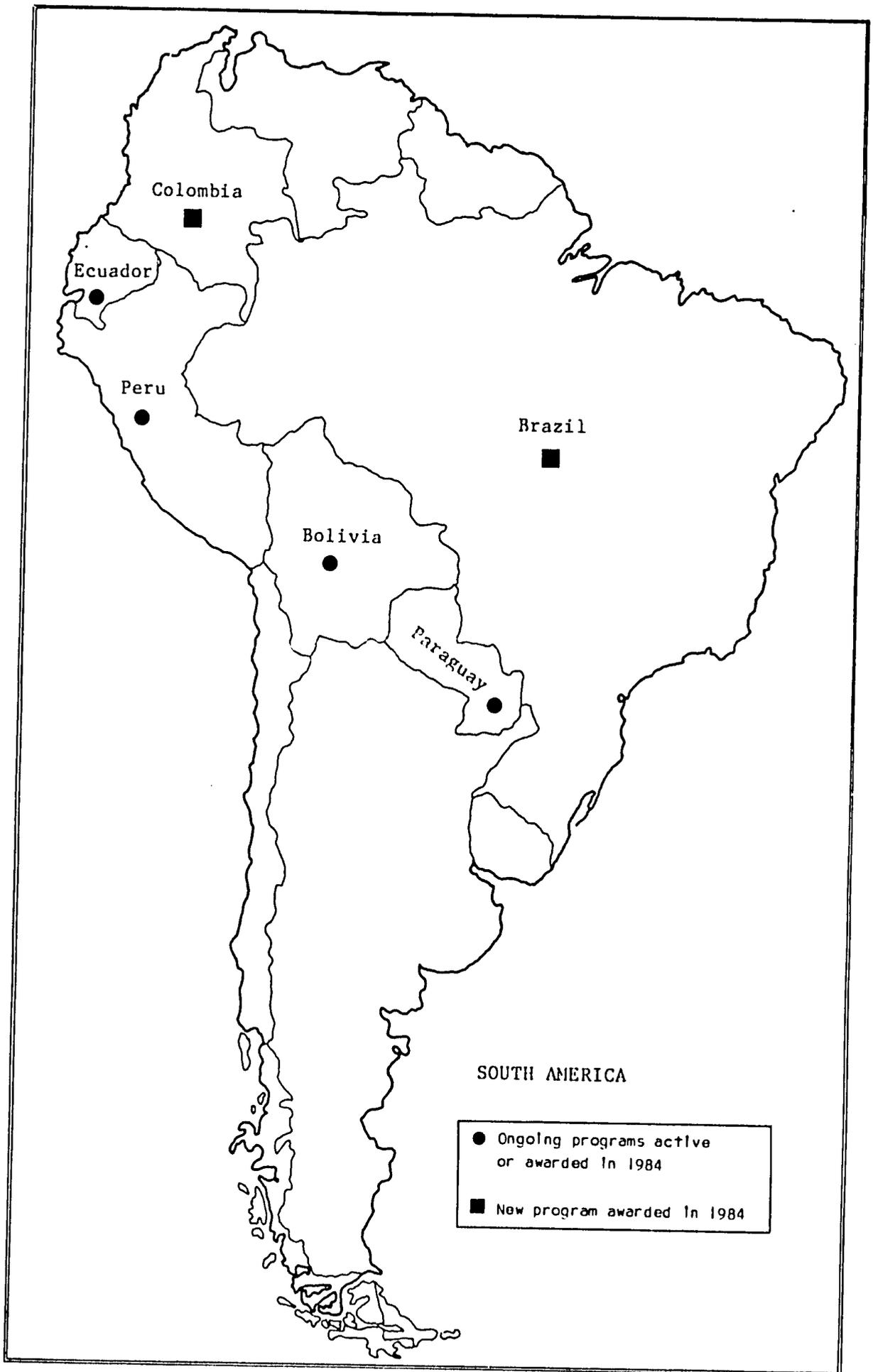
The large region of Latin America is made up of continental South America, Central America, Mexico, and the Caribbean Islands. For administrative purposes AVS divides the region in two. One subregion consists of South America and the Caribbean; the other includes Mexico and Central America. Although each country in the region has different concerns regarding voluntary sterilization, many of the nations share the common factor of limited or no government involvement. Because of this characteristic, AVS collaborates primarily with private and voluntary agencies, many of them affiliates of the International Planned Parenthood Federation. However, in 1984, several social and political changes occurred in the region which may significantly affect the future of voluntary sterilization.

In Brazil the legal risks faced by physicians and institutions that performed VSC over the years will soon be a thing of the past. The Federal Code of Medical Ethics has recently been changed and simplified. A new penal code, scheduled for approval in 1985, will remove all penalties for the performance of voluntary sterilization. The concept of mutilation will disappear altogether from the legal code.

In Peru the Ministry of Health of the outgoing administration (scheduled to leave office in mid-1985) is showing increased interest in the implementation of family planning programs. It is conducting a number of activities such as training health personnel, distributing contraceptives, promoting MCH and family planning through an educational campaign, and signing an agreement with the United Nations Fund for Population Activities for assistance in MCH care.

In Colombia the Catholic Church has taken a more active stand against voluntary sterilization. The cardinal of Medellin has attacked the Asociacion Pro-Bienestar de la Familia Colombiana (PROFAMILIA) and accused them of "castrating" innocent people. Although PROFAMILIA has mobilized considerable support from both the public and professionals, the number of voluntary sterilization requests decreased during the second half of 1984.

In this region AVS faces many obstacles, in particular the Catholic Church, the legal status of VSC, the cautiousness of the medical establishment, and serious social, political, and economic problems. Nevertheless, developments in 1984 give reason for optimism. In Central America program development has gone better than expected, indicating that there is both public and private understanding of the demand for and benefits of voluntary sterilization. Some countries are reviewing the legal constraints and eligibility requirements for VSC. In Honduras new regulations, aimed at improving program implementation and expanding coverage, have been issued.



The situation in the Caribbean is somewhat different from the rest of the region. In the main, bilateral agreements are in existence, and national family planning programs are integrated into maternal-child health settings. Voluntary sterilization is often a component of these programs but limited in availability and accessibility. The main problems encountered in the Caribbean are a lack of service sites, few trained medical personnel, severely overtaxed health facilities, and no or little interest in vasectomy. Nevertheless, voluntary sterilization is expanding in the region. Despite long delays, programs, once implemented, show steady growth. The most common VSC technique used is postpartum minilaparotomy. Younger women are increasingly requesting VSC, and there is a growing interest in providing voluntary sterilization at health centers as well as hospitals.

In South America, the presence of the South America Regional Office (SARO) permitted better and increased communication between the various programs and AVS staff, with an increase in frequency and length of visits. The planned appointment of additional regional and headquarters staff in 1985 both illustrates and reinforces the momentum that is developing in this subregion. Latin America is fortunate to have many experienced and dedicated professionals as resource persons. They play, and will continue to play, an important role in safeguarding the quality and safety of voluntary sterilization. In addition, these professionals have also proven to be a driving force in the continuous search for better and innovative ways of service delivery.

SOUTH AMERICA AND THE CARIBBEAN

Summary of funds obligated

In South America and the Caribbean, 1984 was a year of advancement and success for VSC programs. Thirteen subagreements were awarded for a total of \$1,661,112. In addition, eight small grants were awarded for a total of \$24,884.

Special regional initiatives

In this subregion AVS has emphasized the wider use of minilaparotomy and vasectomy as safe and effective VSC techniques. Experts with long-standing reputations for excellence in performing these procedures have demonstrated their techniques in various places in the subregion, and study tours to their clinics and hospitals have been organized by the regional office. The results have been encouraging. Two prominent VSC leaders from Colombia visited the vasectomy clinic of Promocao de Paternidade Responsavel (PROPATER) in Brazil and returned home with enthusiasm and plans to start up similar facilities in two of Colombia's major cities. Similarly, several Brazilian physicians toured facilities in which minilaparotomy is performed under local

anesthesia; they returned to their country with an increased interest in, and appreciation of, minilaparotomy as a safe and effective technique for small and medium-sized institutions that do not perform a high volume of VSC procedures.

Another major initiative in 1984 concerned counseling. AVS has been working with program directors to demonstrate that counseling and informed consent are fundamental to the success of their programs. With AVS support Brazil has taken the lead by organizing a number of training courses on counseling and the utilization of educational materials. Program directors agree that counseling is essential, not only to insure client satisfaction and to reduce the number of requests for reversal but also for protection against criticism, attacks, or problems with authorities.

To increase the safety of VSC procedures, AVS is stressing the proper use of anesthesia and appropriate supervision of programs. In Brazil PROPATER and the Associacao Brasileira de Entidades de Planejamento Familiar (ABEPF) have each prepared a manual detailing medical norms for voluntary sterilization; these norms reflect AVS guidelines adapted to the Brazilian context. The PROPATER manual, developed with AVS support, describes the organization of a vasectomy clinic and the measures required to insure quality services. The norms have been well received by all other male programs in the country and may serve as a guide for such programs in all of Latin America.

AVS encourages program directors, managers, and administrators to share experiences and exchange information. To this end, the regional office has organized several study tours and work visits throughout the region.

Major programs

During 1984 the VSC program in Brazil, which had been coordinated by the Centro de Pesquisas de Assistencia Integrada a Mulher e a Crianca (CPAIMEC), was transferred as planned to ABEPF. ABEPF, representing some 150 private institutions that offer family planning services all over Brazil, assists those organizations with research projects, distribution of contraceptives, training and I&E materials, and technical advice in medical as well as administrative matters. It also distributes reimbursement funds for VSC services provided. AVS expects ABEPF to become a key collaborator in Brazil.

Two separate subagreements with the Sociedade Civil Bem-Estar Familiar no Brasil (BEMFAM) were consolidated into one subagreement in 1984, and a one-year continuation was approved. The consolidation

will facilitate the execution and administration of BEMFAM's service and training program. During 1985 AVS will negotiate with BEMFAM regarding future cooperation.

As part of the fourth year of the subagreement with PROPATER, vasectomy services were extended to three more cities. At each new site, training will be provided to a well-known and experienced urologist and to counseling personnel.

In Colombia AVS continues to work with PROFAMILIA to make voluntary sterilization services available to all sectors of the population. VSC procedures declined in 1984, compared to the previous year, in large part because of measures introduced by the Ministry of Health, as a direct result of the attacks on VSC by the cardinal of Medellin, that prohibit PROFAMILIA from providing services through state hospitals. The MOH regulations have had considerable effect on potential VSC clients in the many cities and towns that do not have PROFAMILIA clinics. AVS is optimistic, however, that services will return to their previous levels in 1985.

In the Dominican Republic AVS continued to support the Asociacion Dominicana Pro-Bienestar de la Familia (PROFAMILIA). In that program private physicians insure that VSC services are available in most large and medium-sized cities. In 1984 AVS began collaborating with the Ministry of Health through the Consejo Nacional de Poblacion y Familia (CONAPOFA). CONAPOFA initiated a comprehensive training program in minilaparotomy under local anesthesia, and, by the end of 1984, VSC services were being offered and used in 32 public hospitals.

In Haiti voluntary sterilization is provided in 21 of the 178 health institutions that offer family planning services. AVS stresses the improvement and upgrading of facilities, as well as information and education activities. One of the two subagreements awarded during 1984 is for the production and distribution of 20,000 booklets and 5,000 posters on male and female VSC. The booklets are intended to be used by social workers and other health personnel in their contacts with clients and in an adult literacy campaign of the Ministry of Education.

Although female VSC is still the predominant procedure, vasectomy has slowly begun to gain ground after six Haitian physicians were trained in 1983 in Brazil. These doctors performed some 300 vasectomies during 1984 (as compared to approximately 2,500 female procedures).

In Jamaica two 1983 subagreements with the National Family Planning Board were reprogrammed in 1984 and extended to permit objectives to be met in 1985. Voluntary sterilization is available at 21 of some 350 family planning facilities; the number of procedures is slowly increasing, with most of them being performed at hospitals on an inpatient basis. Under past subagreements AVS has renovated or equipped four facilities that now provide VSC on an ambulatory basis.

As of April 1984, the Jamaican Ministry of Health absorbed expenses for the repair and maintenance (RAM) center, which had been supported by AVS until that time. AVS will continue to help the ministry procure spare parts, possibly with bilateral funds in the future. Upon expiration of the present subagreement for the RAM center, the center will become institutionalized.

Planned initiatives for 1985

*New programs and countries: The priority country for expansion remains Peru, where a change of government in early 1985 promises a more favorable climate for family planning, possibly including VSC. During a staff visit in 1984 AVS made new contacts which are expected to result in two new requests for assistance. In Paraguay a stalled project may get a fresh start after an encouraging report from an AVS consultant. While the original project was funded from private funds, Paraguay is now eligible to receive AID funds, so the prospects for setting up VSC services are now brighter. In the Caribbean, AVS has started a dialogue with the Ministry of Health of St. Lucia, in an attempt to involve that organization more directly in service delivery.

*Counseling: As a result of field visits, staff members have indicated a need for more standardized counseling procedures. The Bogota office intends to develop a regional counseling conference, organized along the same lines as the successful Asia Regional Workshop on VSC Counseling (Manila, October 1983).

*Safety and quality: In Colombia PROFAMILIA will develop a series of medical norms, recommended by AVS and adapted to the local situation. Also, during PROFAMILIA's annual meeting, clinic directors will take part in a one-day seminar to analyze all medical aspects of VSC, including techniques, anesthesia, and patient selection. In the Dominican Republic AVS has started discussions with CONAPOFA about the need to train their eight regional supervision teams to make them more effective in overseeing VSC programs.

*Safe and cost-effective techniques: AVS will continue to stress minilaparotomy and vasectomy as safe and effective techniques. Along this line PROPATER in Brazil and the Nuestra Senora de la Altagracia Maternity Hospital in the Dominican Republic will train South American physicians in these procedures.

*Research and evaluation: AVS is planning a comprehensive evaluation of some of the major programs in the subregion in order to adjust strategies to existing conditions and establish realistic objectives for each program. In Brazil AVS will examine how training is conducted, how trainees are selected, and how they use their new knowledge. In the Dominican Republic a study will be done about the use of private physicians to increase PROFAMILIA's self-sufficiency.

In addition, PROFAMILIA will assess the demand for voluntary sterilization in the Dominican Republic and determine if that demand can be met through the public or private sector, or both.

*Information and education: These activities are particularly important in countries where there is currently little or no VSC activity, such as Peru. The 1985 congress of the Peruvian Obstetrics and Gynecology Society offers an opportunity to inform the Peruvian medical establishment about voluntary sterilization. The society has agreed to devote part of the congress exclusively to voluntary sterilization, and AVS will finance the participation of three Latin American physicians with vast experience in VSC who will address the congress. The Peruvian Obstetrics and Gynecology Society has been instrumental in achieving changes in Ministry of Health programs, and their collaboration will be crucial if AVS is to become more involved in this country.

AVS expects to implement an I&E campaign in Bolivia in 1985, after approval of the proposal in 1984.

*Expansion of services: In the Caribbean expansion of services means moving into rural areas to increase accessibility. AVS's activities in this area will continue to supplement those of the USAID missions. However, AVS will also seek to identify new contacts in each country, to maximize output and the best use of scarce resources. To this effect, AVS has made preliminary proposal development contacts with private, nonprofit groups in Haiti and Jamaica, to initiate VSC services in competition with government programs.

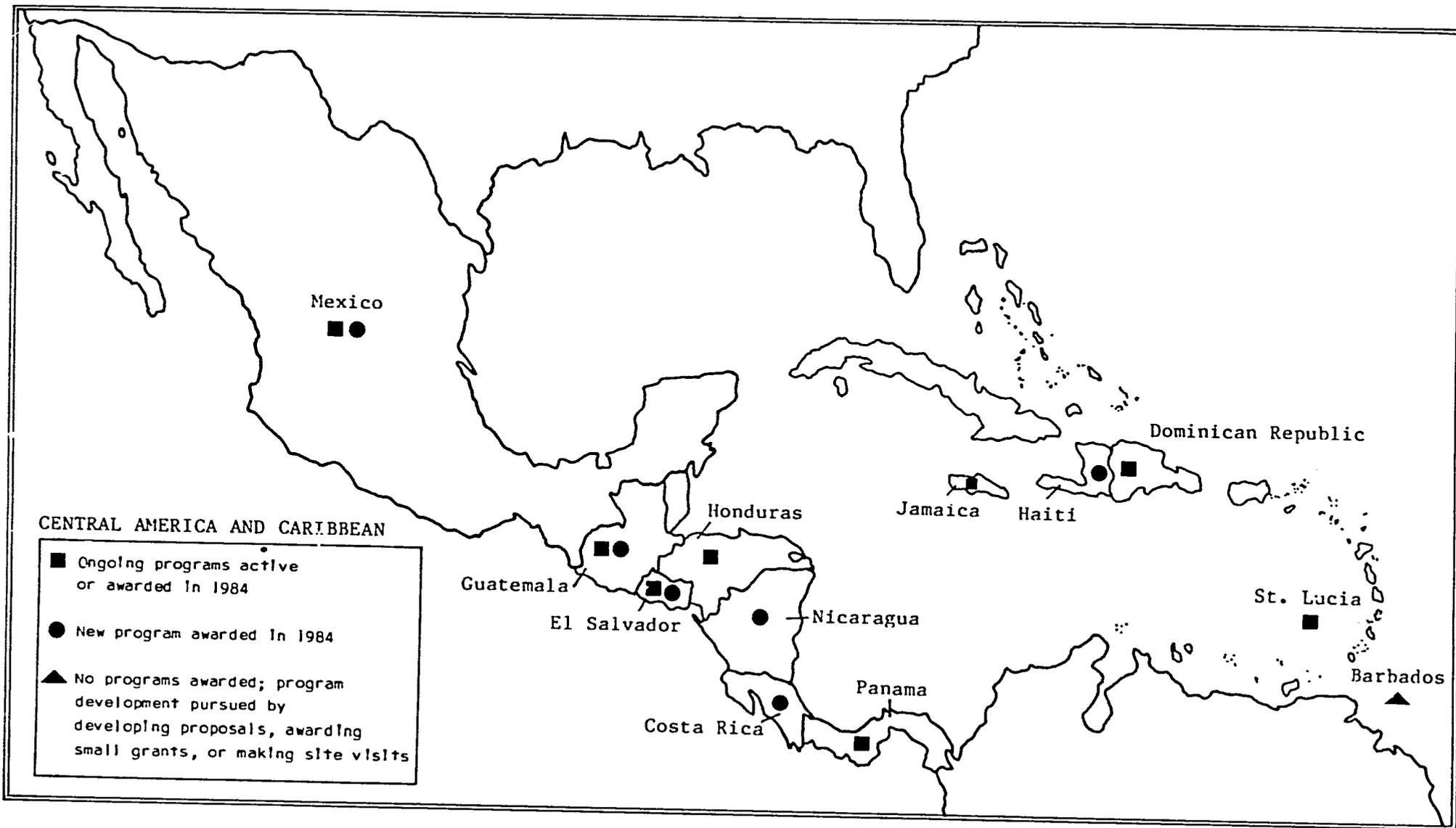
CENTRAL AMERICA AND MEXICO

Summary of funds obligated

In 1984 AVS obligated 16 subagreements in this subregion for a total of \$1,302,962, more than half of which are for programs in Mexico. In addition, 13 small grants were awarded for a total of \$40,572. A substantial subagreement with Guatemala, for a total of \$349,958, is not included in the 1984 figures because it is composed of a series of amendments to a 1983 subagreement, rather than a new subagreement.

Special regional initiatives

AVS's goals in Central America during 1984 were to insure quality; to promote an awareness of the benefits and safety of VSC; to extend the availability of services, especially to campesinos; to involve the private sector; to encourage efficient program management; and to train medical and paramedical personnel.



Throughout this subregion special attention has been given to training in vasectomy and provision of male VSC services. Eighteen Mexican physicians, six of whom are working in the private sector, have been trained in vasectomy in Guatemala and Brazil. The implementation of an official vasectomy program in Mexico is a sure sign that this method of permanent contraception is both publicly and privately more acceptable in this country than was expected.

Qualitative aspects of service delivery received a great deal of attention during 1984. The safety, quality, and efficiency of service delivery and other program components were evaluated in two large AVS-supported programs in El Salvador and Guatemala. The first Latin America Safety Seminar was held in Guatemala to provide participants an opportunity to exchange medical strategies that prevent accidents and complications related to voluntary sterilization. AVS also stressed the use of local anesthesia as a safe, effective, and inexpensive alternative to general or regional anesthesia when performing VSC procedures.

Major programs

The program in El Salvador, which is one of the largest in the subregion, entered its eighth year of AVS assistance and continued to make available quality VSC services despite the civil strife. The Asociacion Demografica Salvadorena, a private association, administers a comprehensive effort including male and female service delivery, training activities, an I&E component, and a repair and maintenance center. In early 1984 U.S. press reports alleged the program was coercing clients to accept permanent contraception. In February a consultant was sent to El Salvador to assess the status of the project, to advise on future directions for AVS assistance, and to look into the allegations regarding coercion. The consultant found no evidence of coercion and, in fact, reported that the Salvadoran program provides quality services and is designed to prevent inappropriate sterilizations and abuses.

In Mexico both public and private agencies and individual service providers continued to show increasing interest in voluntary sterilization, as they had done in 1983. Nine new subagreements were awarded for male and female VSC services, I&E activities, and physician training, making Mexico the second major receiver of AVS funds in the region (Brazil is the first). During site visits an AVS staff team held productive discussions with officials from the various public and private agencies that provide voluntary sterilization services and uncovered several new areas of interest, such as vasectomy, expanding access to rural areas via mobile teams, and appropriate anesthesia regimens. In Mexico, program management and coordination are particular concerns because there are many public and private sector organizations conducting parallel programs. Many of AVS's own efforts are discrete projects spread out increasingly over a large territory.

For this reason, AVS is encouraging consolidation of programs whenever possible. In 1984 the Mexican Federation of Private Family Planning Organizations (FEMAP) began to lay the groundwork for a consolidated program with 10 of its affiliates.

The program in Guatemala, which is implemented by the Asociacion Pro-Bienestar de la Familia (APROFAM), has clearly demonstrated that vasectomy is acceptable to Latin American males. APROFAM performs the largest number of vasectomies in relation to the male population in the region. As a result, medical and paramedical personnel from all over the region have come to visit and be trained in all aspects of vasectomy service delivery. In 1984 AVS participated in a research project to find out the most cost-effective and appropriate ways to conduct education campaigns about vasectomy. The data are presently being analyzed, and conclusions and recommendations are expected in 1985. It is hoped that the outcome of this study will serve as a model for vasectomy I&E campaigns throughout Latin America. The Guatemalan program, one of the most innovative in the region, has continued its efforts to reach rural populations by using mobile teams in five health regions.

During 1984 USAID funded an evaluation of APROFAM's program. Several areas were reviewed including cost-effectiveness of the different service-delivery models; the opinions about these models held by the program's medical personnel; the clients' satisfaction with voluntary sterilization; people's attitudes and opinions about the cost of VSC; and clients' sources of information and influence. Although the final conclusions are not yet available, preliminary results show that voluntary sterilization is the leading contraceptive method in Guatemala and that people are usually very satisfied with the procedure.

In Honduras a new law was passed in 1984 legalizing voluntary sterilization for everyone who has completed his or her family. In that country AVS has assisted both Ministry of Health hospitals and private clinics, and has also contributed funds to the private agency the Asociacion Hondurena de Planificacion de la Familia (ASHONPLAFA) for the establishment of clinic facilities in Tegucigalpa.

Planned initiatives for 1985

*Counseling: In 1985 special attention will be given to counseling and client education, and a regional seminar on these subjects will be held in Mexico. Also, a pilot vasectomy education and counseling program for rural males is planned in Costa Rica by the Campesino Union.

*Quality and safety: As a follow-up to the Central America Safety Seminar held in Guatemala in 1984, country-specific meetings will be held in Mexico and El Salvador to address surgical techniques, local

anesthesia, and safety precautions to reduce complications. Another meeting is planned in Mexico by the Mexican Social Security Institute (IMSS) to educate its physicians on the effectiveness and safety of vasectomy as a contraceptive option. The expected outcome is to increase acceptability of vasectomy among this large group of family planning service providers.

*Institutionalization: AVS will continue to emphasize transfer of funding responsibility, particularly for service delivery, from AVS to government and bilateral sources. In 1985 AVS hopes to receive supplementary funding from USAID missions in El Salvador, Guatemala, and Honduras.

*Enhanced program management: To better manage the anticipated increase in funding for this subregion, AVS plans several measures in 1985. Where feasible, single grants will be consolidated into large, comprehensive programs; this strategy will be pursued aggressively in Mexico. Furthermore, AVS hopes to recruit an in-country adviser for Mexico in 1985 to help manage the large number of programs in the various sectors. Finally, a grants-officer position will be added at headquarters in 1985, to enhance program monitoring in both Central America and South America/Caribbean.

TABLE 2.5

Subagreements Awarded in 1984: Latin America and Caribbean

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|--|---------------|--|
| <u>BOLIVIA</u> | | |
| Sociedad Boliviana de Reproduccion Humana BOL-05-SV-1-A | \$33,021 | To establish a VSC program and an I&E campaign to raise awareness of VSC services. |
| <u>BRAZIL</u> | | |
| Promocao de Paternidade Responsavel BRA-09-SV-4-A | \$225,992 | To continue vasectomy programs in Sao Paulo and to start three new clinics for the training of physi- cians in the procedure. |
| Sociedade Civil Bem-Estar Familiar no Brasil BRA-14-TR-3-A | \$130,128 | To conduct a female VSC program in order to provide enough cases for training in minilaparotomy and laparoscopy. |
| Associacao Brasileira de Entidades de Planejamento Familiar BRA-25-SV-2-A | \$447,695 | To expand the availability and accessibility of high quality VSC services throughout Brazil. |
| <u>COLOMBIA</u> | | |
| Asociacion Pro-Bienestar de la Familia Colombiana COL-11-SV-2-A | \$337,550 | To continue VSC services and to increase the proportion of locally generated resources. |
| Asociacion Pro-Bienestar de la Familia Colombiana COL-14-EV-1-A | \$20,000 | To conduct a follow-up study of women who have had voluntary steril- izations. |
| <u>COSTA RICA</u> | | |
| Federacion Sindical Agraria Nacional COS-07-SV-P-V | \$23,143 | To continue a vasectomy referral service program as part of a compre- hensive I&E program; to provide male surgical contraception services. |

TABLE 2.5 - continued

Subagreements Awarded in 1984: Latin America and Caribbean

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|--|---------------|--|
| <u>DOMINICAN REPUBLIC</u> | | |
| Asociacion Dominicana Pro-Bienestar de la Familia DOM-03-SV-4-A | \$320,127 | To expand the VSC service program to private clinics using minilaparotomy and vasectomy under local anesthesia. |
| <u>ECUADOR</u> | | |
| Asociacion Pro-Bienestar de la Familia Ecuatoriana ECU-03-SV-1-P | \$3,050 | To continue VSC services in Guayaquil using minilaparotomy under local anesthesia. |
| <u>EL SALVADOR</u> | | |
| Latin American Studies Center, Tulane University ELS-15-EV-1-A | \$42,706 | To identify factors in the client's decision-making process and to gather information on the client's opinions regarding the quality of services. |
| Asociacion Demografica Salvadorena ELS-13-CO-3-A | \$415,340 | To continue performing voluntary sterilization using laparoscopy, minilaparotomy, and vasectomy in four clinics. |
| <u>GUATEMALA</u> | | |
| Asociacion Pro-Bienestar de la Familia CA-01-PE-1-A | \$20,800 | To provide a forum for influential physicians and chief operating nurses from Guatemala, El Salvador, Honduras, Dominican Republic, Nicaragua, Costa Rica, Mexico, and Panama, with the objectives of reducing complications related to VSC and improving safety in clinics. |
| <u>HAITI</u> | | |
| Division D'Hygiene Familiale et de Nutrition HAI-06-SV-1A | \$31,139 | To increase the availability and accessibility of VSC and to insure quality services in rural areas. |

TABLE 2.5 - continued

Subagreements Awarded in 1984: Latin America and Caribbean

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|--|---------------|--|
| Haiti - cont'd | | |
| Division D'Hygiene Familiale et de Nutrition HAI-07-IE-1-A | \$12,300 | To conduct a method-specific I&E program to raise awareness among the general public about VSC and the availability of services (this program will be integrated into a general education campaign about family planning and the Ministry of Education's functional education program for adults). |
| <u>HONDURAS</u> | | |
| Asociacion Hondurena de Planificacion de la Familia HON-09-CO-5-A | \$256,870 | To increase the availability of male and female VSC services in seven Ministry of Health hospitals; to train 15 paramedics in VSC techniques; to continue I&E activities. |
| Instituto Hondureno de Seguridad Social HON-11-SV-2-A | \$73,103 | To expand the availability of VSC by integrating it into overall programming. |
| <u>MEXICO</u> | | |
| Asociacion de Planifi- cacion Familiar de Tijuana MEX-16-SV-4-A | \$38,755 | To continue and expand the male and female VSC service program; to continue I&E activities designed to raise awareness about VSC among the general public. |
| Asociacion Pro-Mejora- miento de la Familia de Nuevo Leon MEX-17-SV-4-A | \$61,220 | To expand the female and male program at Maternidad Lolita, Guadalupe Health Unit, and Hospital Universitario; to continue I&E activities for the general public and hospital patients. |
| Centro Social Cooperativo de Nogales MEX-20-SV-2-A | \$32,500 | To provide male and female VSC services; to continue I&E activities in support of the service program. |

TABLE 2.5 - continued

Subagreements Awarded in 1984: Latin America and Caribbean

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|---|---------------|---|
| Mexico - cont'd | | |
| Centro de Orientacion Familiar de Matamoros MEX-21-SV-2-A | \$24,797 | To expand the delivery of VSC service using minilaparotomy, laparoscopy, and vasectomy; to conduct I&E activities in support of the service-delivery program. |
| Instituto Nacional de la Nutricion, Mexico City MEX-23-SV-2-A | \$21,150 | To provide male and female VSC services; to train 10 Ministry of Health physicians in minilaparotomy and local anesthesia techniques; to sponsor a national symposium for physicians to discuss and demonstrate the effectiveness of local anesthesia and the use of minilaparotomy; to provide services to a high-risk population who would otherwise go unserved. |
| Federacion Mexicana de Asociaciones Privadas de Planificacion Familiar, Juarez MEX-24-CO-1-A | \$114,080 | To consolidate service programs into one coordinated and consistent program; to provide high-quality VSC services and to provide medical and programmatic supervision, technical assistance, and financial management to the consolidated service program. |
| Promotora de Planificacion Familiar, Queretaro MEX-32-IE-1-A-V | \$92,550 | To encourage greater awareness of vasectomy in Mexico and neighboring countries of Central America. |
| Unidad de Biologia de la Reproduccion, Universidad de Yucatan, Merida MEX-34-SV-1-A | \$17,216 | To establish a vasectomy program; to train 12 resident physicians in vasectomy; to establish an I&E program in rural areas. |
| Desarrollo e Investigacion de la Planificacion Familiar MEX-36-TR-1-A | \$26,804 | To train eight physicians at a model vasectomy program in the region; to acquaint them with a successful male-oriented program in the private sector. |

TABLE 2.5 - continued

Subagreements Awarded in 1984: Latin America and Caribbean

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|---|---------------|--|
| <u>NICARAGUA</u> | | |
| Asociacion Demografica Nicaraguense NIC-05-SV-2-P | \$41,928 | To provide VSC services to men and women; to train 20 physicians in minilaparotomy and vasectomy; to sponsor the medical director's participation at the Central American safety workshop. |
| <u>PARAGUAY</u> | | |
| Centro Paraguayo de Estudios de Poblacion PAR-02-SV-1-A | \$40,000 | To continue providing VSC services; to establish an I&E campaign to support the services. |
| <u>PERU</u> | | |
| Hospital Nacional Edgardo Rebagliati PER-11-SV-1-A | \$21,730 | To establish a VSC service using laparoscopy; to create a training and demonstration center for other Social Security facilities. |
| Centro Medico Carmen de la Legua PER-12-SV-1-A | \$38,380 | To establish an outpatient family planning service for low-income urban residents. |

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TABLE 2.6

Small Grants Awarded in 1984: Latin America and Caribbean

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|---|---------------|---|
| <u>BRAZIL</u> | | |
| Sociedade Civil Bem-Estar Familiar no Brasil S-730-TR | \$504 | To train physicians in minilap- arotomy. |
| <u>COLOMBIA</u> | | |
| Asociacion Pro-Bienestar de la Familia Colombiana S-727-EV | \$7,000 | To conduct research on the cost of different VSC techniques performed at large, medium-sized, and small clinics and in mobile clinics using different anesthesia regimes. |
| Corporacion Centro Regional de Poblacion S-734-R | \$6,000 | To conduct secondary analysis of Colombian fertility data to determine VSC trends. |
| <u>EL SALVADOR</u> | | |
| Hospital de Maternidad S-715-EQ | \$2,457 | To provide spare parts for an autoclave. |
| Asociacion Demografica Salvadorena S-745-TV | \$4,699 | To organize a VSC seminar. |
| <u>HAITI</u> | | |
| Division D'Hygiene Familiale et de Nutrition S-708-EQ | \$3,600 | To provide male and female pins for distribution to VSC and family planning clients, to raise awareness of voluntary sterilization. |
| <u>MEXICO</u> | | |
| Desarrollo e Investigacion de la Planificacion Familiar S-691-EQ | \$7,500 | To provide laparoscopic equipment. |

TABLE 2.6

Small Grants Awarded in 1984: Latin America and Caribbean

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|---|---------------|--|
| Mexico - cont'd | | |
| Desarrollo e Investigacion de la Planificacion Familiar S-692-EQ | \$6,412 | To provide laparoscopic equipment. |
| Hospital Civil de Guadalajara S-697-TV | \$1,099 | To provide for a physician's travel to AVS headquarters, to develop plans for the Central America safety workshop. |
| Universidad de Yucatan S-714-EQ | \$650 | To provide lamps for Laprocaters. |
| Promotora de Planificacion Familiar S-728-EV | \$7,000 | To conduct a study on vasectomy attitudes and knowledge. |
| Hospital General de Mexico S-732-EQ | \$3,400 | To provide a Laprocaters. |
| Hospital Civil de Guadalajara S-752-EQ | \$100 | To provide 20 ampules of Narcan. |
| Hospital Civil de Guadalajara S-754-EQ | \$1,900 | To provide Falope-Rings. |
| Instituto Mexicano S-759-EQ | \$450 | To provide medical equipment. |
| <u>PANAMA</u> | | |
| Caja de Seguro Social S-716-EQ | \$4,705 | To provide medical equipment. |
| Ministry of Health S-717-EQ | \$200 | To provide lamps for Laprocaters. |

TABLE 2.6

Small Grants Awarded in 1984: Latin America and Caribbean

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|---|---------------|---|
| <u>PARAGUAY</u> | | |
| Centro Paraguayo de Estudios de Poblacion S-744-TV | \$1,671 | For a resource person to attend a VSC workshop in Paraguay. |
| <u>PERU</u> | | |
| Hospital Loaiza, Lima S-712-EQ | \$120 | For legholders for an OR table. |
| Instituto Peruano de Paternidad Responsable S-733-TR | \$2,649 | For a physician to receive minilap- arotomy training in the Dominican Republic. |
| Peru Obstetrics and Gynecology Society S-749-TV | \$3,340 | For attendance of three participants at the eighth congress of the society in March 1985. |

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ASIA

Summary of regional strategies and issues

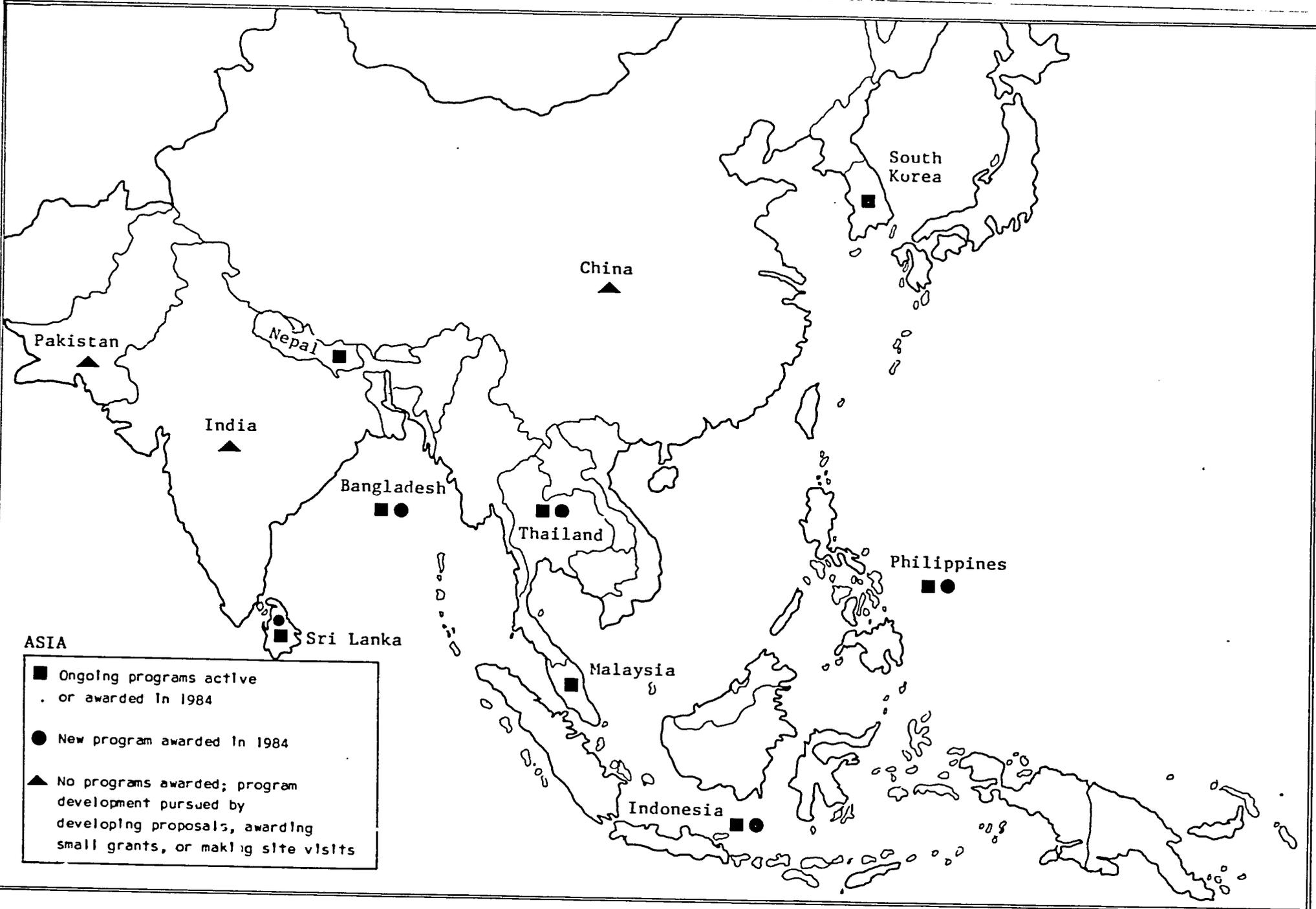
The Asia region distinguishes itself from the other regions because of its long history of active involvement in VSC, because of official government participation in many countries, and because of a large body of expertise and experience. Because Asian nations offer VSC programs that are quite mature and successful, AVS is becoming more and more involved in technical assistance, as its financial support declines or plateaus in each country. Thus, in 1984 AVS continued the gradual shift from capital-intensive efforts (start-up and program expansion) to qualitative efforts (program refinement and improvement in the quality and safety of programs).

To accompany this shift, AVS has identified key program areas which were the focus of work in Asia in 1984 and which will continue to be in the future. These include medical quality assurance, operations research, counseling, development of appropriate information and education programs, and institutional development (including self-reliance). Such efforts demand fewer dollars, but require greater technical sophistication. Therefore, although AVS will probably commit a smaller share of its financial resources, particularly central funds, to Asia, staff efforts will continue to be intensive.

Because it is the one region where vasectomy is relatively prevalent, another major program area for Asia is vasectomy. AVS is supporting demonstration and operational-research projects to help build a base of knowledge and experience from which vasectomy programs can be developed in both Asia and the rest of the world.

One special characteristic of AVS's work in Asia is the strong presence of national leadership organizations devoted to voluntary sterilization. In large part, these organizations deserve credit for many of the program innovations characteristic of the Asian region. As the shift from extensive to intensive programming occurs, and as governments assume a larger share of responsibility for voluntary sterilization, these national leadership groups are shifting to a new focus as well. For example, both the Thai Association for Voluntary Sterilization (TAVS) and the Indonesian Society for Secure Contraception (PKMI) are adopting new roles and being formally recognized by their governments as key technical resources for voluntary sterilization in their countries.

Two countries in which AVS's involvement has been low-key or nonexistent gave reason for optimism in 1984. In Pakistan AVS initiated the first project development efforts since work was stopped in that country in 1978. Also, substantial progress was made in developing a significant national project in India. In a major initiative,



ASIA

- Ongoing programs active or awarded in 1984
- New program awarded in 1984
- ▲ No programs awarded; program development pursued by developing proposals, awarding small grants, or making site visits

AVS's executive director travelled to India to explore possible cooperative activities with officials of that country. As a result of these discussions, AVS has received a formal invitation from the Indian government to collaborate in establishing centers for training in laparoscopy and reversal techniques.

Summary of funds obligated

In 1984 AVS obligated 34 subagreements in Asia, including amendments, for a total of \$3,815,135. The total includes \$1,485,284 in bilateral funds from USAID Dhaka (see Appendix A). The Asia Region is receiving the largest amount of AVS assistance. In 1984 eight small grants were awarded for a total of \$57,528, of which \$22,500 was given from bilateral funds.

Special regional initiatives

To address the increased concern for voluntarism and informed consent, AVS helped to develop counseling components in the national programs of FPAN (Nepal), PKMI (Indonesia), TAVS (Thailand), SLAVSC (Sri Lanka), BAVS (Bangladesh), and PASS (Philippines). These organizations constitute AVS's major collaborating leadership groups in the region. During 1984 they worked to design national counseling policies, to produce counseling materials, and to develop or upgrade counseling training and services. Sri Lanka, Nepal, and Thailand have already held national policy meetings, which will result in the publication of official policy statements. Also, in Malaysia in 1984, a counseling training project was developed with the government.

To facilitate program execution and administration, AVS decided to begin developing multiyear consolidated projects in Asia. As a result of this decision, several projects in Nepal and Bangladesh have been combined into multiyear programs. Two more programs, in Thailand and Indonesia, will follow this example in 1985.

In 1984 AVS intensified its activities to increase the availability of male sterilization services and improve local expertise in vasectomy. As a result of this work, a vasectomy proposal was received for Pakistan, the first male-only clinic in the Philippines was opened, an operational-research outreach project was begun in Thailand, and a vasectomy service program was started in Indonesia. A number of other proposals for vasectomy-related projects are currently being developed.

Many nongovernmental organizations have had difficulty maintaining the effectiveness of their trained volunteer workers. To respond to this problem, AVS developed and approved in 1984 a proposal for a workshop on the utilization of volunteers as field workers and educators in VSC programs. The workshop will be held in 1985 in Sri Lanka.

Key personnel from participating organizations will exchange information and will observe a successful volunteer program in the host country.

Major programs

AVS's key effort in Asia is its support of the Bangladesh Association for Voluntary Sterilization (BAVS). The program has a national impact and is a clear response to health and family planning needs in Bangladesh. The main emphasis is the provision of services, based on high standards for counseling, voluntarism, informed consent and medical quality assurance. In addition to providing as much as 2 of all voluntary sterilization services in the country, this model program has had a significant and positive impact on the government's VSC activities. AVS's support to BAVS has recently been consolidated from three projects into one multiyear (1985-1987) program. Significant achievements of the Bangladesh program are reported in Appendix A.

With AVS's assistance the Indonesian Association for Secure Contraception (PKMI) has worked to achieve its goal of convincing the official health and family planning program to support VSC services throughout the country. With the government's decision to upgrade selected health facilities for the provision of VSC services throughout the country, PKMI's objective appears to have been achieved. Consequently, AVS's support in Indonesia is now in a transition period. AVS's many projects with PKMI branches at university training centers will be phased out in 1985. Several of them have already received or are scheduled to receive government funds, now that VSC is becoming a public service in Indonesia. In 1985 AVS will work with PKMI on counseling, vasectomy service delivery, and VSC quality assurance.

As in Bangladesh and Indonesia, AVS is making considerable impact in Sri Lanka by collaborating with the national leadership group, the Sri Lanka Association for Voluntary Surgical Contraception (SLAVSC). In 1983 and 1984, SLAVSC designed and distributed a national VSC consent form. It also organized a national counseling and quality assurance meeting. The current 18-month project includes counseling, medical supervision, and monitoring activities that will have significant impact on the Sri Lanka voluntary sterilization program.

In the Philippines AVS is supporting a national VSC training center at Philippines General Hospital. This center maintains high-quality training standards and is the center for excellence in voluntary sterilization in the Philippines.

The Family Planning Association of Nepal (FPAN), the major nongovernmental family planning organization in Nepal, provides considerable input into the service delivery efforts and program

development activities of the national voluntary sterilization program. AVS support to FPAN has helped to establish VSC medical standards, counseling guidelines, and services. FPAN provides 20% of all voluntary sterilization services delivered in the country.

Planned initiatives for 1985

AVS plans to continue working along the same lines in 1985, with emphasis on qualitative program aspects such as counseling and quality assurance, as well as on the further development of vasectomy initiatives.

*New countries: During 1985 AVS hopes to support voluntary sterilization programs in two additional Asian countries: India and Pakistan.

India has a well-established voluntary sterilization program, but has recently expressed interest in strengthening its training programs, particularly in laparoscopic sterilization and reversal. An AVS team will visit India in early 1985 to continue discussions initiated in 1984 and to identify specific training needs. AVS expects to assist with the development of the first two or three "centers of excellence," to be established by the government for improved and standardized training in sterilization and reversal. These centers will serve as models for other centers to be established in all major states of the country.

In 1985 AVS will resume funding of voluntary sterilization programs in Pakistan, after a gap of over five years. Two pilot projects, developed in late 1984, will improve the acceptability and accessibility of voluntary sterilization services in selected geographical areas. A third project, designed to demonstrate the feasibility of providing male sterilization services as an integral part of an ongoing industrial family planning program, will be initiated during the latter part of the year.

Program development efforts will also be initiated in Burma, a country in which AVS is not involved at present.

*Counseling: The counseling initiatives, begun in 1984, will continue to receive special attention in 1985 in Indonesia, Nepal, the Philippines, and Thailand. National committees, consisting of government and private-sector officials, will be established in these countries to develop appropriate counseling policies, guidelines, and training curricula. AVS will provide expert consultant services. Pilot counseling programs will be started in selected clinics to serve as models for other clinics in these countries.

*Quality assurance: Improvement and standardization of medical quality will receive priority in Indonesia, Sri Lanka, and Thailand. National workshops and seminars will be organized to develop uniform

medical standards and guidelines for voluntary sterilization services. Pilot monitoring and supervision systems, based on the guidelines developed by the World Federation, will be established in these countries. If successful, these systems will be introduced in other countries of the region at a later date.

In Nepal cost-effectiveness studies of static and mobile services will be initiated in 1985. A number of activities are planned in Bangladesh to improve existing monitoring and supervision systems.

*Information, education, and communication: To assess the impact of freestanding, community-based information and education centers on family planning acceptance, particularly sterilization acceptance, an in-depth evaluation of the family planning information centers in Thailand will be undertaken in 1985. These centers were established with AVS support. Lessons learned from the centers will be used to plan and develop IEC programs in other countries of the region and in Africa and Latin America. In addition, commercial marketing techniques used in family planning education programs by the Population Center Foundation of the Philippines will be evaluated for potential use in other Asian programs.

*Vasectomy service development: Efforts to improve the acceptance of vasectomy as a viable contraceptive option will continue in all Asian countries. Pilot vasectomy demonstration programs will be established in Indonesia, Pakistan, and the Philippines. The Thai Association for Voluntary Sterilization (TAVS) will undertake special programs, designed to improve vasectomy acceptance at government family planning clinics in Thailand.

TABLE 2.7

Subagreements Awarded in 1984: Asia

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|--|---------------|--|
| <u>BANGLADESH</u> | | |
| Bangladesh Association for Voluntary Sterilization BGD-03-CO-9-B (Bilateral) | \$1,485,284 | For a national service-delivery program. |
| Quest and Mitra and Associates BGD-39-EV-1-A | \$20,100 | For a follow-up study of steril- ized women. |
| <u>INDONESIA</u> | | |
| Indonesian Association for Secure Contraception, Jakarta INS-03-NV-8-A | \$258,906 | To support the national leadership and quality-assurance activities. |
| Indonesian Association for Secure Contraception, Bali INS-15-SV-2-A | \$45,292 | To increase the accessibility and acceptability of VSC by main- taining a VSC program at eight hospitals and six health centers in Bali. |
| Indonesian Association for Secure Contraception INS-16-SV-2-A | \$17,033 | For a program at three hospitals in two regencies in South Sumatra. |
| Indonesian Association for Secure Contraception, Bogor INS-17-SV-2-A | \$17,189 | For VSC Services at the Bogor Municipal Health Clinic in West Java. |
| Dr. Soetomo Hospital, East Java INS-21-SV-2-A | \$75,574 | To provide continued support of a VSC program in nine hospitals in East Java. |
| Gadjah Mada University, Yogyakarta INS-22-SV-2-A | \$54,742 | For a VSC program at seven hospi- tals in Yogyakarta and Central Java. |
| Hasan Sadekin Hospital, Bandung INS-23-SV-2-A | \$51,292 | For VSC services through four health centers and six regency hospitals in West Java. |

TABLE 2.7 - continued

Subagreements Awarded in 1984: Asia

| RECIPIENT | AMOUNT | PURPOSE |
|---|-----------|---|
| <u>Indonesia - cont'd</u> | | |
| Indonesian Association for Secure Contraception, Jakarta INS-24-SV-2-AV | \$15,405 | To support a vasectomy clinic for lower income groups in Jakarta. |
| University of North Sumatra INS-25-SV-2-A | \$61,240 | For VSC services at five hospitals in North Sumatra. |
| Indonesian Association for Secure Contraception, Jakarta INS-27-EV-1-A | \$20,000 | For a follow-up study of steril- ized women. |
| Indonesian Association for Secure Contraception, Jakarta INS-29-TR-1-A | \$85,656 | For a pilot project to strengthen VSC counseling by training nurses and midwives at selected health facilities. |
| Indonesian Association for Secure Contraception INS-30-SV-1-A-V | \$65,926 | For a demonstration male VSC program through six health centers in Central Java. |
| <u>KOREA</u> | | |
| Korean Association for Voluntary Sterilization ROK-04-NV-10-P | \$25,050 | To support the leadership activi- ties of the Korean Association for Voluntary Sterilization. |
| <u>NEPAL</u> | | |
| Family Planning Asso- ciation of Nepal NEP-01-CO-8-A | \$297,944 | To increase the accessibility and acceptability of VSC as a contra- ceptive method in Nepal through a VSC service program. |
| <u>PHILIPPINES</u> | | |
| Philippines Association for Surgical Sterilization, Manila PHI-08-NV-7-A | \$81,057 | For national leadership, pro- fessional education, and quality- assurance activities. |

TABLE 2.7 - continued

Subagreements Awarded in 1984: Asia

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|---|---------------|--|
| Philippines - cont'd | | |
| Family Planning Organization of the Philippines, Manila PHI-14-SV-3-A | \$96,739 | To support voluntary sterilization services at five static clinics in Pampanga, Cavite, Iloilo, Camarines Sur, and Cotabato. |
| Family Planning Organization of the Philippines, Manila PHI-14-SV-4-A | \$81,865 | To continue VSC services at the five sites named in the preceding subagreement. |
| Institute of Maternal and Child Health, Manila PHI-15-SV-1-A | \$60,659 | For the delivery of VSC services at four clinics in Isabela and North Zamboanga. |
| Philippines General Hospital PHI-17-TR-3-A | \$48,902 | To support the National Training Center for Surgical Sterilization. |
| Population Center Foundation, Manila PHI-18-SV-2-A | \$60,154 | For an outreach service program to 19 provinces of Luzon. |
| Children's Medical Center, Manila PHI-20-SV-2-AV | \$24,850 | For a pilot male VSC program. |
| Children's Medical Center, Manila PHI-20-SV-3-AV | \$25,205 | To provide continued support for a pilot male VSC program. |
| Neighbours Family Planning Center PHI-22-SV-1-AV | \$48,498 | For a pilot vasectomy program in South Zamboanga. |
| Gabriel Medical Assistance Group, Manila PHI-24-SV-1-A | \$53,665 | To provide technical assistance to mobile VSC teams in Zamboanga, Iloilo, Isabela, and Laguna. |
| <u>SRI LANKA</u> | | |
| Sri Lanka Association for Voluntary Surgical Contraception SRL-02-NV-6-A | \$175,724 | For national leadership and quality-assurance activities. |

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TABLE 2.7 - continued

Subagreements Awarded in 1984: Asia

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|--|---------------|---|
| Sri Lanka - cont'd | | |
| Sri Lanka Association for Voluntary Surgical Contraception, Kandy SRL-07-SV-2-A | \$46,465 | To support a VSC clinic and training center in Kandy. |
| Community Development Services SRL-12-SV-2-A | \$62,175 | To provide continued support for a VSC service program. |
| Family Planning Association of Sri Lanka SRL-15-IE-1-AV | \$21,498 | For a vasectomy information and education program. |
| Family Planning Association of Sri Lanka Asia-02-PE-1-A | \$45,000 | To conduct a workshop on volunteer field worker utilization for VSC program managers in Asia. |
| <u>THAILAND</u> | | |
| Thai Association for Voluntary Sterilization THA-08-NV-8-A | \$159,954 | To support the national leadership and quality-assurance activities. |
| Population and Community Development Association THA-14-SV-5-A | \$37,120 | For a community-based voluntary sterilization service in Korat. |
| Population and Community Development Association THA-18-IE-1-A | \$88,972 | To provide male contraceptive education and services at two centers in Bangkok. |

TABLE 2.8

Small Grants Awarded in 1984: Asia

| <u>RECIPIENT</u> | <u>AMOUNT</u> | <u>PURPOSE</u> |
|--|---------------|--|
| <u>BANGLADESH</u> | | |
| Bangladesh Association for Voluntary Sterilization-- Bilateral | \$20,000* | For a study tour by eight doctors to Indonesia and Thailand. |
| Bangladesh Association for Voluntary Sterilization-- Bilateral | \$2,500 | For attendance of two BAVS staff at a workshop in Thailand. |
| <u>MALAYSIA</u> | | |
| National Population and Family Planning Board S-750-TR | \$7,174 | For a pilot counseling training program. |
| <u>PHILIPPINES</u> | | |
| Philippines General Hospital S-746-EV | \$6,432 | To revise a VSC training manual. |
| <u>SRI LANKA</u> | | |
| Sri Lanka Association for Voluntary Surgical Contraception S-720-EV | \$5,230 | For a vasovasostomy demonstration program at Kandy. |
| <u>THAILAND</u> | | |
| Thai Association for Voluntary Sterilization S-719-EV | \$7,492 | For vasectomy outreach operations research. |
| Thai Association for Voluntary Sterilization S-736-PE | \$7,500 | For a seminar to develop a national VSC counseling policy. |
| Population and Community Development Association S-750-TV | \$1,200 | For attendance of staff at a PKMI workshop in Indonesia. |

*Individual travel grants

CHAPTER 3

ACCOMPLISHMENTS

The fundamental aim of AVS is to give men and women everywhere in the world access to safe and effective VSC services. Some major activities that are undertaken to achieve this aim are direct support for service delivery; training of medical and paramedical service providers; and provision, repair, and maintenance of equipment. This chapter reports the accomplishments of AVS and its grantees in these three areas during 1984. The following two chapters discuss the accomplishments of several special AVS programs and of the World Federation which are supported to enhance access to quality services.

VSC SERVICES

Number of procedures

In all regions of the developing world, AVS's efforts, through support of local or national service programs, are succeeding: More and more people now have access to voluntary sterilization. The increasing number of VSC procedures not only attests to the growing demand for these services but also pays tribute to those health workers who are committed to providing the services.

Figure 3.1 shows how VSC use, as reported by AVS recipients, has increased steadily since 1976. Over 270,000 procedures were reported performed by AVS recipients in 1984. Over 1.1 million procedures were reported performed between 1976 and 1984.

Although such numbers and trends are impressive, they do not convey the full extent of AVS's impact on VSC service delivery. Millions of voluntary sterilizations are performed each year without direct AVS support. However, these numbers would be substantially smaller had it not been for the service, training, and leadership projects that AVS supported in earlier years and that are now institutionalized, and for the thousands of satisfied VSC users served by AVS projects who have shared their satisfaction with other persons.

Choice of surgical procedure

Female voluntary sterilization is still the predominant procedure in every region and subregion of the developing world. However, its share of the total number of procedures performed in AVS-supported programs is steadily decreasing, while vasectomy is increasing.

FIGURE 3.1: Number and Percent Distribution of Female and Male Sterilization Procedures Reported by AVS Recipients, All Funding Sources, 1976-1984

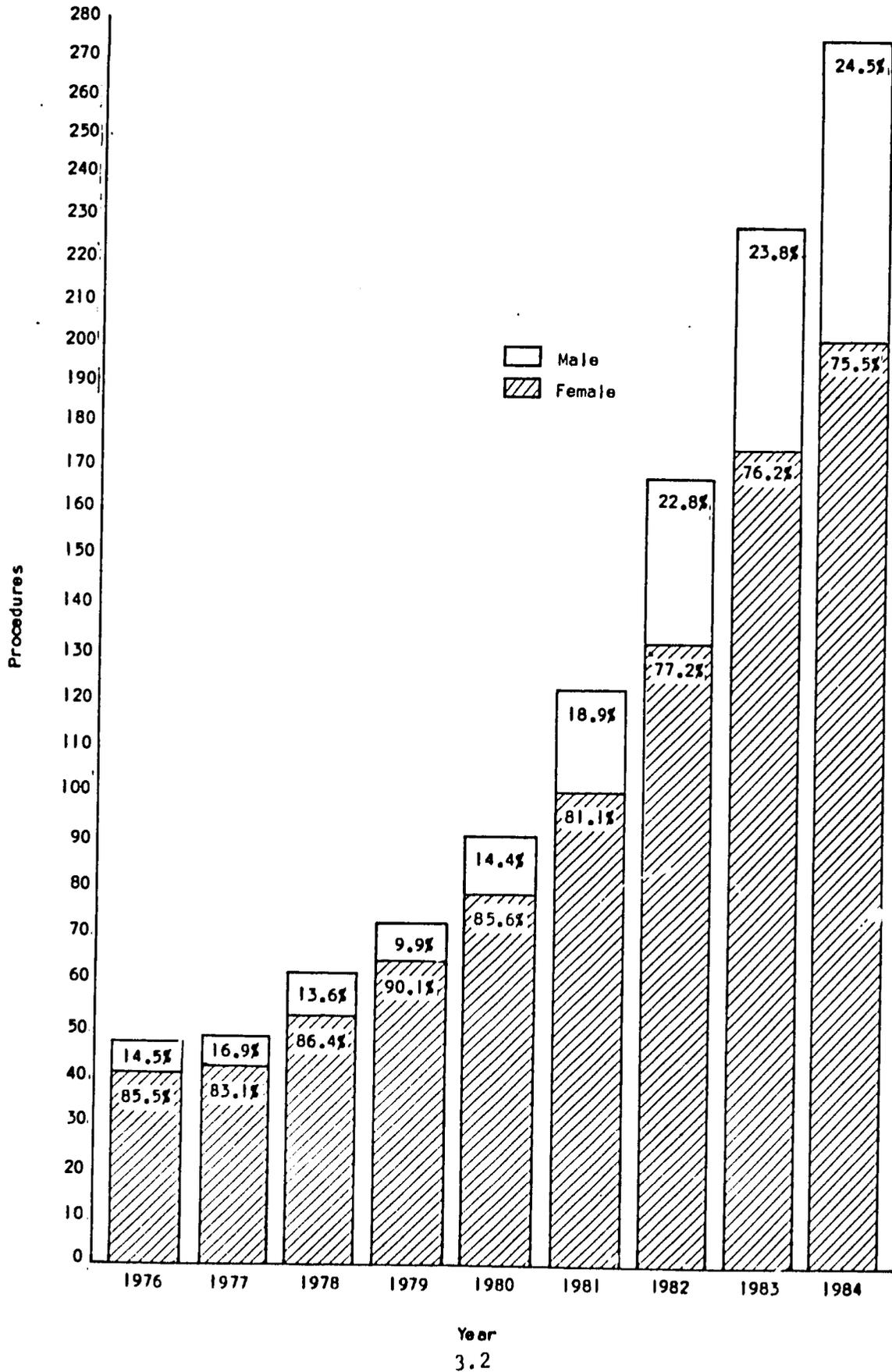


TABLE 3.1 Number and Percent Distribution of Female and Male Sterilization Procedures Reported by AVS Recipients, All Funding Sources, 1976-1984

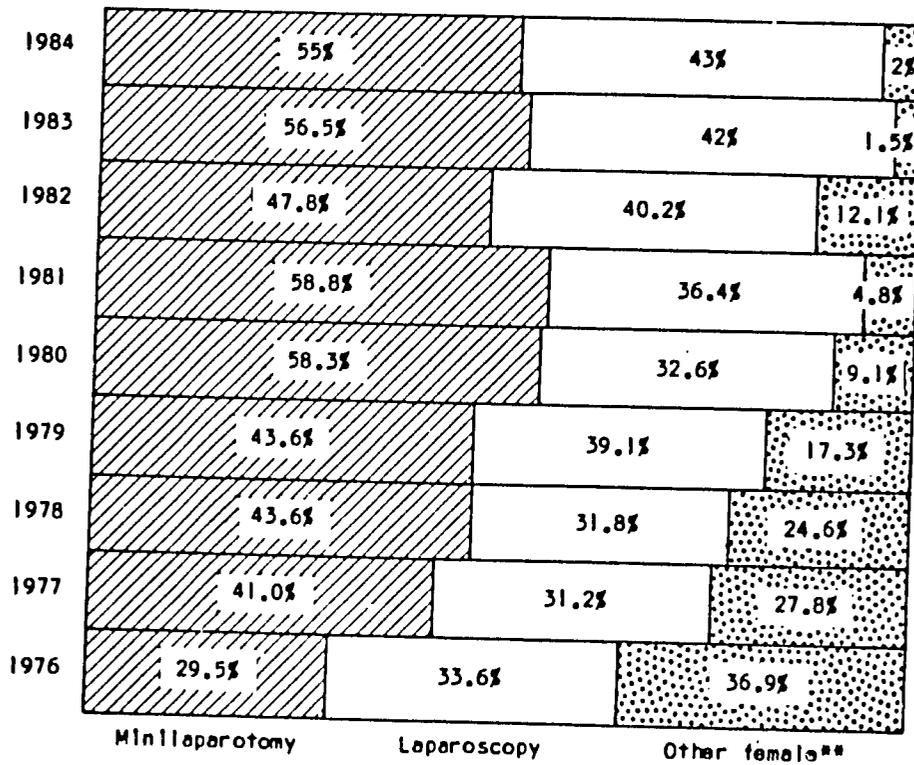
| Year | Female Procedures | | Male Procedures | | Total Procedures | |
|--------------|-------------------|------|-----------------|------|------------------|-------|
| | Number | % | Number | % | Number | % |
| 1976 | 40,365 | 85.5 | 6,838 | 14.5 | 47,203 | 100.0 |
| 1977 | 41,453 | 83.1 | 8,424 | 16.9 | 49,877 | 100.0 |
| 1978 | 53,771 | 86.4 | 8,494 | 13.6 | 62,265 | 100.0 |
| 1979 | 65,878 | 90.1 | 7,277 | 9.9 | 73,155 | 100.0 |
| 1980 | 79,496 | 85.6 | 13,389 | 14.4 | 92,885 | 100.0 |
| 1981 | 101,935 | 81.1 | 23,697 | 18.9 | 125,632 | 100.0 |
| 1982 | 128,316 | 77.2 | 37,797 | 22.8 | 166,113 | 100.0 |
| 1983 | 174,251 | 76.2 | 54,324 | 23.8 | 228,575 | 100.0 |
| 1984* | 204,046 | 75.5 | 66,382 | 24.5 | 270,428 | 100.0 |
| <u>TOTAL</u> | 889,511 | 79.7 | 226,622 | 20.3 | 1,116,133 | 100.0 |

*1984 figures include projections.

Of the various types of female VSC procedures, minilaparotomy accounted for over 50% of all female procedures reported performed in 1984, a percentage that has remained more or less stable over the last several years (see Figure 3.2). This percentage will probably increase in the future, as AVS increasingly emphasizes the use of minilaparotomy as a safe and effective technique, especially for clinics that do not perform large numbers of procedures. Both in regions where laparoscopy has traditionally been the technique of choice, such as Latin America, and in newer regions, such as Sub-Saharan Africa, future reports may very well note the growing use of minilaparotomy.

Other female VSC techniques (which include laparotomy, vaginal methods, and other methods) have decreased steadily over the last nine years; this combined category accounts for only 2% of all female procedures at present.

FIGURE 3.2: Proportion of Female Sterilization Techniques Performed by AVS Recipients, 1976-1984*



* 1984 percentages are based on projections.

** Other techniques include laparotomy, vaginal methods, and unspecified methods.

As Figure 3.1 shows vasectomy is gaining in popularity in AVS-supported projects. In 1976 vasectomy services accounted for only 14% of all VSC services. while the projection for 1984 is nearly 25%. This is a significant increase considering the antipathy toward vasectomy that is often shown by health professionals and public leaders, and the misconception often held by the general public.

The most striking demonstrations of the latent demand for vasectomy come from South America and South Asia, two areas that are as far apart culturally as they are geographically. In both places men were expected to show great resistance to vasectomy on cultural and religious grounds. However, once services have been made available, the assumptions have been proved wrong. In South America the number of vasectomies leapt from the insignificant figure of 29 in 1976 to nearly 3,000 in 1983. The projection for 1984 approaches 5,000. The increase in South Asia, primarily accounted for by Bangladesh, is even more pronounced. In that subregion the projected reported number of vasectomies exceeds the number of female sterilizations; the vasectomy trend is following a steep upward direction, while the number of female procedures has been slowly decreasing since 1982.

This reversal in the popularity of vasectomy can hardly be explained by a sudden change in men's attitudes regarding permanent contraception. Rather, it should be ascribed in part to AVS's intensive efforts to make vasectomy available where it was not before, and to inform and educate officials and service providers about vasectomy.

AVS's Vasectomy Initiative, launched in July 1982, has played an important role in expanding the availability of services and increasing awareness about the man's role in family planning, particularly in regard to his option to choose safe, effective permanent contraception. (For more information on the Vasectomy Initiative, refer to Chapter 4.)

Regional distribution of reported procedures

The history of procedures reported in various subregions is depicted in the several graphs in Figure 3.3. The number of reported procedures in a given area is obviously influenced by several factors including the following:

- ° The number, extensiveness, and maturity of AVS projects in the subregion
- ° The type of AVS projects supported (e.g., service and training projects vs. leadership development or information-education projects)
- ° The degree and length of official acceptance and support for VSC in the countries of the subregion

FIGURE 3.3: Number of Female and Male Sterilization Procedures Reported by AVS Recipients, All Funding Sources, 1976-1984, by Subregion and Year

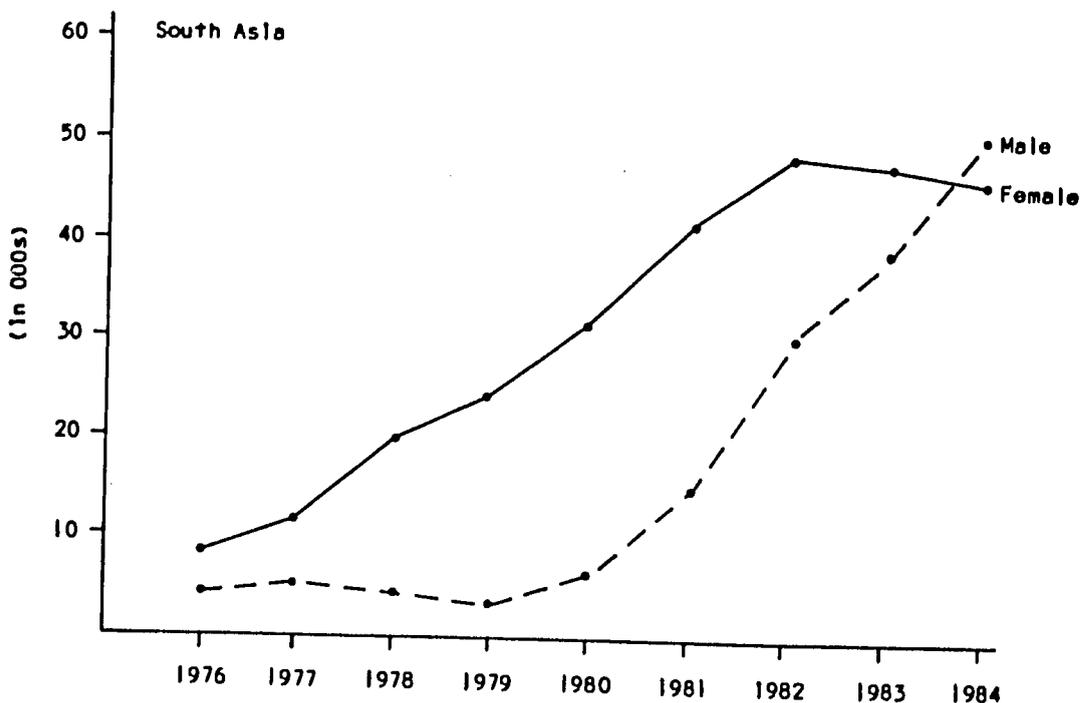
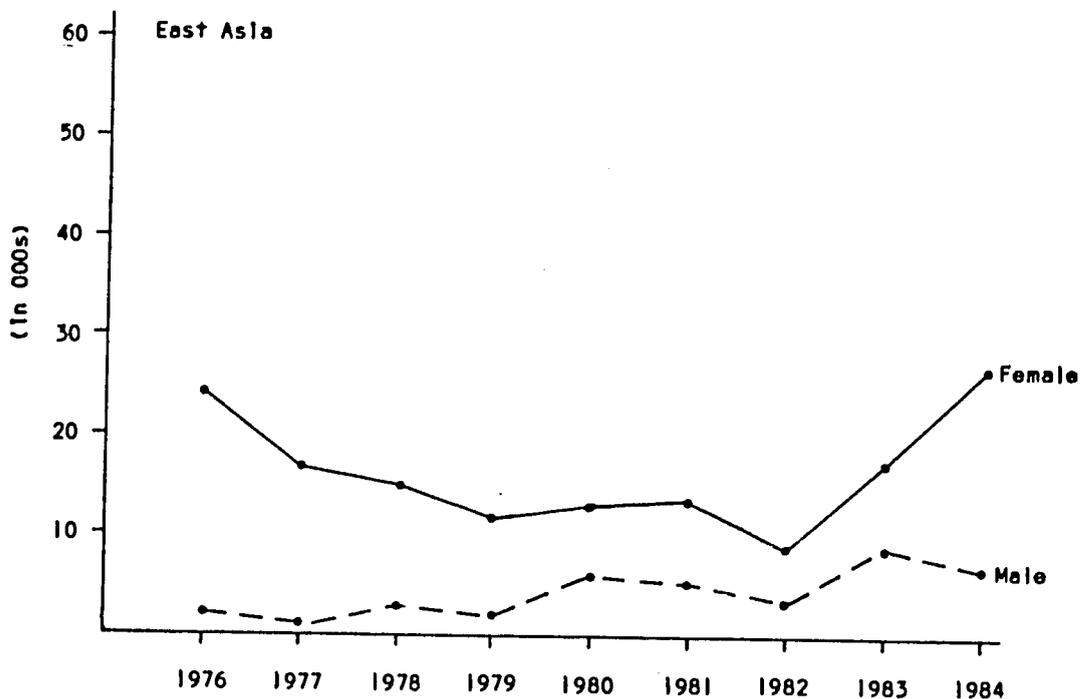


FIGURE 3.3 - continued

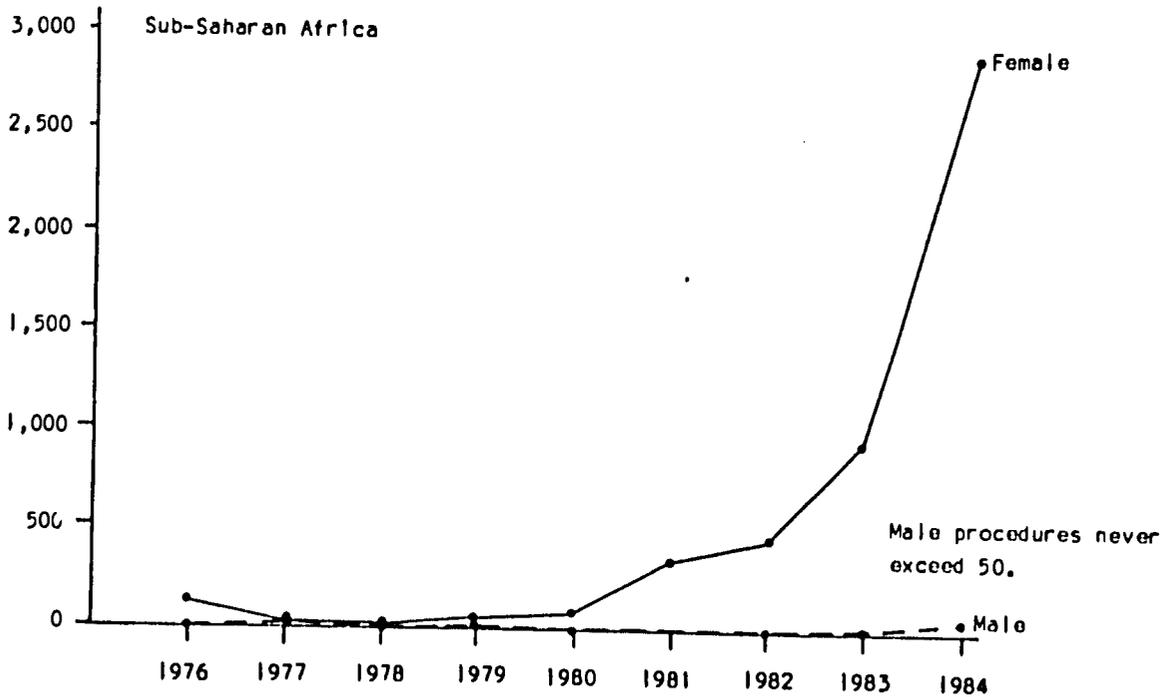
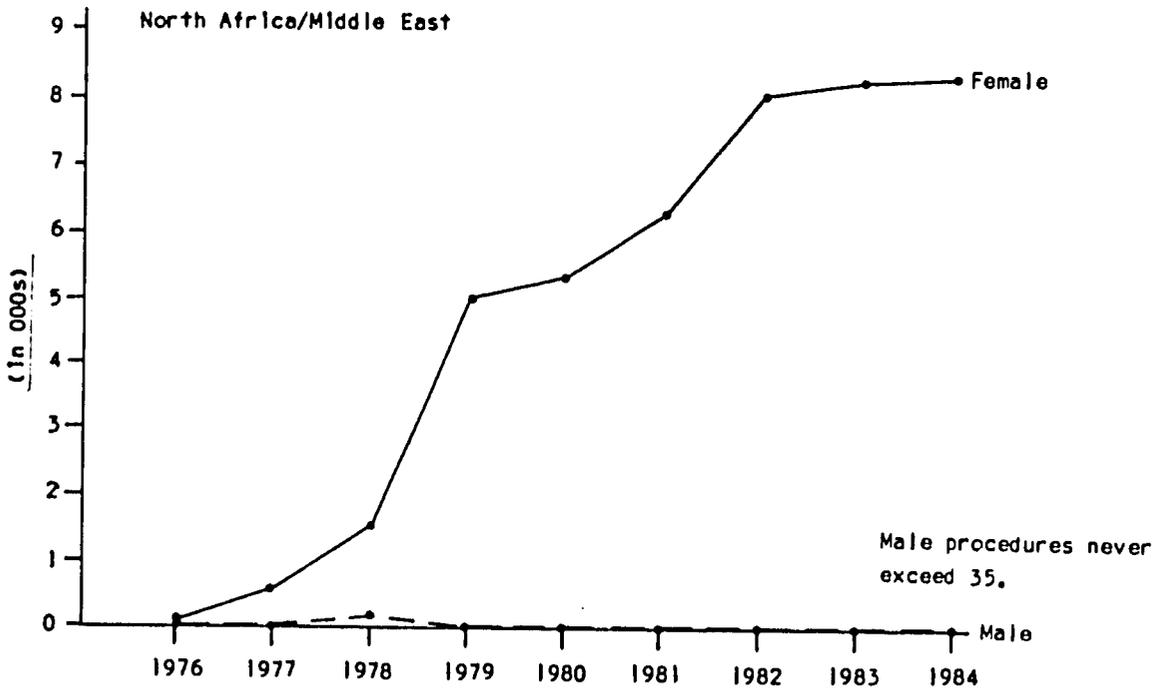
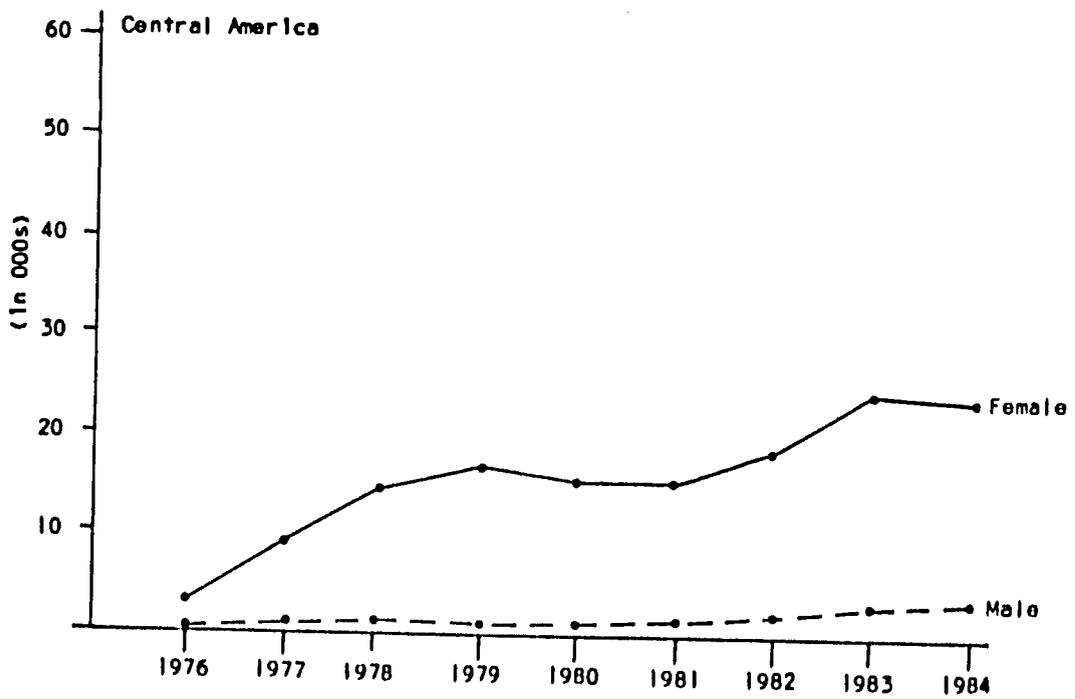
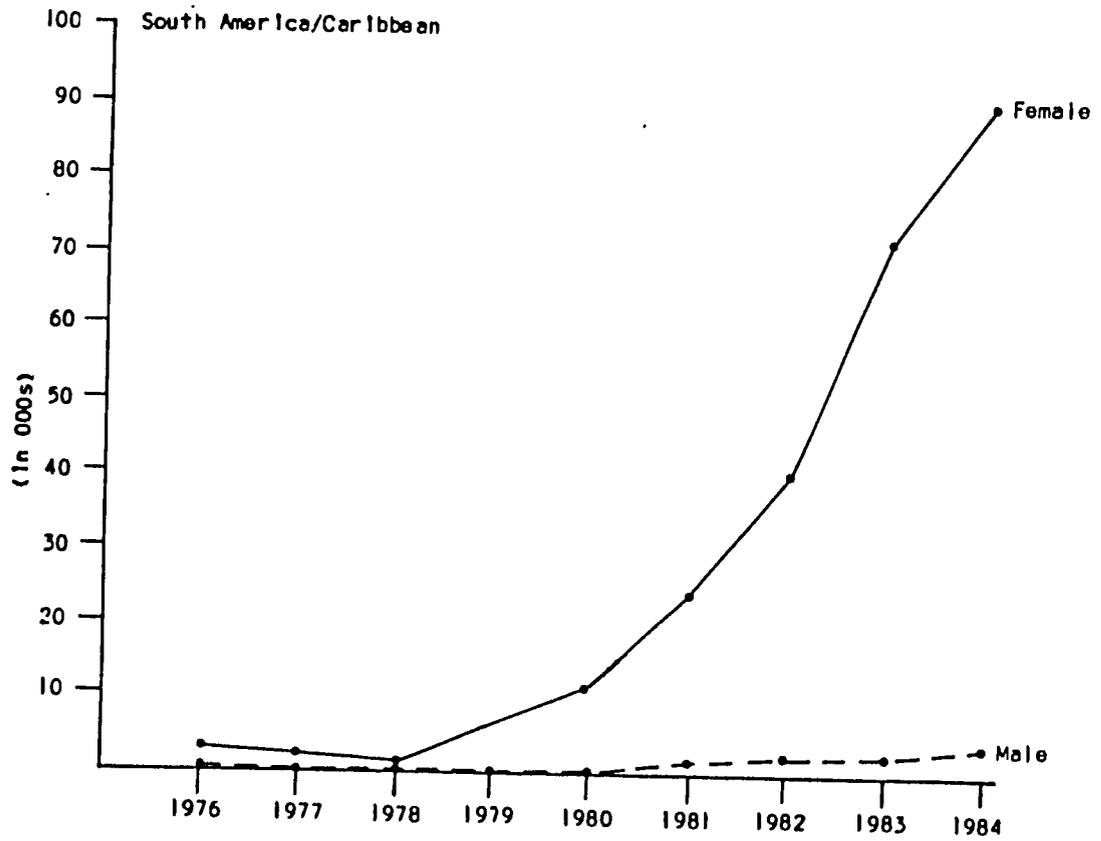


FIGURE 3.3 - continued



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The number of procedures reported by AVS projects often reflects the overall trends in VSC acceptance in their particular countries or regions. For example, reported procedures in Central America and South America have grown steadily, representing the success of AVS projects over many years in countries where governments, by and large, have not included voluntary sterilization in their national family planning programs.

On the other hand, in East Asia, the increase in total procedures reported by AVS projects has not been as dramatic as the phenomenal increase in the total number of procedures performed in the subregion. This is because nearly all governments in East Asian countries have accepted responsibility for VSC provision. Consequently, AVS projects in the area are emphasizing activities other than direct support of services. They are improving quality, introducing vasectomy, and supporting local leadership and policy-development efforts.

Brief commentary on the trends in reported procedures for each subregion follows.

*East Asia: This subregion is distinguished by two characteristics: the existence of national family planning programs and the official inclusion of voluntary sterilization as part of those programs in most countries. Quality issues such as safety and counseling are high on AVS's agenda in East Asia, whereas expansion of services is increasingly left to local and national programs. Nevertheless, Figure 3.3 shows an overall increase in the number of reported procedures, primarily because of the success of service-delivery projects in Indonesia and the Philippines, two countries in which services provided are still not approaching the demand.

*South Asia: The trends in this subregion are dictated by AVS's extensive support for the Bangladesh Association for Voluntary Sterilization (BAVS). The following is a summary of the major BAVS program accomplishments in 1984:

- ° The number of procedures performed increased by 50% over 1983; this is the largest annual increase since 1975 when services began.
- ° For the first time in its ten-year history, BAVS provided over 100,000 VSC procedures.
- ° For the first time and by a wide margin, BAVS provided more vasectomies (60,764) than female procedures (41,552).
- ° BAVS reduced the program's mortality rate to its lowest level ever.
- ° For the first time BAVS significantly reduced the cost per case.

- ° The BAVS nationwide service-delivery system grew to 34 clinics, with the completion at midyear of a nine-clinic expansion program.

A comprehensive report on the AVS-supported Bangladesh program is found in Appendix A.

Outside of Bangladesh, sizable and growing numbers of procedures are performed in Nepal by the Family Planning Association of Nepal (FPAN). FPAN performed over 20,000 procedures in 1984, approximately 8,000 with AVS funds and the remainder with funds provided by the government. As AVS becomes increasingly involved in Pakistan and India, a further rise in reported procedures may be expected for this subregion in future years. (See Figure 3.3.)

*Sub-Saharan Africa: The groundwork and seeding activities that AVS has supported in this subregion are slowly beginning to bear fruit. The number of procedures projected for 1984 accounts for more than half of the total number of procedures performed during the period 1976-1984 (see Figure 3.3). Most of these procedures took place in only a few countries, such as Nigeria, Senegal, and Mali. VSC is often provided at university teaching hospitals where it is offered as part of the routine services provided by obstetrics and gynecology departments. The governments of Kenya and Nigeria are now developing national family planning programs, and voluntary sterilization is becoming more and more acceptable to health-care professionals in those countries. Many hospitals in Kenya have waiting lists of up to 18 months for people requesting VSC.

The role of vasectomy is still insignificant in Sub-Saharan Africa, and will probably continue to be so for a while, as voluntary sterilization is often best introduced as a measure of maternal and child health care. In view of Africa's most pressing health concerns, male reproductive health care, if not considered an oddity, is still a luxury. It is therefore likely that vasectomy can only be introduced when there is general access to comprehensive family planning services, a situation that is not yet a reality in most African countries.

*North Africa and the Middle East: Over the last several years, AVS grantees in North Africa and the Middle East have reported steady increases in the number of procedures performed, although the pace has slowed during the past two years (see Figure 3.3). This plateauing is the result of two factors: (1) institutionalization of the VSC program in Tunisia, where the government is assuming more and more responsibility for the cost of procedures, and (2) the reduction of the number of training programs supported in Egypt. The number of procedures should increase in 1985 and beyond as new projects in Tunisia, Jordan, North Yemen, South Yemen, Sudan, and Morocco become established. All VSCs performed in this region have been female

procedures, reflecting cultural biases against male participation in family planning among professional service providers and the general public.

*South America and the Caribbean: In terms of numbers of procedures performed, AVS-supported programs in South America led the way, with a 1984 projection of 76,000 female VSC procedures, bringing the total number for 1976-1984 to over 200,000 procedures (see Figure 3.3). This accomplishment reflects AVS's firm support for a few very large and very successful service programs. The countries that have contributed most to this accomplishment are Colombia, Brazil, and the Dominican Republic, where AVS primarily supports private agencies. Achievements regarding vasectomy are just as promising, although not yet as impressive in absolute numbers. In this subregion the number of vasectomies has increased from 29 in 1976 to a projected 4,917 in 1984, bringing the total to 10,468 for the period. This increase is accounted for primarily by Brazil's PROPATER program which has greatly contributed to the accessibility and acceptability of male VSC services in that country and the subregion.

*Central America and Mexico: The growth in the total number of procedures in this subregion slowed in 1984, primarily because of service disruptions in Honduras and Guatemala where programs came under temporary political attack (see Figure 3.3). In addition, the civil strife in El Salvador had some negative impact on VSC services. These declines were somewhat offset by an increase in services in Mexico, where AVS-supported projects are maturing and gaining momentum. It is noteworthy that, despite the overall plateauing of reported procedures in the subregion, vasectomy showed a healthy increase in 1984. This is due primarily to Guatemala's APROFAM, which runs one of the most innovative and successful vasectomy programs in the subregion.

TRAINING AND PROFESSIONAL DEVELOPMENT

High-quality training of service providers is a critical precondition for the delivery of safe and effective voluntary sterilization services. Consequently, training of both physicians and nonphysicians is an important focus in AVS's global work. The following is a summary of some of the major indicators of training activity supported by AVS in 1984.

Subagreements

Physician training was the main emphasis of 10 subagreements awarded in 6 countries. In 8 other subagreements physician training was an important but secondary component. In addition, 10 small grants were awarded for training purposes.

Physician training

Over 800 physicians from 21 countries were reported to have been trained in AVS-supported projects in 1984. A summary of physician training accomplishments by country is presented in Table 3.2.

Health-support personnel training

The dedication and competence of the entire health-provider team, not only of the physician, is essential for delivering high-quality, safe services and for producing satisfied clients. AVS, therefore, supports training of program managers, nurses, midwives, counselors, technicians, and others. In 1984, a total of 1,243 health support personnel from 17 countries were reported to have been trained. Most of the training occurred in Asia.

Training resource development

AVS and its grantees took significant steps in 1984 to strengthen training resources at international, regional, and national levels. AVS's Medical Division recruited for a coordinator of technology and training, and the position was filled as of January 1, 1985. With AVS support, the World Federation organized and conducted in September 1984 an expert workshop to develop guidelines for physician training in surgical contraception; these standards will be published in 1985.

On the regional level, AVS further developed training capability. In 1984 the sites described below were identified as regional training centers for AVS:

- The National Training Center for Surgical Sterilization at Philippine General Hospital in Manila provides local-anesthesia minilaparotomy training for Asians and others.
- PROPATER, in Sao Paulo, Brazil, provides vasectomy training for Latin American physicians and can also provide training in English and French for physicians from other regions.
- APROFAM, in Guatemala City, Guatemala, accepts trainees in vasectomy and female sterilization techniques from Latin America.
- PROFAMILIA, in Santo Domingo, the Dominican Republic, accepts trainees in local-anesthesia minilaparotomy from Latin America.
- The Family Planning Association of Kenya accepts limited numbers of African physicians for training in local-anesthesia minilaparotomy.

TABLE 3.2: Summary of Reported Physician Training in AVS Projects by Country, 1984

| Trainees' Country | Type of Training | Number Reported Trained | Commentary |
|--|--------------------------------|-------------------------|--|
| <u>ASIA</u> | | | |
| Bangladesh | Minilaparotomy and vasectomy | 497 | Comprehensive and initial training for government and NGO physicians with emphasis on local anesthesia techniques; provided at the Bangladesh Association for Voluntary Sterilization. |
| Indonesia | Laparoscopy and minilaparotomy | 48 | 39 trained at Klinik Raden Saleh (KRS) in Jakarta. KRS is the last of five university-based training centers funded by AVS over the last several years; KRS will be funded by the Indonesian Family Planning Board (BKKBN) in 1985. 9 trained at Blitang Hospital, Palembang. |
| Philippines | Minilaparotomy | 28 | Trained at the National Training Center for Surgical Sterilization (NTCSS) at Philippine General Hospital. This premiere regional training center, which was supported by Family Planning International Assistance for several years, was in the second year of AVS funding in 1984. |
| <u>AFRICA AND THE MIDDLE EAST</u> | | | |
| Egypt | Laparoscopy | 65 | Trained at seven university-based medical centers; coordinated by the Egyptian Fertility Care Society. An additional 53 physicians received orientation to laparoscopy. |
| Kenya | Minilaparotomy | 11 | Trained at the FPAK in Nyeri. |
| Nigeria | Minilaparotomy | 7 | Trained at the University of Ife Teaching Hospital at Ile-Ife and Ilesha. |
| | Program Management | 1 | Trained at the University of North Carolina, Chapel Hill. |

TABLE 3.2: Summary of Reported Physician Training in AVS Projects by Country, 1984 (continued)

| Trainees' Country | Type of Training | Number Reported Trained | Commentary |
|--|------------------------------|-------------------------|---|
| <u>cont'd Africa/ Middle East</u> | | | |
| Somalia | Minilaparotomy | 2 | Ministry of Health physicians trained at the NTCSS in the Philippines. |
| South Yemen | Vasectomy | 1 | Physician from Al Gamhuria Hospital trained in Sri Lanka at Kandy General Hospital. |
| Tunisia | Laparoscopy | 20 | Indirect support of training program at El Ariana Clinic funded by JHPIEGO; AVS funded service component of the training program. |
| Uganda | Minilaparotomy | 3 | Trained at the FPAK Clinic in Nyeri, Kenya. |
| <u>LATIN AMERICA AND THE CARIBBEAN</u> | | | |
| Brazil | Minilaparotomy | 10 | Coordinated by BEMFAM; for physicians in the northeastern states of Ceara and Piaui. |
| | Vasectomy | 25 | Trained at PROPATER in Rio de Janeiro. |
| | Laparoscopy | 31 | Trained at BEMFAM in Rio de Janeiro. |
| | Minilaparotomy | 1 | Trained at Altigracia Maternity Hospital in the Dominican Republic. |
| Costa Rica | Minilaparotomy and vasectomy | 1 | Trained at APROFAM in Guatemala. |
| Dominican Republic | Minilaparotomy | 14 | Trained at Altigracia Maternity Hospital. |
| Ecuador | Minilaparotomy | 4 | 3 trained in Ecuador; 1 at PROFAMILIA in Colombia. |

TABLE 3.2: Summary of Reported Physician Training in AVS Projects by Country, 1984 (continued)

| Trainees' Country | Type of Training | Number Reported Trained | Commentary |
|---------------------------------------|--------------------------------|-------------------------|---|
| <u>cont'd Latin America/Caribbean</u> | | | |
| El Salvador | Minilaparotomy | 1 | Trained at Altagracia Hospital in Dominican Republic. |
| Guatemala | Minilaparotomy and laparoscopy | 5 | Conducted at APROFAM in Guatemala. |
| Haiti | Vasectomy | 3 | Conducted at PROPATER in Brazil. |
| Honduras | Minilaparotomy | 10 | Trained at the Social Security Hospital, Tegucigalpa. |
| Mexico | Vasectomy | 18 | Conducted at PROPATER in Brazil, at APROFAM in Guatemala, and at the Family Planning Association of El Oro. |
| | Minilaparotomy | 8 | Conducted at the National Institute of Nutrition and at the Family Planning Association of El Oro. |
| Peru | Minilaparotomy | 1 | Trained at PROFAMILIA in Colombia. |
| Nicaragua | Minilaparotomy | 1 | Trained at the ADN Model Clinic. |
| | | 816 | Physicians from 21 countries were trained in 1984. |

For the immediate future, AVS's biggest training challenge will be to identify and develop national and regional training centers for Sub-Saharan physicians. The most serious obstacle for the moment is the relatively low VSC caseload at eligible institutions, a fact which severely restricts the number of trainees that can be accepted.

Professional development activities

In addition to formal training activities, AVS encourages the professional development of all personnel who are involved with VSC programs. During 1984 AVS supported study tours, participation in conferences and seminars, guest lectures and demonstrations, exchange visits, and the publication and dissemination of relevant information and materials. Such activities stimulate interest, help to diffuse program and technical innovations, reward individuals and institutions for their efforts, and encourage the transformation of interest into commitment and action. Because most professional development activities do not require large amounts of financial assistance, small grants are the usual financial mechanisms to support such activities.

Several study tours were organized in both Latin America and Asia. Several physicians and program directors visited PROPATER's all-male clinics in Brazil; staff members of Brazilian private agencies visited PROFAMILIA in Colombia; and a physician from Ecuador spent a week at PROFAMILIA's Bogota clinic to be trained in laparoscopy. The doctors' study-tour program to Indonesia and Thailand, organized by the Bangladesh Association for Voluntary Sterilization, continued in 1984, with the same purpose of sharing experiences among colleagues.

A surgeon from the Dominican Republic, highly skilled in performing minilaparotomy under local anesthesia, conducted a two-week demonstration tour through Brazil in 1984. He generated great interest in the technique, as revealed by the many requests AVS has since received for further training.

During the Fourth National Convention on Voluntary Surgical Contraception, organized by the Philippine Association for the Study of Sterilization, Dr. John Fishburne, a U.S. expert on anesthesia for VSC, was a special guest speaker. In his address Fishburne emphasized the use of local anesthesia as an appropriate regimen for outpatient voluntary sterilization clients.

Several small grants were awarded to enable individuals to participate in national, regional, and international conferences and workshops. For example, the president of the Bangladesh Association for Voluntary Sterilization served as a national delegate to the World Population Conference in Mexico City in August. AVS also supported the attendance of two BAVS program and evaluation staff members at a course in Bangkok.

The Asociacion Panamena para el Planeamiento de la Familia, the IPPF-affiliate in Panama, conducted a minilaparotomy and vasectomy seminar in Panama City for 30 medical practitioners. AVS and the Pathfinder Fund collaborated in funding the travel costs of participants. The techniques were demonstrated by two experts from Colombia and Guatemala. The purpose of the seminar was to orient physicians from rural areas to these relatively simple techniques, and to motivate them to refer vasectomy clients to Santo Tomas Hospital in Panama City.

During 1984 AVS provided professional development assistance to several individuals in Africa. Health professionals from Algeria, Morocco, and Egypt received funds to attend the Second International Maternal-Child Health Conference in Tunisia. The University of Nairobi in Kenya received support for 34 Kenyan delegates to attend the National Conference on Reproductive Health held in August. Two Nigerian health professionals were sent to the United States to participate in specialized workshops.

Although the dissemination of professional literature to interested VSC providers around the world is predominantly a task of the World Federation (see Chapter 5), AVS supports the acquisition of relevant medical and professional journals where necessary. Furthermore, AVS's Medical Division publishes the Biomedical Bulletin which contains the latest information on topics related to the safety and quality of VSC service delivery. In 1984, one issue of the Bulletin, about open laparoscopy, was published; it was disseminated to all AVS grantees as well as interested professionals.

EQUIPMENT

The procurement, distribution, repair, and maintenance of equipment for VSC programs are not in themselves goals in AVS's global program, but they are essential ingredients for the uninterrupted performance of quality VSC services.

Equipment provision

During 1984, AVS distributed \$432,116 of medical, surgical, and audiovisual equipment, and medical commodities; \$200,691 of this amount was for major equipment items (see Appendix B). Almost all equipment (91% of the dollar amount) was provided through subagreements, with the remainder provided under small grants. The total funds expended in 1984 represent a decrease of nearly 43% from 1983. This decrease reflects the fact that, in those regions with established VSC programs, governments, bilateral donors, and multilateral donors are increasingly assuming the capital expenditures required to expand service-delivery capability.

As AVS shifts its attention to Africa, annual expenditures for equipment are expected to increase. For instance, in 1984 a large shipment of medical equipment was sent to the Government of Zaire to establish dedicated space for voluntary sterilization in medical centers located in nine cities. Because the basic health-care infrastructure in this region is weak, large capital investments in equipment will be needed to start VSC services. Also, expendable medical supplies are in short supply in many countries of the region; AVS will be called upon to satisfy these requirements in new projects until satisfactory solutions can be found.

Repair and maintenance (RAM) centers

Since 1976 AVS has supported RAM programs for endoscopic equipment in 14 countries. These centers keep delicate and sophisticated laparoscopic units in good working order so that service provision is uninterrupted. AVS encourages the institutionalization of these RAM centers, so that these programs can be made viable and enduring over the long run without AVS support, and so that AVS funds can be freed to support the provision of even more services throughout the world. AVS has been quite successful in this regard, as illustrated in Table 3.3. It should be noted that, although RAM centers may be institutionalized, AVS may continue to procure spare parts for them and provide technical assistance as needed. Table 3.3 summarizes the current status of RAM Centers ever funded by AVS.

Technical assistance

AVS provides technical assistance related to equipment provision by reviewing equipment needs and specifications, and by procuring required items. In 1984 AID awarded AVS a \$224,000 amendment to the cooperative agreement, to assist the Indonesian Family Planning Board (BKKBN) with equipment procurement. The details of this project are being developed. In addition, Indonesia is conducting an equipment needs assessment for 343 clinics and 173 regency hospitals; AVS is assisting with the needs assessment, equipment-specifications development, procurement, and shipping. A great deal of work has already been done to determine the specifications of the equipment that will be required. The magnitude of the project will depend on the final outcome of the needs assessment, which will indicate the specific requirements for each facility.

TABLE 3.3: Status of RAM Centers Ever Funded by AVS, as of December 1984

| Country | Institution | Current Funding Responsibility | Commentary |
|---------------------------------------|--|--------------------------------|--|
| Dominican Republic (Santo Domingo) | Consejo Nacional de Poblacion y Familia (CONAPOFA) | AVS | AVS supports the costs of spare parts and the salary of the equipment technician. CONAPOFA is being urged to assume funding responsibility for the center, possibly with USAID bilateral funds. |
| Egypt (Cairo and Assiut) | Egyptian Fertility Care Society (EFCS) | AVS | The centers are being reorganized due to changes in location and personnel that took place in 1984. Prospects for institutionalizing these centers in the near future are limited. However, as AVS has provided only a small percentage of the laparoscopic equipment in Egypt, it is seeking to transfer funding responsibility to either USAID/Cairo or JHPIEGO. |
| El Salvador (San Salvador) | Asociacion Demografica Salvadorena (ADS) | AVS | USAID/San Salvador has requested that AVS assume funding responsibility from JHPIEGO. AVS provided some spare parts in 1984 and will fund a technician and spare parts in 1985. |
| Guatemala (Guatemala City) | Asociacion Pro-Bienestar de la Familia (APROFAM) | AVS | AVS supports the technician's salary, operational costs, and spare parts. AVS expects to use both AID central and USAID/Guatemala bilateral funds in 1985 for this center. |
| Honduras (Tegucigalpa) | Asociacion Hondurena de Planificacion de la Familia (ASHONPLAFA) | AVS | AVS supports the technician's salary, operational costs, and spare parts. AVS expects to use USAID/Honduras bilateral funds to continue funding for this center in 1985 and beyond. |

TABLE 3.3: Status of RAM Centers Ever Funded by AVS, as of December 1984 (continued)

| Country | Institution | Current Funding Responsibility | Commentary |
|----------------------|---|--------------------------------|--|
| Indonesia (Jakarta) | Indonesian Association for Secure Contraception (PKMI) | Institutionalized, 1984 | The Indonesian government, with USAID/Jakarta bilateral funds, assumed funding responsibility in 1984. The program, managed by PKMI, encompasses a headquarters in Jakarta and seven satellite centers throughout the country. AVS will continue to procure the spare parts with bilateral funds. |
| Jamaica (Kingston) | National Family Planning Board (NFPB) | Institutionalized, 1984 | Through 1985 AVS will provide spare parts to NFPB for the Kingston RAM center, which was institutionalized by the Ministry of Health after four years of AVS funding. |
| Korea (Seoul) | Korean Association for Voluntary Sterilization (KAVS) | Institutionalized, 1982 | KAVS receives funding from the Korean government for the operation of this center. |
| Mexico (Mexico City) | Direccion General de Planificacion Familiar (DIPLAF) | AVS | The Mexican RAM Center is in a transitional period. PIACI of Mexico previously directed the center but was unsuccessful in institutionalizing it. The center is now being reorganized by DIPLAF of the Ministry of Health with AVS support and technical assistance. It is expected that DIPLAF will assume all costs after two more years of AVS funding. |
| Morocco (Rabat) | National Training Center for Reproductive Health (NTRH) | JHPIEGO | AVS provided initial support for the Morocco center. In October 1984 JHPIEGO assumed funding responsibility as the majority of laparoscopes in Morocco were donated by JHPIEGO. |

TABLE 3.3: Status of RAM Centers Ever Funded by AVS, as of December 1984 (continued)

| Country | Institution | Current Funding Responsibility | Commentary |
|-------------------------|--|--------------------------------|---|
| Nepal (Kathmandu) | Family Planning Association of Nepal (FPAN) | Institutionalized, 1984 | With USAID bilateral funds, the Government of Nepal now provides assistance to FPAN to manage RAM services in the country. AVS supported the center for three years; it will continue to procure spare parts for FPAN for the foreseeable future. |
| Panama (Panama City) | Asociacion Panamena para el Planeamiento de la Familia (APLAFA) | Institutionalized, 1982 | Using USAID bilateral funds, AVS continues to assist APLAFA with procurement of spare parts. |
| Thailand (Bangkok) | National Family Planning Program, Ministry of Health | Institutionalized, 1981 | AVS supported this RAM center with the Thai Association for Voluntary Sterilization until 1981 when it was transferred to the Thai government. JHPIEGO provides spare parts. |
| Tunisia (Tunis) | Office National du Planning Familial et de la Population (ONPFP) | JHPIEGO | Funding responsibility for this center was transferred from AVS to JHPIEGO in 1983. |

CHAPTER 4

ACHIEVEMENTS OF SPECIAL AVS PROGRAMS

In order to improve access to voluntary surgical contraception and quality of services, AVS is committed to being at the forefront of technical and programmatic improvements in VSC. From time to time special needs in VSC programs become apparent and must be addressed. In addition, initiatives must often be undertaken to overcome the inertia and complacency that develop in programs. In such cases, AVS identifies functional areas or themes that receive special attention. In 1984 AVS emphasized the following:

- Quality maintenance and assurance
- Voluntarism, counseling, and client satisfaction
- Management and development of financial resources
- Evaluation and research
- New technologies
- Vasectomy initiative
- Information and education programs

QUALITY MAINTENANCE AND ASSURANCE

Assuring and maintaining high-quality services are AVS's top priority. Achieving these aims offers the best guarantee that clients get what they come for: permanent and safe protection from pregnancy. Also, by pursuing these goals, programs have the greatest opportunity for success: satisfied clients speak positively about their experiences to others and, in countries where public funds are not yet available, authorities see that services are in demand, acceptable, and well-performed by qualified service providers.

AVS approaches the issue of quality assurance and maintenance from two sides:

- Preventive actions: AVS provides technical and financial assistance for high-quality training and professional education (see Chapter 3) and establishes medical standards by organizing expert meetings and developing manuals.
- Strict medical monitoring: AVS collects data, makes medical site visits, promptly investigates reports of death and serious complications, and takes immediate corrective actions as needed.

Developing medical standards

The successful Expert Committee Meeting on Safety, which was held in May 1983 in Manila, proved to be a highly useful instrument for developing norms to assure safety and quality of VSC services. The recommendations originated with specialists who are experts in various aspects of VSC delivery and who are familiar with the constraints that exist in many developing countries. The publication containing the committee's conclusions and recommendations has been disseminated to a large audience, enabling even the smallest programs to stay informed of the latest developments regarding safety and quality.

The example set at the Manila meeting has been followed in Central America. The first Latin American Workshop on the Safety of VSC Services was held in August 1984 in Guatemala. Participants came from Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, and the Dominican Republic. The workshop was sponsored by AVS and hosted by the Asociacion Pro-Bienestar de la Familia (APROFAM), an AVS grantee.

Participants made several recommendations covering a broad range of safety issues, such as pre- and postoperative care, anesthesia regimens, profile of the surgical team, and place of surgery. As a first step towards standardizing practices, the recommendations from this workshop will be disseminated within the region, with the aim of reducing VSC-related complications.

The publication and dissemination of recommendations related to safety and high-quality services do not need to be preceded by formal expert meetings. In Brazil private agencies have prepared two manuals to provide guidance. The Associacao Brasileira de Entidades de Planejamento Familiar (ABEPF) has produced a publication providing medical norms for VSC, which are essentially AVS's norms adapted to the Brazilian situation. Promocao de Paternidade Responsavel (PROPATER) has prepared a manual, with AVS support, describing how to organize a vasectomy clinic and how to take steps to insure high quality and safety of services.

The Indonesian Association for Secure Contraception (PKMI) has developed minimum medical standards for voluntary sterilization. PKMI has also helped to introduce VSC into the curriculum of 11 medical schools in Indonesia. As a result, the message of high-quality VSC services is being communicated more widely, particularly to a new generation of professionals. In Colombia the Asociacion Pro-Bienestar de la Familia (PROFAMILIA) is developing norms for service provision. This came about because AVS had observed that vital signs were not being appropriately monitored during and after surgery and that anesthesia procedures were sometimes done incorrectly. PROFAMILIA will use the norms to train medical and paramedical personnel.

In September 1984 the World Federation convened an international expert task force in Rio de Janeiro, to review VSC training practices around the world and to develop guidelines for surgical training programs. AVS expects the guidelines to serve as the authoritative reference for VSC training programs worldwide.

Monitoring

By carefully monitoring complications and deaths resulting from or related to voluntary sterilization, local programs, national programs, and AVS are able to take swift corrective actions whenever necessary. In 1984 AVS moved to further systematize and standardize monitoring procedures.

In June the Statistics Committee of the World Federation met in London to develop a model framework for recording, reporting, and analyzing medical information related to VSC. As a result of the guidelines suggested by the Statistics Committee, several AVS-supported programs began developing research or pilot programs designed to improve their medical monitoring activities. Many of these initiatives will be funded and implemented in 1985.

In Sub-Saharan Africa groundwork is being done to improve monitoring. The Kenya Protestant Churches Medical Association will implement a quality-assurance data collection system along with its service project. The system is based on the work of the World Federation's Statistics Committee.

Complication and mortality monitoring is one component of an 18-month grant to the Sri Lanka Association for Voluntary Surgical Contraception (SLAVSC). The program is finalizing a questionnaire on complications and deaths that will be distributed to all government and nongovernment service sites in the country in 1985.

The Family Planning Association of Nepal has begun evaluating 1983-1984 services, to determine with greater accuracy the extent and nature of VSC-related complications. Late in 1984 a quality-assessment team was organized to visit VSC mobile service sites and to monitor compliance with program, medical, and voluntarism standards.

In 1985 in the Dominican Republic, AVS expects to support a pilot program to monitor complications and deaths resulting from VSC.

In 1984 the Sierra Leone Association for the Management of Infertility and Fertility (AMIF) received a small grant to begin developing a national VSC data collection system.

*Mortality surveillance: All reported fatalities in AVS-funded programs are thoroughly investigated by AVS so that those attributable

to VSC can be identified and followed up. Three VSC-attributable deaths were reported in 1984, compared to eight in 1983. (At the time the AVS report for 1983 was written, some deaths were still under investigation, and one had not yet been reported.) The deaths in 1984 occurred in Bangladesh, Colombia, and Brazil, countries which have very large caseloads. All 1984 deaths followed female voluntary sterilization, yielding a mortality rate of 1.5 deaths per 100,000 procedures. This low rate reflects the efforts made, particularly by large programs, to improve safety and to provide high-quality services. It also reflects, to some extent, the underreporting inherent in any such surveillance system.

The death in Bangladesh occurred 12 days after a minilaparotomy procedure. The presumptive diagnosis was bowel injury, and the cause of death was septic shock. Delay in appropriate treatment of the complication was apparently a factor, as the Bangladesh clinic was not informed of the illness until three hours before the client expired. At a medical site visit in February 1985, AVS reviewed the case and made recommendations regarding client follow-up.

The death in Colombia resulted from cardiac arrest following the administration of a muscle relaxant as an anesthesia supplement. It occurred during a minilaparotomy procedure in a mobile clinic setting. Appropriate emergency measures were taken but were ineffective. Although the death was attributable to VSC, it was not deemed preventable. At a subsequent medical site visit, AVS reviewed the program's practices and made recommendations regarding safe anesthesia regimens.

The death in Brazil was reported in March 1985 and is still under investigation. The physician did not initially report the fatality because it occurred before surgery. The death was related to anesthesia, perhaps in combination with an underlying heart condition.

*Review of complications: All 372 complications reported in 1983 (306 female and 66 male) were reviewed by staff during June 1984, and suggestions for improved care were made when appropriate. The complication rates of 0.19% for female procedures and 0.12% for vasectomies are lower than many reports in the medical literature. (Underreporting of complications is suspected.) The most commonly reported complication for female procedures was pregnancy after VSC (89 intrauterine and 1 ectopic); wound infection was the second most prevalent with 21 reports of complications. The most common complication for vasectomy was hematoma (23) followed by wound infection or abscess. In order to differentiate luteal pregnancies from surgical failure, AVS's Medical Division is revising the current reporting form for complications.

During medical site visits made during the year, AVS medical staff found that the type of uterine elevators being used may be adding to the risk of uterine perforation. Arrangements are under way to supply shorter-tipped, safer uterine elevators. It was also learned that some programs underreport complications or fail to report them. Program directors have been contacted and encouraged to improve

reporting. At the time of this writing, a total of 410 complications had been reported for 1984. Analysis of all 1984 complications will be done in 1985, after all reports have been received from the field.

VOLUNTARISM, COUNSELING, AND CLIENT SATISFACTION

Voluntarism and informed consent

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

*Monitoring informed consent: All subagreements for service programs contain explicit requirements about voluntarism and informed consent. During field visits AVS routinely monitors compliance with these requirements. In some cases program staff also play a monitoring role. For example, in Bangladesh, BAVS regional medical supervisors, internal auditors, and the counseling coordinator routinely oversee the quality of counseling and randomly check informed consent forms.

AVS reacts promptly when it receives reports that AVS-supported programs are using coercion to increase the use of VSC. For example, early in 1984, reports in the American press accused the program in El Salvador of using coercive methods. An outside consultant and AVS staff members investigated the program and concluded that the allegations appeared to be false. Despite these reassuring conclusions, AVS took the additional step of commissioning a special follow-up survey to determine if women who had been sterilized were knowledgeable about the procedure and had given informed consent. This action illustrates how seriously AVS treats reports of coercion. The survey has been conducted by the Center for Latin American Studies at Tulane University. Results show that clients are very satisfied with their choice of voluntary sterilization, including the surgical procedure itself, and that they chose VSC because it is widely known, culturally acceptable, and highly reliable. The survey did note some administrative problems with the documentation of informed consent in some sectors of the program; corrections are now being made.

During the year the regional office in South America received a report that clinics in Colombia were failing to fully document VSC procedures and that signed consent forms were missing in some cases. The Bogota office responded by closely monitoring procedures and records at 15 clinics. The problem was pinpointed to one particular clinic which operates as a referral point and which has routinely returned client folders, including signed consent forms, to the

referring institutions. To prevent similar problems in the future, the clinic will keep copies of all documents that are returned.

A special investigation was held at one AVS-supported clinic in Brazil to determine "the factors that affect approval for and follow-through of female sterilization among new clients at a family planning clinic." The investigators found that, after three months, only 50% of all women requesting VSC had undergone surgery. The study indicates that clients at this particular clinic choose voluntary sterilization of their own free will, but that surgery is performed only after approval by clinic personnel and a waiting period.

Counseling initiatives

To insure that prospective clients fully understand the nature of the operation they are about to undergo, thorough preoperative counseling is required for all individuals requesting voluntary sterilization. For this reason, most AVS-supported service programs incorporate some type of counseling into their daily routines. In 1982 AVS began to actively assess the need for counseling and to explicitly program for it. In October 1983 AVS sponsored a highly successful counseling workshop for Asian VSC program managers. As a result of this event and of subsequent follow-up by AVS regional staff, AVS began a significant number of counseling initiatives in 1984:

- ° The Indonesian Association for Secure Contraception (PKMI) has started a counseling training program for 144 nurses and midwives in Indonesia. A national steering committee is planning, implementing, and evaluating a counseling program for VSC services and is developing and designing curriculum and materials.
- ° The Family Planning Association of Nepal (FPAN) convened an interagency task force on counseling, the first group of its kind in Nepal. The task force developed counseling standards and a plan of action, which were presented at a national counseling seminar funded by AVS.
- ° The Philippine Association for Surgical Sterilization (PASS) has developed a detailed plan for several counselor training workshops throughout the country. PASS is also working to establish a national committee on counseling for the Philippines, which will be responsible for formulating policies about VSC counseling and for developing training materials.
- ° In Malaysia AVS has developed a counseling training project in collaboration with the government.

- ° In Sri Lanka the first national counseling seminar was held in Colombo in May 1984. The meeting produced a national counseling policy.
- ° A similar national seminar was organized in late 1984 in Thailand, also with the purpose of developing a national counseling policy. Early in the year the Thai Association for Voluntary Sterilization (TAVS) organized a workshop for administrators and staff from 10 district hospitals, to orient them to the basic principles and techniques of patient counseling and to plan how to introduce counseling into the hospital system.

Intensified counseling activities have not been limited to Asia. In Latin America AVS examined the quality of counseling in various programs throughout the region and demonstrated to program directors the importance of specialized counseling systems as integral components of VSC service delivery. Brazil took the lead by organizing, with the support of AVS, two training courses for physicians, psychologists, nurses, social workers, and educators. The courses generated such a demand for additional training that a third course was organized at the end of the year, with the support of Development Associates.

During the last quarter of 1984, AVS staff took a closer look at PROFAMILIA's counseling procedures in Colombia. Although the assessment is not fully completed, preliminary results indicate that there is a definite need to reinforce PROFAMILIA's counseling capacity.

In 1985 AVS will continue to emphasize counseling. In Africa two major counseling training events are planned. The Family Planning Association of Kenya will train counselors in its AVS-supported projects. In Nigeria the Fertility Research Unit of University College Hospital in Ibadan will also train its counselors working in AVS programs throughout the country. Two regional workshops, organized along the lines of the workshop that was held for Asian program managers in 1983, will take place in Latin America. A number of national counseling workshops are scheduled in several Asian countries.

Client follow-up surveys

Although VSC acceptance has increased dramatically in many countries in the world, little is known about clients' motivation for choosing voluntary sterilization or about their satisfaction with, and understanding of, the surgery. To learn more about these very important issues, AVS is funding follow-up surveys of female VSC clients in five developing countries: Bangladesh, Colombia, El Salvador, Indonesia, and Tunisia. The criteria for site selection were AVS's experience in the country, a relatively large caseload, well-developed technical ability required to undertake the survey, and an interest by the local implementing agency in the results of the study.

The country surveys are based on a core questionnaire developed by AVS. Sample sizes range from 600 to 1,500 female clients, and interviews take place during the client's follow-up visit to the clinic or hospital seven days after surgery. Two of the five surveys have been completed (in El Salvador and Tunisia); two surveys are currently being conducted (in Bangladesh and Indonesia); and one survey is in its final stage of preparation (in Colombia).

Although much more data will be collected and analyzed, preliminary results from El Salvador, Tunisia, and Bangladesh indicate the following:

- Motivation: The desire to cease childbearing was the most frequently mentioned reason for choosing voluntary sterilization. Economic and health reasons were the second and third most frequently named reasons.
- Information sources: Relatives, friends, and neighbors were the main sources of information. Previously sterilized women were important to confirm information the client had received.
- Other family planning methods: Almost all women in the El Salvador and Tunisia surveys knew about other family planning methods. In addition, over 60% of the women in both countries had used other methods before choosing voluntary sterilization.
- Decision making: Although most husbands had been consulted beforehand and had expressed favorable attitudes toward VSC, most women made the final decision themselves.
- Characteristics of the women: In El Salvador the women's average age was 28.2 with 3.4 children, while in Tunisia women were 36.2 years old with 6.1 children.
- Quality of services: Almost all of the women in the El Salvador survey felt that the quality of services was good; three-fourths of the Tunisian respondents felt the same way.
- Satisfaction: Most of the women were satisfied with the operation, mainly because of relief from anxiety about pregnancy. Most also said that they would recommend voluntary sterilization to other women.

Clinic management

Now that services have been established in many countries, AVS is placing less emphasis on expansion of services, particularly in Asia; more attention is being given to quality of services and effective management of clinics. The goal of better serving the needs of clients will become more and more important in the future.

With the help of a relatively simple tool, patient flow analysis (PFA), clinic directors can observe how their daily or weekly case-loads are handled. PFA reveals if staffing patterns follow the demand for services. This is particularly important in clinics or hospitals (1) where clients tend to arrive in clusters at particular times of the day or week and (2) which serve populations engaged in seasonal labor, resulting in fluctuations in demand at different times of year. For example, in Bangladesh the demand for VSC increases sharply during times of low agricultural activity. Although patient flow analysis is not yet common in either family planning or VSC programs, it may well become an important tool, helping AVS staff and program personnel to solve management problems. Late in 1984 AVS program staff in New learned about PFA techniques in a two-day in-house seminar.

MANAGEMENT AND DEVELOPMENT OF FINANCIAL RESOURCES

The time has passed when financial resources for family planning programs exceeded demand or the ability to absorb them. The efficient management of resources has emerged as a priority concern. This concern will become more important as funding dwindles, as interest in, and competition for, resources increases, as the need for self-sufficiency becomes more pressing, and as the effects of efficient management become clearer to program managers. In 1984 AVS addressed this concern in several ways.

Effective financial management

Improving the effectiveness of financial management is an important way to enhance the productivity and impact of a VSC program, and to increase the prospects for the long-term viability of the program. AVS staff stimulate financial-management improvements by carefully planning, by monitoring programs constantly, and by providing specific technical assistance, when needed.

***Planning:** Proposal negotiation and development provide the first opportunity for AVS staff to assess the financial-management abilities of the prospective recipient. During this period AVS determines the adequacy of the applicant's accounting and financial-control systems and of financial staff. Funds for additional staff or other resources may be included in the proposed budget; or AVS may recommend special technical assistance. Proposed budgets are meticulously negotiated with every budget line justified and explained as to its need, appropriateness, composition, and reasonableness.

In 1984, AVS accelerated its reliance on multiyear subagreement programming, a comprehensive program-planning system that includes the development of a financial plan for the entire duration of the program. The essential elements of a financial plan are a description of the program's total costs (planned expenditures) for each year and an

outline of income the program plans to receive from all sources. In addition to AVS's contributions, income estimates from the local institution, the government, other international donors, and project activities must be included. In most cases AVS expects to reduce its contribution as the program becomes increasingly self-reliant and funded from local sources. Such multiyear financial planning helps AVS to identify the true costs of a program and to establish early in the grant process that it expects projects to become institutionalized.

*Monitoring: Once a subagreement is awarded and a project becomes operational, AVS continually monitors the financial-management health of the program. This is done primarily through (1) on-site visits by staff members, (2) review and analysis of periodic financial reports, and (3) end-of-project-year audits. Accounting and financial control systems are examined during site visits. In 1984 the Finance and Administration Division drafted the Financial Management Review Checklist to be used by AVS program staff to identify weaknesses and potential problems. This checklist was introduced in August 1984 at the annual program development meeting and is being tested and refined.

By studying financial reports from recipients, AVS staff members have frequent opportunities to review the adequacy of financial management of programs. Incorrect or incomplete reports, persistently delinquent reports, over- and underexpenditures, unauthorized expenditures, and cash-flow difficulties are all indicators of potential problems that are followed up by program and financial staff. An AID management audit of AVS on May 17 and 18, 1984, found AVS's systems for reviewing financial reports to be generally acceptable. The auditor did recommend some modifications, which will be implemented in 1985.

Audits are the third major way to monitor financial management. Audits of projects by independent auditors are routinely commissioned at the end of each project year. Both financial and program staff of AVS review the audit reports; any problems are followed up. In 1984 AVS made several improvements in its subagreement audit systems. For example, audits are now commissioned earlier, so that they begin as soon as possible after the termination of the subagreement year. Guidelines for AVS-appointed auditors have been revised, and overall audit procedures have been modified to include a joint audit review by program and financial staff.

*Technical assistance: In some cases programs require special technical assistance in financial management. Preproject planning may reveal a special need, or staff members may identify problems while visiting programs, reviewing financial reports, or examining audit findings. The number of technical-assistance efforts increased significantly in 1984 as AVS began placing increased emphasis on sound financial management. In 1984 special assistance was provided to projects in Bangladesh, Indonesia, Sierra Leone, Uganda, Brazil, and Paraguay.

In Bangladesh AVS worked closely with the Bangladesh Association for Voluntary Sterilization (BAVS), to increase cost-effectiveness and to improve overall financial management. BAVS manages an annual budget of over \$3 million from AVS and Bangladeshi government grants. Steps taken by BAVS in 1984 included the following:

- ° Recruiting a highly qualified finance manager
- ° Improving local clinic management by appointing a local project director at each of BAVS's 34 clinics
- ° Revising BAVS's staffing formula for clinics
- ° Developing a comprehensive, standardized accounting manual and procedures for all clinics
- ° Introducing flexible budget-reallocation procedures so that clinics can respond more efficiently to variations in local demand for voluntary sterilization
- ° Simplifying and standardizing budget procedures
- ° Improving logistics management by developing a centralized, less costly system for procurement, warehousing, and distribution of medical supplies.

In Indonesia AVS-commissioned audits revealed financial-control problems that required technical assistance visits by financial and program staff. As a result of these visits, the grantee made changes in systems and staffing. In October 1984 an international audit firm conducted a week-long special review commissioned by AVS; this review led to further improvements and recommendations. By the end of the year, the grantee had substantially improved its financial management systems, was consolidating its various programs for more efficient management, and had positioned itself to assume more responsibility within its national context.

In Sierra Leone and Uganda, AVS program staff, working with the Finance and Administration Division, selected local audit firms to assist subgrantees in developing accounting and financial-control systems. Preproject financial-management surveys were arranged for programs planned in Brazil and Paraguay. In Brazil the purpose of the survey was to determine whether the potential recipient, a relatively young institution, was capable of managing a large multisite program with affiliated local institutions.

VSC cost analysis

By clearly understanding the costs of delivering VSC services, AVS and its subgrantees can develop more efficient and effective VSC

programs. Unfortunately, determining VSC costs is neither straightforward nor easy. And, because cost determination and analyses vary from one program to the next, it is difficult to compare costs among programs. Nevertheless, an appreciation of cost is essential for good program management and financial planning.

A number of concrete steps were taken in 1984 to better understand VSC costs. Program staff were instructed to document more carefully the cost components of VSC service projects. AVS evaluation staff began developing a checklist of cost components for a VSC procedure, to guide program staff in identifying and evaluating cost items. An operations-research grant was awarded to PROFAMILIA in Colombia to study the most cost-effective way of delivering VSC services. AVS collaborated in a similar effort in Guatemala where a USAID-funded evaluation of APROFAM's national VSC program examined the cost-effectiveness of various service-delivery modes. The results of the PROFAMILIA and APROFAM studies will be available in 1985. These and other approaches to VSC cost questions will be pursued in 1985.

Self-sufficiency

In 1985 AVS will accelerate its efforts to improve the self-reliance and local financing of VSC programs. Planned activities include carefully studying and analyzing successful local financing schemes, developing case studies for use by AVS staff and grantees, and establishing better guidelines for multiyear financial plans for AVS staff and grantees.

EVALUATION AND RESEARCH

Evaluation and research are indispensable tools in developing cost-effective, efficient, and acceptable VSC programs.

Evaluation

During the proposal-development process, AVS's evaluation staff in the Medical Division provide technical assistance to insure that the project proposal contains proper evaluation mechanisms. Program staff informally evaluate the progress and impact of programs by reviewing quarterly reports and making site visits. In some instances outside consultants conduct formal evaluations, often at the request of USAID, as in El Salvador and Guatemala in 1984. In El Salvador, the evaluation focused on the policies, organization, and implementation of the program; its impact from social, demographic, and health perspectives; and the effect of civil strife on program implementation, quality of services, and client satisfaction. The results indicate that, despite the adverse circumstances under which the

program operates, it is one of the best in Latin America, and clients are satisfied with the quality of services. Results of the evaluation in Guatemala will be available in 1985.

Research

The need for more research on the social and psychological aspects of VSC led AVS to establish a social science research-grant program. Three studies were funded with private funds in 1983, and two of these were completed during 1984. The first study, "The Status and Potential for Contraceptive Sterilization in Egypt" by Dr. A. Tsui, examined knowledge of VSC, attitudes regarding its safety and reliability, potential demand, and potential demographic impact. The study found that, despite some gaps in public information regarding health risks and reliability, attitudes toward VSC were generally favorable, especially among the underprivileged sectors of the population. Religious attitudes at the grassroots level did not have a negative effect on attitudes towards VSC. The study strongly suggests that, if current restrictions on VSC are eased, service delivery should be accompanied by a well-designed and well-implemented health education program aimed at both husbands and wives.

The second study, "Husband-Wife Characteristics and the Decision for Voluntary Sterilization" by Dr. F. Bean, investigated (1) the socioeconomic and demographic determinants for choosing or not choosing VSC, (2) the socioeconomic and demographic determinants for choosing male or female VSC, and (3) the process underlying sterilization decision making in the United States. The results challenge earlier assumptions that female participation in the labor force has a positive influence on the choice for VSC. The data also showed considerable regional differences in the acceptance of voluntary sterilization.

The third study, "Couple Decision Making and Sterilization" by Dr. W. Miller, is an in-depth, descriptive, hypothesis-generating effort which seeks to enrich our understanding of how married couples go about making their decision. This study will be completed in 1985.

Voluntary Sterilization: An International Fact Book is nearing completion, and publication is expected in the summer of 1985. It will be the first work of its kind ever published on VSC. The fact book draws together much of the statistical literature on voluntary sterilization, including historical data and the most current information for the entire world. AVS expects the fact book to be used by national family planning programs, donor agencies, researchers, the media, and the interested public. The book should clarify both the actual and potential role of VSC.

AVS and the Centers for Disease Control are conducting a joint study about the safety of vasectomy; the project is privately funded.

The objective is to document the short-term incidence of minor and major complications after vasectomy. Epidemiological data are being collected on the number of procedures, service locations, and type of procedures. Survey data are now being collected, and a report is expected in 1985.

In 1984 the regional office in South America supported two small research projects in Colombia. The first project, undertaken in collaboration with PROFAMILIA, is investigating the cost of VSC services at PROFAMILIA clinics. Cost comparisons will be made between such variables as minilaparotomy versus laparoscopy, small versus large clinics, and local versus general anesthesia. The results of this investigation will provide information to AVS and PROFAMILIA as they move the program toward self-sufficiency. The research may also provide data about the relative costs of various service-delivery mechanisms for other programs in the region.

The second investigation in Colombia is being conducted by the Corporacion Centro Regional de Poblacion (CCRP). Researchers are systematically analyzing the large body of data on VSC that have been collected over the years. The hypothesis of the study is that voluntary sterilization is not a recent phenomenon in Colombia, and that private physicians and public hospitals were offering services long before family planning programs came into existence.

NEW TECHNOLOGIES

In keeping with AVS's effort to improve the quality of services, the Medical Division closely follows new developments in medical technologies and techniques. Particular emphasis is given to those innovative methods that are most appropriate for AVS's programs; an assessment is made of their acceptability, cost-effectiveness, and safety.

In 1984 the Medical Division established the position of coordinator of technology and training; responsibilities include familiarizing international program staff with new developments, introducing new technologies and techniques into AVS programs, and assessing their potential. The coordinator will play an active role in disseminating information to field offices and in working with New York staff to insure a sound, centrally designed introduction and assessment process. As the technologies become more familiar to program managers and project directors, they will assume greater responsibility for further introduction activities.

This new position will allow AVS to coordinate training activities and to evaluate important programmatic issues related to new technologies.

Norplant

AVS's Science Committee has reviewed the current status of this long-acting contraceptive and its potential role in AVS programs. The committee has approved pilot use of Norplant in AVS programs once the contraceptive is officially approved by a recognized drug regulatory agency or by the World Health Organization. The World Federation, as well as staff members in the regional offices and at the New York headquarters, favor introducing Norplant on a pilot basis in selected AVS programs. AVS medical and program staff have had several discussions with the Population Council and other international organizations about the use of this new contraceptive in family planning and VSC programs.

Because careful surgical technique is required to insert and remove the implants, it is logical to pilot test Norplant in AVS programs. Moreover, the implants are long acting and highly effective, almost as effective as voluntary sterilization. Because of these characteristics, Norplant is a particularly promising alternative for women who want no more children but who, for one reason or another, do not elect VSC.

In 1985 AVS plans to train medical and program staff in the clinical and programmatic aspects of Norplant programs. Proposals for pilot projects utilizing private funds may be developed during the year.

Electrocautery for vasal occlusion

AVS's Science Committee has encouraged staff to explore the use of electrocautery for vasectomy. Current information from the United States suggests that electrocautery may be the most effective method of vasal occlusion. Instruments for either needle electrocautery or the hot wire technique are used to cauterize the lumen of both ends of the divided vas. At present, the most common vasectomy technique in AVS programs is ligating the cut ends of the vas. Efforts are now under way to identify suitable equipment and to determine instrumentation needs in programs. Assessment of training needs and of the technique's effectiveness will be important elements in any pilot electrocautery programs.

Clips for tubal occlusion

The Science Committee has also encouraged AVS to explore the use of clips for female sterilization. Because the clip damages only 3 to 4 mm of the tube, the chances for reversal are increased (by contrast, the Pomeroy technique and the Falope-Ring damage 2 to 3 cm of the tube). Clips may also have some additional advantages in terms of safety. AVS is especially interested in the Filshie clip, which is

widely used in the United Kingdom and several developing countries, but it has not yet been approved by the Food and Drug Administration (FDA). Specific advantages of the Filshie clip are the following:

- The clip may be applied through a minilaparotomy incision or through a laparoscope.
- Because the clip can accommodate enlarged as well as normal-sized tubes, it is suitable for postpartum application.
- The application equipment is durable.

AVS is collecting information on clinical experiences with the clip in various countries and will be exploring the acceptability and suitability of the Filshie clip among service providers. The Science Committee has recommended that the clip be used in AVS programs after FDA approval but that the contraceptive effectiveness of the device be carefully assessed.

Training for modified techniques

Training is required not only when new technologies are introduced but also when current techniques are modified to improve safety, effectiveness, and acceptability of VSC. For example, refined minilaparotomy techniques using local anesthesia with lighter sedation and smaller incisions may well increase client satisfaction and safety, and reduce costs. However, surgeons in many programs need additional skills to perform such techniques. To improve the effectiveness and safety of procedures, AVS continues to stress clinical training even in mature VSC programs.

Operational research

Whenever new technologies are introduced, evaluation should be incorporated in a way that is useful for program administrators and managers. Toward this end AVS's evaluation and research staff develop criteria to measure acceptability, safety, contraceptive effectiveness, and cost-effectiveness.

VASECTOMY INITIATIVE

In 1982 AVS launched the Vasectomy Initiative by offering financial support for new vasectomy programs to over 600 health leaders and organizations throughout the developing world. The purpose was not so much to correct the imbalance between male and female sterilization procedures (an estimated ratio of 1 to 5) but to challenge health professionals, family planning administrators, and international donor agencies to address an unmet need.

As a result of the AVS offer, over 60 individuals and organizations from 37 countries responded in 1983, requesting technical assistance and almost \$2 million in funds. Program staff scrutinized all requests and awarded over \$500,000 to 10 new vasectomy projects in nine countries.

The momentum generated by the initiative in 1983 continued during 1984:

- ° Ten more subagreements were awarded for vasectomy-focused projects in Mexico, Egypt, the People's Democratic Republic of Yemen, the Philippines, Indonesia, Sri Lanka, and Thailand. The goal of four of these projects is to inform and educate men; five are focusing on vasectomy services; and one is emphasizing training.
- ° Six small grants were awarded for vasectomy-related activities such as I&E materials, surveys, training, and counseling.
- ° The total amount of obligations for vasectomy projects in 1984 was \$739,089, more than was obligated in 1983.

In addition to these vasectomy-focused projects and small grants, AVS signed another 24 subagreements that included vasectomy services along with female services. In 1984, 41% of the total AVS subagreements included male services, as compared to 34% in 1982. The effects of this rising percentage can be seen in the increasing number of vasectomies that were reported by AVS programs in 1982 and 1983 and that are projected for 1984.

Another encouraging and significant outcome of the Vasectomy Initiative is that vasectomy has been introduced in several "first-time" countries which in the past showed no interest in vasectomy. For example, in Latin America, supposedly a region in which male-dominant attitudes are strong and men fiercely resist vasectomy, AVS supports vasectomy programs in Brazil, Costa Rica, the Dominican Republic, Haiti, Honduras, Mexico, Nicaragua, and Panama. In Africa south of the Sahara, where governments oppose family planning programs in general and sterilization especially, and where many people are unaware of modern contraceptive methods, Kenya, Mauritius, and Uganda each have a program that provides vasectomy among other services.

The following examples, one from each region, illustrate some of the vasectomy programs supported by AVS.

- ° Mexico: Under a subagreement awarded to Promotora de Planificacion Familiar (PROFAM), AVS is supporting the publication of a special vasectomy issue of a popular comic book for men, Los Supermachos. This highly interesting, easy-to-under-

stand publication will be distributed for free through pharmacies, family planning programs, and health clinics in Mexico and in neighboring countries. AVS and PROFAM believe this booklet will help dispel rumors and correct misconceptions about vasectomy.

- ° People's Democratic Republic of Yemen: In 1984 AVS awarded a grant of \$35,000 from private funds to the Al-Gamhuriya Hospital in Aden, to support dedicated space and equipment to serve 500 vasectomy clients. This grant will allow the hospital to satisfy a demand for vasectomy that the currently inadequate service facilities cannot meet. The popularity of vasectomy among Yemen's male population is quite unusual for the region; it is undoubtedly related to the hospital staff's interest in vasectomy and their several years of experience providing services. Indeed, Yemen's experience is likely to yield useful lessons for many of its neighbors.
- ° Thailand: The Population and Community Development Association (PDA) has long been in the forefront of Thailand's vasectomy program. Its innovative and sometimes nontraditional approaches have often provided successful models for both the public and private family planning sectors. For example, PDA has developed highly successful models for delivering vasectomy services to rural and urban populations through fully equipped mobile service units and day-long vasectomy camps on special occasions.

In 1984 AVS provided support to PDA to establish two family planning information centers in Bangkok, where low-income working men can obtain information, counseling, and high-quality vasectomy services in the evening hours. These centers, manned by trained staff, are likely to satisfy a long-standing unmet need in the densely populated urban areas of the city, where many men do not have time during working hours to visit vasectomy clinics.

In 1984 AVS recipients reported performing an estimated 66,382 vasectomy procedures. This figure exceeds the 54,324 procedures reported for 1983, suggesting the continuing impact of the AVS Vasectomy Initiative.

The AVS Vasectomy Initiative will be continued indefinitely as a way to focus the world's attention on the potential role and contributions of vasectomy services in comprehensive family planning programs. By the end of 1984, six new vasectomy proposals from Indonesia, Pakistan, the Philippines, and Sri Lanka were under development, and AVS was working on several additional proposals for 1985.

During 1984 AVS took the lead in drafting Guidelines for Vasectomy Programs, a World Health Organization manual. As of this writing, the manual is still being developed, with worldwide distribution planned for 1986.

INFORMATION AND EDUCATION PROGRAMS

Information, education, and communication activities (IE&C) are an essential component of all AVS-supported programs. These activities are needed not only to tell people about voluntary sterilization services but also to obtain the approval and support of policymakers, opinion leaders, and health professionals when services are first being established. Most importantly, well-organized IE&C programs enable individuals and couples to make informed decisions about voluntary sterilization. To insure voluntarism, free access to adequate and accurate information is imperative.

In 1984 AVS supported IE&C activities in 41 projects in 23 countries. Seven subagreements for a total of \$462,436, were awarded with IE&C as the primary emphasis. In addition, seven small grants were awarded, mostly for audiovisual equipment or materials.

The following examples illustrate the IE&C projects and activities supported by AVS:

- ° In Mexico and neighboring countries, pharmacies, family planning clinics, and health centers will distribute copies of a special vasectomy issue of a popular comic book. The publication has been carefully researched and designed.
- ° The University of Benin Teaching Hospital in Nigeria is developing a package of IE&C materials that will be illustrated by a Nigerian artist. The package contains a large flip chart for groups, a small flip chart for individual sessions, a set of slides, posters, and a pamphlet about family planning, with special emphasis on VSC and the risks of grand multiparity. These are intended for client information and are being developed as models for other programs in Africa.
- ° Also in Nigeria, the University College Hospital in Ibadan has designed a training course in IE&C and counseling which will be taught to 20 nurse-midwives who are working in various AVS-funded projects. The five-day training program, scheduled for 1985, will be organized in collaboration with the African Regional Health Education Center. If successful, this project will serve as a model training course for other facilities in Nigeria and other African countries.

- ° A third innovative IE&C project in Nigeria will be implemented by the Lagos University Teaching Hospital (LUTH). This project will test the cost-effectiveness of three different approaches to IE&C and counseling through LUTH's eight peripheral health centers. The most successful and cost-effective approach will then be introduced in other AVS-supported projects with structures similar to the LUTH program.
- ° The Philippine Association for Surgical Sterilization has produced two television spots and four radio spots about voluntary sterilization which have aired in various parts of the Philippines. In another IE&C effort, the Good Luck Club, a group of satisfied vasectomized men who volunteer their time, have made several television appearances and have organized walkathons. The club meets every two to three months and has a membership of approximately 800.
- ° In 1984 AVS awarded a subagreement to the Family Planning Association of Sri Lanka, to organize a regional workshop on the effective utilization of satisfied vasectomy clients as volunteer field workers. This workshop will be held in 1985.
- ° At the request of the Ministry of Health in Thailand, AVS helped provincial hospitals to design IE&C materials, using available resources. This project came about because the expensively produced materials supplied to these rural hospitals proved to be insufficient or inadequate for local use.
- ° AVS has compiled a bibliography of currently available audio-visual materials to be used for client information and education and for training medical and paramedical personnel. The bibliography is being field tested; based on results of this test, it will be revised and then published for selected distribution.
- ° In most of Africa, materials for IE&C and training are lacking. To respond to this need, the regional office in Tunis is developing model seminar programs to inform and educate physicians and other health professionals about voluntary sterilization. The models are being field tested in seven countries in the region.
- ° In a special meeting after the Conference on Reproductive Health Management in Sub-Saharan Africa, 16 experts from 10 African countries discussed IE&C needs of the region. Because not all audiences can be reached in the same way, the experts emphasized the importance of using both traditional methods (songs, dance, drama, stories) and modern means of communication (radio, television, newspapers, films, flip charts). The participants underscored the urgency of providing sex education to youth, of training all categories of field staff in better communication, and of researching the most effective ways to communicate with rural and illiterate populations.

- ° During the year an AVS staff member based in New York traveled to Sri Lanka as part of a USAID mission conducting an IE&C needs assessment and planning a communication project. The AVS representative got a firsthand, in-depth view of Sri Lanka's IE&C program for population and family planning; this experience will undoubtedly contribute to informational efforts conducted by the Sri Lanka Association for Voluntary Surgical Contraception (SLAVSC). This same staff member helped SLAVSC design its 1985 communication program, which will emphasize educating community leaders and health and family planning personnel about the importance of informed consent.

In the years to come, AVS will continue to respond to the growing demand for IE&C funds and technical assistance in support of voluntary surgical contraception programs throughout the world. The need for such activities is greatest in Africa and the Middle East where people except for a small, urban, and literate segment of the population, are generally unaware of family planning and modern methods of contraception. In several countries, especially south of the Sahara, the availability and accessibility of voluntary sterilization will largely depend on the degree to which community leaders, policymakers, and health personnel are informed and educated about VSC and change their attitudes toward it. In Asia, Central America, and South America, where knowledge of voluntary sterilization is generally more widespread, IE&C support is needed to improve the quality of the clients' knowledge and to remind or reassure them as they make decisions.

A major goal of AVS-supported information and education programs is well-informed VSC clients, who not only knowingly give their informed consent but also are satisfied with their decision afterwards. AVS values the satisfaction of VSC users in all its supported programs as it is ultimately upon their good will and trust that the future of voluntary sterilization depends.

CHAPTER 5

ACCOMPLISHMENTS OF THE WORLD FEDERATION

In 1984 the World Federation conducted the following activities in the areas of professional education, leadership and policy development, quality assurance, and information dissemination. (A list of World Federation members is given in Appendix C.)

Professional education

The Conference on Reproductive Health Management in Sub-Saharan Africa, held in Freetown, Sierra Leone, November 5-9, 1984, produced definitive and specific recommendations for Sub-Saharan governments and nongovernmental organizations which should result in a greater emphasis on family planning, including VSC, over the coming years. Several leaders viewed this conference as a turning point for the region. Almost 200 health providers and policymakers participated, representing health agencies and governments from 43 countries. Dr. Siaka Stevens, president of Sierra Leone, opened the meeting with a resounding speech, approving the increased availability of family planning and VSC; the minister of health and the mayor of Freetown repeated the theme. In his keynote address Dr. Fred Sai of Ghana exhorted the Sub-Saharan health leaders to be courageous and energetic in their use of prevention measures, such as family planning, to lower the high morbidity and mortality rates throughout the region. The conference was planned by a Sub-Saharan steering committee.

At the Sub-Saharan conference a legal panel, sponsored by the Pathfinder Fund, and an information and education consultancy, conducted by AVS, also produced specific recommendations for future programming.

Participants at the conference were funded by a number of AID-supported and non-AID-supported organizations, including the United Nations Fund for Population Activities, World Neighbors, the Pathfinder Fund, Family Health International, and Family Planning International Assistance.

Other professional education accomplishments in 1984 were the following:

1. Publication of a book in Arabic about family planning and VSC by the Regional Arab Federation for Voluntary Fertility Care.
2. Preparation of the report summarizing the results of the Fifth International Conference on Voluntary Surgical Contraception, which was held in Santo Domingo in 1983.

3. Attendance by World Federation leaders at eight international scientific and educational meetings:

Asian Forum of Parliamentarians on Population and Development--Dr. T. B. Khatri

Arab Parliamentarians' Conference on Population, Health, and Development--Dr. Zein Khairullah

NGO Planning Committee for the United Nations Conference on Women--Beth S. Atkins

National Council on International Health--Dr. Azizur Rahman

International Medical Women's Conference--Dr. Dinah Jarrett

United Nations Fund for Population Activities Expert Group on Incentives--Dr. Wickrema Weerasooria

Triannual Conference of the International Association of Maternal and Neonatal Health--Dr. Dinah Jarrett

All-India Obstetrics and Gynecology Association Meeting--Dr. Mahmoud Fathalla

4. Publication and distribution of three issues of Communique. The themes of the newsletters were the Fifth International Conference on Voluntary Surgical Contraception, communications in VSC programs, and the Sub-Saharan conference.

Leadership and policy development

Twenty-one experts from seventeen countries served on the World Federation Expert Committee on Training in Voluntary Surgical Contraception, which met in Brazil September 26-28, 1984, and was hosted by the Associacao Brasileira de Entidades de Planejamento Familiar. Of special significance was the participation of a vasectomy expert sponsored by the People's Republic of China; this was the first time China has been represented at a World Federation meeting. Observers at the meeting represented the Pathfinder Fund, the Population Commission of the Philippines, the Population Information Program, and the United States Agency for International Development.

The conclusions and recommendations of the committee were as follows:

- o Where feasible in each country, representatives of private organizations and government leaders and agencies who wish to provide VSC services should join together to develop a coordinating body to plan a system of organized training. This group should set forth objectives that meet the needs of the

people, that recognize country-wide political, cultural, religious and legal constraints, and that are based on an objective analysis of available information in the country.

- o Priority should be given to training personnel from service sites that offer integrated maternal and child health services and a choice of various family planning methods.
- o By the completion of their training, trainees should be competent in performing vasectomy and female VSC under local anesthesia.
- o Where feasible, physicians being trained in laparoscopy should also be trained in minilaparotomy, so that clients will have a choice of methods, and so that trained physicians can perform the most appropriate technique, depending upon the medical evaluation.
- o In addition to learning surgical techniques, trainees should become knowledgeable in all aspects of service delivery, including, but not limited to, (1) counseling, informed consent, and empathetic client management; (2) medical screening and preoperative assessment; (3) proper regimens of analgesia and anesthesia; and (4) management of service delivery and the operating theater.
- o Important elements of trainee selection are personal and institutional commitment and geographic location. Unless there is a documented demand for VSC services at the trainee's home institution, he or she will not be able to utilize newly learned skills. Besides having potential interested clients, the home institution must be prepared to supply adequate space, adequate equipment, and operating time.
- o Although trainees may do part of their practical training in mobile units and itinerant camps, such settings are usually not adequate as comprehensive training centers.
- o A certificate of competence should be issued to each trainee who has completed didactic and practical training and who has been judged by the trainer to have adequate knowledge and practical skills in specific surgical techniques and in service delivery.
- o Individual training institutions should follow up all trainees for a minimum of one year, to insure that quality standards are being met.
- o If the demand for services exceeds the number, capacity, and availability of physicians in a community, it may be necessary for paramedics to perform vasectomies or minilaparotomies.

Under such circumstances, paramedics should work only in suitable settings, and qualified physicians should always be available when needed.

In addition to developing guidelines for training programs, the expert committee produced model curricula for male and female techniques, based on their own experiences and on curriculum examples collected from AVS grantees.

During 1984 the World Federation and AVS worked with the World Health Organization (WHO) to develop that agency's guidelines for vasectomy. Staff members from AVS and the World Federation prepared the original draft of the guidelines, and several World Federation experts were members of the task force that met in Geneva to review and revise the draft. Members of the World Federation Editorial Committee also reviewed the document. This project was the result of earlier discussions with WHO regarding the World Federation's role as an appropriate collaborator for guidelines related to voluntary surgical contraception.

During the Sub-Saharan conference World Federation representatives encouraged Sub-Saharan organizations to become members of the Federation. While in Freetown, leaders from Nigeria met and established a leadership organization which will apply for Federation membership. Other countries expressing interest in the Federation's activities were Zaire and Togo. Two participants from Uganda joined the World Federation as individual members, following the lead of two Chilean professionals earlier in 1984. Individual memberships are growing, increasing the number of professionals directly involved in the Federation's work.

The Federation worked to expand its women's leadership program at the Sub-Saharan conference. Five participants from that conference are preparing a panel "Preventing Maternal Death in Sub-Saharan Africa" for the NGO Forum to be held during the United Nations Women's Conference in Nairobi in 1985.

Throughout 1984 members of the World Federation Legal Committee continued to analyze relevant laws and to support physicians who have been challenged for providing voluntary surgical contraception services.

At the 1984 Conference on Population in Mexico City, Dr. Joaquin Nunez, president-elect of the World Federation, submitted a Federation policy statement as an official document. The statement read as follows:

"Recognizing the unique needs and goals of each nation, the World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception encourages all governments to:

1. Respect and insure the right of couples and individuals to determine the number and spacing of their children in a free, informed, and responsible manner;

2. Respect and insure the right of individuals to receive accurate, objective information and high-quality services for all available means of fertility management, including voluntary surgical contraception; and
3. Include voluntary surgical contraception information and services as an integral part of national public health and family planning programs, taking measures to insure informed consent and to safeguard against coercive practices."

Ten other World Federation leaders represented national nongovernmental organizations as members of their own countries' delegations.

In September, Dr. Wickrema Weerasooria of Sri Lanka, a member of the World Federation's Executive Board, and Georgeanne Neamatalla, a staff observer, represented the Federation at UNFPA's Expert Group on Incentives. Throughout the year the World Federation collaborated with the NGO committee planning the United Nations Conference on Women; Beth S. Atkins is serving on that committee.

Quality assurance

Safety of Voluntary Surgical Contraception was published in 1984, and the impact of this publication in the field of VSC has been remarkable. Members of the expert committee that prepared the report have taken the findings to their own countries and have adapted the guidelines to their own situations.

Countries such as Indonesia, Thailand, and Guatemala have produced similar standards in their own languages. As a follow-up activity, the World Federation has launched a major information program about the publication, including translation of the report into Spanish and French and increased distribution in English. The report has been reproduced by the National Association for Voluntary Sterilization of India for wide distribution in that country. Over 1,000 copies have been distributed by the World Federation Secretariat, member organizations, and regional offices of the Association for Voluntary Sterilization.

Highlights of the safety report are:

- Vasectomy and minilaparotomy are the safest and simplest VSC methods to deliver, given prevailing conditions in developing countries.
- National voluntary surgical contraception programs should implement a standard anesthesia regimen for all sterilization procedures.
- Local anesthesia is safer than general or regional anesthesia.

- Personnel should be adequately trained in clinical skills and in all aspects of service delivery, including patient evaluation and selection, patient monitoring and care, aseptic techniques and procedures, anesthesia and its pharmacology, management of complications, and emergency and resuscitation procedures.
- Facilities should be stocked with all necessary emergency and resuscitation equipment and drugs, and staff working in those facilities should be trained to handle emergencies.
- Programs should develop monitoring and supervision systems to collect and analyze service data and should rectify any problems that hamper safe and effective service delivery.

The publication itself and its distribution have contributed significantly to the safety of voluntary sterilization services worldwide.

In June 1984 the VSC Statistics Committee began developing a model safety-monitoring system to be tested in several countries. The impetus for this effort was the Safety Committee's Task Force 4, which recommended that programs develop simple and effective data collection and monitoring systems for use in developing country settings.

Persons who contributed to the simple, clinic-based monitoring model included Dr. Does Sampoerno, former dean, School of Public Health, University of Indonesia, and chair of the Federation's Statistics Committee; Dr. Carlos Huezo, medical consultant, International Planned Parenthood Federation; Mr. Terrence Jezowski, director, International Programs Division, Association for Voluntary Sterilization; Dr. John Ross, senior evaluation adviser, Medical Division, Association for Voluntary Sterilization; Dr. Herbert Petersen, chief of sterilization, Division of Reproductive Health, Centers for Disease Control; Dr. George L. Rubin, medical officer, Centers for Disease Control; Dr. Earle Wilson, medical officer, World Health Organization; and Beth S. Atkins, executive secretary, World Federation.

The World Federation will disseminate the model monitoring system and will encourage its implementation. The International Planned Parenthood Federation, the World Health Organization, the Centers for Disease Control, and the Association for Voluntary Sterilization are considering funding projects that use the system. They are also encouraging programs to improve and standardize data collection by using Standard Terms for Voluntary Surgical Contraception, a World Federation publication produced in 1983 and now available in English, French, and Spanish.

The World Federation is working among policymakers and program managers to increase their awareness of the need for the client's informed decision making and psychological readiness for voluntary

surgical contraception. A comprehensive counseling manual for counselors, trainers, and managers was completed in 1984 and will be published in 1985. The book will address the planning, implementation, and administration of counseling programs.

The policy guidelines "Ensuring Informed Consent" were widely distributed in 1984, and many agencies have adopted them for use. The Federation's Information and Education Committee was instrumental in developing these guidelines.

Information dissemination

The World Federation continued its technical mailings and information dissemination activities during 1984. The purpose of these efforts is to create a climate of understanding about VSC among the general public and international agencies. By providing membership news and by responding to international requests for information, the Federation maintained an ongoing communications network about male and female VSC services and about its own activities. Information about the Federation is now included in all major population reference books.

CHAPTER 6

FISCAL AND PROGRAM MANAGEMENT

Contract status and fiscal management

*Expenses: Table 6.1 presents the 1984 AID-funds expenses (central and bilateral) by category compared with 1983. A total of \$14.11 million in AID funds was expended in 1984. Although this is an overall 4% reduction from 1983, there was only a 0.1% reduction in the subagreements category.

*Central AID funds: 1984 was the third year of the current five-year cooperative agreement with AID. In general, AID funds enable AVS to continue its program of technical assistance and grant awards, thereby contributing to the increased availability and accessibility of VSC in developing countries. Support for the important leadership activities of the World Federation is also provided under this agreement.

In 1984 this agreement was increased by \$10,814,011 to an overall total of \$30,398,011. The 1984 additional funds obligated to AVS are shown below:

| <u>Funding Action</u> | <u>AID Obligation Date</u> | <u>Purpose</u> | <u>Amount</u> |
|---------------------------|--------------------------------|--|---------------------|
| Amendment 4 | January 31, 1984 | To support and implement the overall purposes of the cooperative agreement. | \$9,700,000 |
| Amendment 5 | July 31, 1985 | To fund projects in countries of the Near East. | 390,011 |
| Amendment 6 | November 26, 1984 | To purchase medical equipment for BKKBN, Indonesia. | 224,000 |
| Amendment 7 | December 18, 1984 | To provide technical, commodity, and operational support to the Moroccan National Training Center for Reproductive Health. | 500,000 |
| | | Total: | <u>\$10,814,011</u> |

| TABLE 6.1: AID Funds Expended by Budget Category, 1983 and 1984 (000 Omitted) — Unaudited | | | | | | |
|--|-----------------------------------|--|----------|------------------|------------------|--------|
| Category | 1984 | | Total | | Percent of Total | |
| | Cooperative Agreement DPE 0968 | Bilateral Grant USAID Dhaka 3880050 | 1984 | 1983 | 1984 | 1983 |
| Salaries | \$ 1,763 | \$ 25 | \$ 1,788 | \$ 1,569 | 12.7% | 10.7% |
| Fringe | 443 | 7 | 450 | 415 | 3.2% | 2.8% |
| Consultants | 129 | 33 | 162 | 256 | 1.1% | 1.8% |
| Rent and Utilities | 514 | | 514 | 507 | 3.7% | 3.4% |
| Equipment and Furniture | 27 | | 27 | 23 | 0.2% | 0.2% |
| Supplies and Services | 163 | 4 | 167 | 109 | 1.2% | 0.7% |
| Communications | 115 | | 115 | 121 | 0.8% | 0.8% |
| Travel | 263 | 20 | 283 | 209 | 2.0% | 1.4% |
| Information and Education | 47 | | 47 | 91 | 0.3% | 0.6% |
| Regional Offices | 457 | | 457 | 772 | 3.2% | 5.3% |
| Technical Assistance and Leadership Activities | 531 | | 531 | 959 ^a | 3.8% | 6.5% |
| Subagreements | 8,084 ^b | 1,485 | 9,569 | 9,669 | 67.8% | 65.8% |
| TOTAL | \$12,536 | \$1,574 | \$14,110 | \$14,700 | 100.0% | 100.0% |
| ^a Includes \$173,699 of conference expense. | | | | | | |
| ^b Includes obligations for subagreements, small grants, and amendments. | | | | | | |

*Bilateral USAID funds: In August 1984 the USAID Mission in Bangladesh amended its bilateral agreement with AVS by adding \$2,700,000 and extending the grant period to September 1988. This brings the total of this bilateral agreement to \$6,467,550. The purpose of this assistance is to enable AVS to provide financial and technical assistance to the Bangladesh Association for Voluntary Sterilization. See Appendix A for a detailed report on the Bangladesh agreement.

In addition, AVS received USAID mission funds that are channeled to AVS through AID/W. As listed in the above discussion of central AID funds, AVS in 1984 received \$224,000 which was channeled from USAID/Jakarta and \$500,000 from USAID/Rabat. During 1984 AVS field staff contacted several other USAID missions regarding bilateral assistance, and positive results from some of these contacts are expected during 1985.

*Private funds: AVS continues to seek financial assistance from individual contributors, private corporations, and foundations to diversify and broaden its funding base.

Organizational structure

AVS's headquarters in New York City is composed of four functional divisions: International Programs, National Programs (which receives no support from AID), Finance and Administration, and Medical. AVS also houses and provides administrative services for the World Federation Secretariat.

Currently AVS maintains three regional offices under the direction of the International Programs Division: the Africa and Middle East Regional Office (AMERO) in Tunis, Tunisia; the Asia Regional Office (ARO) in Dhaka, Bangladesh; and the South America Regional Office (SARO) in Bogota, Colombia. Because of increased activities in Anglophone Africa south of the Sahara, AVS is planning to open a fourth regional office in Nairobi, Kenya, during 1985.

Local project management

AVS's program of financial and technical assistance is directed by the regional offices and field staff, with support and policy direction from management and the technical divisions in New York. This decentralized system of project management depends upon effective communication and coordination between the field and headquarters. 1984 was a year of assessment, both internal and external, of AVS's systems for effective project and resource management.

In August 1984, the International Programs Division held its fourth annual Program Planning and Development Meeting in New York for

headquarters staff and key regional office representatives. A major goal of this meeting was to review coordination and communication between the various divisions at headquarters, as well as between headquarters and regional offices. Interdivisional task forces discussed current needs and systems, and participants made decisions which are serving as the basis for a revised procedures manual for coordination and local project management, scheduled for finalization in 1985. The meeting also highlighted major program directions such as counseling and education, quality assurance and surveillance, and the introduction of new and refined VSC and anesthesia technologies. The Program Planning and Development Meeting also signaled the beginning of the 1985 budget-development and resource-allocation process.

As for external assessments, AID conducted a two-day management audit in May which focused on both financial and program-management issues. The results of this review showed that, although the financial and program management system is sound, AVS's ability to manage local programs would be enhanced if the system were strengthened and expanded.

The management review was followed by another audit conducted by the AID Inspector General's Office from August to November. This review dealt mainly with programmatic issues, including the effectiveness of projects, grants development, technical assistance activities, and decision making for resource allocation. In August the auditors spent several days in New York working with staff members from headquarters and the regional offices. Accompanied by AVS personnel, the auditors then visited projects in Kenya, Egypt, Indonesia, Thailand, and Bangladesh. A final report will be issued in 1985; AVS expects the results of this audit to help it refine local project-management systems and procedures.

Staffing

*Headquarters: The number of staff positions remained the same in 1984 as in 1983 with a total of 56 (32 administrative/technical and 24 support). At the end of 1984, 54.79 positions (31.02 administrative/technical and 23.77 support) were fully funded with USAID monies. (See Appendix D for a list of staff members and positions.)

*Regional offices: At year's end the Asia Regional Office had 26 positions (9 administrative/technical and 17 support). The Africa/Middle East Regional Office had 16 positions (7 administrative/technical and 9 support). The South America Regional Office had 2 administrative/technical positions and 2 support positions.

In 1984 AVS expanded its regional staff network by hiring three permanent staff members in the South America Regional Office in Bogota.

Plans are under way to further decentralize and expand regional staff presence in 1985. These plans include:

- Establishing a regional office for Anglophone Sub-Saharan Africa in the latter half of 1985, probably in Nairobi, Kenya
- Recruiting local country advisers in a few countries where AVS has large, complex commitments (e.g., Mexico, Nigeria)
- Increasing staff for Central America and Mexico (these programs are managed out of New York as a separate cost center)
- Assigning an AVS staff member to serve as a local adviser to Indonesia for six months (in that country the national program is about to launch a major expansion of VSC services)

Personnel administration and employee relations

During 1984 AVS gave increased emphasis to training and developing its support personnel. Over 50% of support staff received instruction in word processing. In addition, several in-house workshops geared to the particular needs of secretaries were conducted.

Several professional employees enrolled in internal or external foreign language programs.

Grants for tuition assistance for all categories of personnel were at an all time high during 1984.

AVS personnel systems continued to work effectively. The uniform application of these systems was carefully scrutinized during the organization's first external labor-arbitration hearing; AVS received a favorable judgment.

AVS also continued to participate in and organize several employee-relations activities, such as after-work racing events and several social activities, including the annual staff picnic and end-of-year party.

AVS library

AVS maintains a specialized library to serve as a reference center and information clearinghouse, primarily for staff members of the New York and regional offices. The library also serves a broad spectrum of other patrons such as AVS grant recipients, other family planning libraries, researchers, and the general public.

The AVS library currently contains 3,010 monographs and receives 221 periodicals. Over 87 linear feet of vertical files contain reprints, educational materials, and pamphlets related to family

planning, with emphasis on VSC. Over 145 audiovisual items such as films, videotapes, audiocassettes, and slides are on file as well.

AVS obtains interlibrary loans through several consortia and the Greater Northeastern Regional Medical Library. In addition, AVS is a member of the Association for Population/Family Planning Libraries and Information Centers (APLIC), the Manhattan/Bronx Health Planning Sciences Library Groups, and the New York Metropolitan Reference and Research Library Agency (METRO).

The AVS library conducts computerized literature searches over MEDLARS, BRS, and DIALOG, with emphasis on POPLINE and MEDLINE.

Information processing

In 1984 AVS worked to maintain the improvements and changes introduced in 1983. By continually taking stock of its information needs and its processing abilities, AVS is able to respond to the changing and increasing demands that develop.

During 1984 AVS began to investigate where and how program and financial information could be utilized in combination. Particular attention was given to combining data for subgrant funding and administration. In the future these data will be retrievable in a consolidated format, thereby enabling grant managers to expedite grant administration. This system will become operational in 1985.

The follow-up surveys of female VSC clients which are being undertaken in five different countries (see Chapter 4) require sophisticated data analysis, with corresponding demands on AVS's information-processing capabilities. To stay ahead of such demands, AVS is investigating how it can install a comprehensive data processing system that can deal with widely varying requests and that can expand beyond the traditional grant information.

APPENDIX A

Annual Report 1984

USAID/Bangladesh Cooperative Agreement with AVS

#388-0050-A-00-1014- 06.

I. Introduction and Summary

There follows a report on USAID/Bangladesh cooperative agreement #388-0050-A-00-1014-06 with AVS. This report supplements the AVS "Biannual Report: January-June 1984" and, according to the terms of the cooperative agreement, the narrative focuses on activities and issues related to the six-month period July-December 1984. The narrative is accompanied by various tables and graphs which offer a statistical summary of inputs and outputs for the entire 12 month period. As of the date of this writing, 1984 financial records are not yet closed or audited so the financial information presented in this report cannot be considered final.

AVS wishes to take this opportunity to thank the USAID/Bangladesh mission staff for the considerable assistance, advice, and cooperation extended to us throughout 1984.

The program's main focus in 1984 remained the provision of technical and financial assistance to BAVS, the country's largest NGO vsc service provider. However, significant attention was also devoted to the improvement and expansion of vsc training on the national level.

A summary of the foremost program accomplishments of 1984 follows:

- USAID's FY1984 obligation of \$2.7 million to AVS was larger than in any previous year and AVS's CY1984 sub-obligations and expenditures of more than \$2.6 million were likewise, the largest ever.
- BAVS increased the volume of vsc services provided in 1984 by 50% over 1983, the largest annual increase since 1975 when services began.
- BAVS provided over 100,000 vsc procedures for the first time in their ten-year history while reducing the vsc mortality rate to its lowest level ever and for the first time making significant reductions in the vsc cost per-case.
- By a wide margin, BAVS provided more vasectomies (60,764) than tubectomies (41,552) for the first time ever.
- The BAVS nationwide service delivery system grew to 34 clinics with the completion at mid-year of the nine-clinic expansion program.

- BAVS program costs will be reduced for the first time in 1985 with the implementation of a program and budget which is expected to result in the continued expansion of quality services but at a funding level approximately 10% lower than in 1984.
- All necessary plans were made in 1984 for the system-wide introduction of IUD services on 1 January 1985.
- AVS streamlined and consolidated support to BAVS with the development of a single, mission funded, multi-year grant to begin on 1 January 1985.
- Several significant steps were taken leading towards increased organizational self-sufficiency such as the procurement of a parcel of land for the construction of a national headquarters and model clinic facility, the establishment of national and clinic-level self-reliance committees, the decision to devote BAVS's 1985 annual conference to the issue of self-sufficiency, and the achievement of real reductions in the costs of operating the program.
- A major new program was developed for implementation during the first quarter of 1985 which is designed to increase the performance and efficiency of the entire BAVS program through intensive technical and financial assistance focused on the least successful clinics.

II. The Bangladesh Association for Voluntary Sterilization(BAVS) Program

The main quantifiable BAVS program outputs during 1984 are summarized in Table 1. These outputs were achieved with total BAVS annual expenditures of approximately Tk.37,636,000 or \$1,500,000. In addition to AVS inputs, the government provides approximately \$16 per-case in cash and in-kind via the ISP and MSR program. Therefore, the true cost of providing the 102,316 vsc procedures is in the range of \$3.1 million for a per-case cost of about \$30.00 (See Tables 10 and 11 for a summary of financial information regarding the cooperative agreement and estimates of per-case cost).

A. Family Planning Service Provision

- i. Performance: VSC services provided by BAVS in 1984 increased by 50% over 1983 -- from 68,378 to 102,316. Vasectomy acceptance doubled in 1984, from 30,254 in 1983 to 60,764, while tubectomy acceptance increased by 9%, from 38,124 to 41,552. Vasectomy acceptance in 1984 alone came close to approximating total male and female vsc acceptance in 1983. In addition to vsc services, a variety of temporary methods were provided to requestors, mainly those rejected for vsc.

Approximately 25% of the increase in performance between 1983 and 1984 can be accounted for by the fact that the BAVS clinic expansion program was completed at mid-year resulting in a service delivery system 33% larger than in previous years. The remainder

of the increase can reasonably be attributed to a variety of factors which have led to increased demand for services including: the growing number of satisfied acceptors, particularly males, serving as reliable sources of information about vsc; the growing number and effectiveness of BAVS field agents; continued attention to the quality of services and the needs of requestors; and continued, perhaps enhanced, socio-economic pressures to limit family size.

The trend of increased acceptance of vasectomy relative to tubectomy which began in 1983 continued throughout the year and resulted in 1984 being the first year in which BAVS provided more vasectomy than tubectomy services. The change in the ratio of male to female services has been rapid and marked; from a ratio of 1:11 in 1980 to 1.5 : 1 in 1984. AVS continues to work with BAVS to explore the reasons for this change and to make the appropriate programmatic adjustments to it.

The temporal pattern of vsc acceptance in 1984 did not follow the previously observed pattern in a couple key respects: July and August, typically one of the year's slowest periods saw sustained high demand, whereas November, typically one of the years' busiest months, saw a sharp decline in demand from 12,445 in October, the busiest month in the program's history, to 5,386. The most commonly heard hypothesis to explain these fluctuations relates to the effect of the agricultural cycle on the timing of the vsc decision. When agricultural employment opportunities and income are scarce, and when time therefore is abundant, people can most afford to request services. In 1984, due to exceptionally heavy monsoon rains in July and August, the "aman" rice harvest which normally falls in October, fell in November instead. This resulted in employment opportunities for agricultural day laborers in November/December and caused people who would have sought vsc services during this period to postpone their decision. Because such a large percentage of vsc requestors are males, and because such a large percentage of male requestors are day laborers employed in the agricultural sector, sharp fluctuations in the demand for vsc services may be a permanent feature of vsc service delivery in Bangladesh, and significant program-induced changes in the pattern are probably unlikely. VSC demand in 1984, with its unexpected "peaks and valleys", suggests that the temporal pattern of demand is probably not predictable with any precision other than in its broadest outlines. However, BAVS has undertaken a special study to determine with greater accuracy the reasons behind the pattern of vsc demand. Results of the study, which involves the interviewing of 100 BAVS field agents and clients, are expected to be ready in January 1985.

Sterilization service statistics and trends are presented in Table 2-6 and Figures 1-6.

2. Quality of Services:

- Mortality/Morbidity: Six vsc-associated deaths were reported by BAVS and investigated during 1984. Four of the mortality cases have been closed and found by BAVS and AVS not to be attributable to the sterilization operation, while two cases are

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considered open pending the receipt of additional information. If these two cases are ultimately found vsc-attributable, the 1984 vsc mortality rates per 100,000 cases would be 1.6 for vasectomy and 2.4 for tubectomy, indicating a further decline in vsc mortality and the maintenance of commendable medical quality (see Table 7 for a summary of vsc-associated mortalities in 1984).

There were 158 complications reported by BAVS during 1984 in connection with the performance of 102,314 procedures; 56 vasectomy complications (92 per 100,000) and 98 tubectomy complications (236 per 100,000). Complication rates in 1983 were 40 and 121 per 100,000 vasectomy and tubectomy cases. The increase in 1984 complication rates probably indicates more comprehensive reporting rather than a decline in medical quality but this assumption will be explored further in early 1985. (see Table 8 for a summary of reported vsc complications in 1984).

- Follow-Up: Follow-up rates of 84% for males and 91% for females for the second half of 1984 were down slightly from the first half of the year. One reason may be the government's recent effort to prohibit NGOs from reimbursing travel costs of field agents' follow-up visits on the grounds that this confers an unfair advantage on NGO field workers unavailable to their government counterparts. This is an issue which will need to be addressed during 1985 (see Table 5 and 6 for a summary of follow-up performance by clinic and month).
- Voluntarism, Informed Consent and Verification of Services: There were no reports of voluntarism or informed consent problems associated with BAVS vsc service delivery during 1984. AVS staff as well as BAVS Regional Medical Supervisors, internal auditors, and the counseling coordinator routinely monitor the quality of counseling and undertake random checks of informed consent forms.

In July BAVS undertook a systematic preventive verification of a sample of reported vasectomy cases at eight of BAVS's 34 clinics. The results of the verification were, with one exception, reassuring and indicated a high-level of vasectomy service quality was being maintained. All cases checked were verified and found to meet the main vsc eligibility criteria but at BAVS Chittagong verification was not possible because addresses of certain vasectomy clients had been incorrectly recorded to maximize travel reimbursements to field agents. As a result of this finding several actions have been taken including special monitoring and technical assistance visits to BAVS Chittagong by a group of BAVS senior volunteers, the BAVS Regional Medical Supervisors, and the BAVS internal auditor. In addition, because of this problem and others, BAVS Chittagong has been selected

as one of the BAVS clinics most in need of priority attention and will therefore be visited on 16-17 January 1985 by a joint BAVS/AVS program development team undertaking the inaugural visit of the 1985 "exceptional" clinic project.

To routinize the periodic evaluation and verification of BAVS vsc services, AVS worked with USAID/Bangladesh to ensure BAVS's inclusion in the quarterly evaluation of the national vsc/IUD program beginning 1 January 1985 and, AVS is in the process of arranging for a local consulting firm to provide the necessary technical assistance and training to BAVS staff to establish their own in-house quarterly vsc verification and evaluation capability.'

As evidence of BAVS's continuous application of vsc eligibility criteria, almost 13,000 vsc requestors were rejected in 1984, a rejection rate of over 10%. Many of those rejected were provided with temporary contraceptive protection by BAVS and efforts will be intensified in 1985 to more fully meet the needs of rejected requestors.

3. Cost of Services:

AVS devoted considerable attention in 1984 to the control of BAVS program costs. As a result, BAVS cost per-case declined in 1984 by 7% from Tk.394 to Tk.368. Because a substantial portion of the variable costs associated with vsc service provision are provided by the government, cost reductions were achieved by focusing on fixed costs and the remaining variable costs covered by BAVS. Also contributing to a decline in cost per-case was the method mix shift from tubectomy to less costly vasectomy.

B. Training and Professional Education

AVS continued in 1984 the study tour program whereby BAVS doctors travel to Indonesia and Thailand to share their vsc service delivery experiences with colleagues from those countries. It is expected that through this interaction program improvements will result as key policy and program personnel from BAVS return with fresh perspectives to apply the lessons learned during such tours. The program will continue in 1985 when four more BAVS doctors undertake a similar study tour. Other professional education activities during the period include:

- The President of BAVS was provided support to participate in the August 1984 Population Conference in Mexico City as one of Bangladesh's nine-member official delegation.
- Two staff members from BAVS's program and evaluation unit received support to participate in an ACPGD course on evaluation in Bangkok.
- To compare different service delivery and clinic management approaches, inter-clinic visits were arranged for BAVS Project Directors and Regional Medical Supervisors.

(See Table 9 for a summary of training and consulting activities funded in 1984).

C. Efficient Resource Management: The 1985 BAVS Program and Budget

The primary focus of AVS's work during the latter half of 1984 was to undertake steps to increase cost efficiency and improve financial management at BAVS - both of which are considered priorities and prerequisites for the ultimate attainment of organizational self-sufficiency.

One major step taken to improve BAVS financial management was the development of a new mechanism for AVS funding of BAVS. For ten years AVS has been funding BAVS with a variety of separate grants running simultaneously but for different durations and since 1981 AVS support to BAVS has been a mix of both mission and central funds. In 1984 AVS synchronized all current grants to BAVS to terminate on 31 December 1984, and developed a single consolidated three-year grant to begin on 1 January 1985 with purely mission funding. By simplifying the grant support mechanism, it is expected that important improvements will result in the areas of program and budget development and day-to-day financial management. The consolidated grant was awarded on schedule on 29 December 1984 thus ensuring a smooth program transition and the uninterrupted flow of vsc services.

A major step taken towards improving overall cost-efficiency was the development of the 1985 budget. The budget development process, which involved continuous input from BAVS volunteers, resulted in a mutually agreeable budget representing the first-ever annual reduction in BAVS's program costs. The 1985 budget is approximately 11% less (accounting for projected inflation of at least 10%) than actual expenditures in 1984. If vsc performance objectives are met in 1985, the budget will result in the second successive 7% reduction in vsc cost per case and BAVS programs and services will be expanded without an increase in the level of funding. The cost-efficient 1985 budget was achieved by sustained technical assistance from AVS to BAVS and is felt to represent an important step towards the financial austerity required for BAVS's long-term program survival. Examples of the steps taken to improve BAVS financial management and improve cost-efficiency include the following:

1. Rationalized Staffing Formula: A new staffing formula was developed to adjust human resources to prevailing performance trends and, when applied to the 1985 budget, resulted in a savings of approximately Tk.650,000.
2. Enhancement of Financial Staff Capabilities: A new Finance Manager who is exceptionally well qualified for the job was recruited and is expected to make significant contributions to improving BAVS financial management.
3. Budget and Cost Analysis: Fixed costs (personnel and rent) which account for 60% of total BAVS costs were analyzed and projected for 1985-87. Certain variable costs were identified and segregated under the IRPA line in clinics' budgets and reallocation procedures were made more flexible to facilitate inter-clinic transfer of funds in response to variations in the volume of services provided.

4. Termination of the Revolving Fund: All outstanding revolving funds are in the process of being reconciled and will soon be aggregated and segregated in a single separate account for use in 1985 if needed. No new revolving fund was budgetted for in 1985 for a savings of several thousand taka.
5. Improved Grants Management Guidelines: A comprehensive set of grants management and implementation guidelines were developed to define proposal development and financial management procedures and to structure the process and terms under which grant funds are disbursed. The guidelines should add efficiency to the grants management process.
6. Improved Clinic Management: Beginning in 1985, for the first time there will be a separate Project Director for each of BAVS's 34 clinics. The placement of responsible and accountable volunteers to head every clinic should help further strengthen BAVS program and financial management.
7. Compensation Study: AVS arranged for a local consulting firm to undertake a study of BAVS's wage and benefits package to determine whether the current package is equitable as well as competitive in relation to comparable NGOs. The study suggests that no major improvement in BAVS's compensation package is warranted and therefore, personnel costs, which constitute 50% of BAVS's overall costs, are expected to increase only incrementally over the next few years.
8. Improved Accounting Procedures: AVS arranged for a local consultant to refine and strengthen BAVS's draft accounting manual. As a result BAVS will soon be utilizing for the first time a comprehensive, consolidated accounting manual developed with major inputs from accounting experts.
9. Budget Revision: The BAVS budget was simplified and standardized for all clinics. A set of comprehensive budget notes was developed to supplement and explain the new budget.
10. Improved Logistics Management: A new centralized and less costly system was developed for the procurement, storage, and distribution of vsc-related medical supplies.

In addition to the abovementioned financial steps, several programmatic innovations were developed in 1984 for implementation in 1985 which should result in greater program efficiency. Among these innovations were:

1. Maximizing BAVS Service Capacity: Clinics with the highest cost per-case and lowest vsc performance were identified and will be visited by a special program development team in the first quarter of 1985. The team will produce an action plan for implementation by the low-performing clinics which should result in declines in cost per-case and increases in the volume of services. If no improvement is seen in a year or so, resources will be cut or clinics closed.

2. Temporary Method Provision: IUD services to all interested, eligible requestors will be introduced on a system-wide basis beginning 1 January 1985 and temporary method performance criteria will be applied to the evaluation of BAVS field agents. The addition of IUD services and the increased attention in general to the provision of temporary methods will lead to a more efficient utilization of BAVS financial and human resources to more fully meet family planning needs.
3. Referrals: Renewed efforts will be made to establish formal referral linkages with service providers who do not offer vsc. By doing so BAVS will help further rationalize the overall national service delivery system and more fully realize their own service delivery potential.
4. Advance Planning: With technical assistance from AVS, BAVS has produced detailed activity, training, and site visit plans and schedules for 1985. Such advance planning will help improve the projection of financial requirements and promote the efficient utilization of funds.

D. Self-Reliance

In addition to achieving real reductions in the costs of running the BAVS program in 1985, other important steps have been taken towards self-reliance. During 1984 BAVS procured a low-cost parcel of land from the government as the future site of its headquarters and model clinic building. BAVS Bhola finished the first phase of its clinic renovation program and in 1985 will complete it to become the first BAVS branch to own its clinic facility and land. Self-reliance committees have been constituted on the national and clinic level and initial discussions began regarding the feasibility of establishing retail outlets for the sale of temporary methods and O.R.S. at BAVS clinics.

III. The National VSC Program

A. VSC Training

After surmounting formidable coordination problems related to the fact that three government departments are involved in the program's implementation, progress was made in 1984 on the provision of vsc refresher training to the estimated 600 government doctors in need of such training. At year's end, over 400 doctors received training at one of the seventeen BAVS clinics involved in the program. A committee has been convened to oversee the program's evaluation which will focus on determining the extent to which trainees are utilizing the training at their home institutions.

As a result of persistent AVS and BAVS follow-up, major progress was made in 1984 on the improvement and expansion of comprehensive vsc training on the national level. An inter-agency (AVS/BAVS/USAID/GOB) committee was convened to update and consolidate the training needs assessments done by AVS and the Health and Population Control directorates and to develop an action plan for the recommendations' implementation. One of the main recommendations, to improve the family planning curriculum used in the nation's medical schools, began to be addressed at the end of 1984 with the establishment of a curriculum task force consisting of the deans of all medical schools and other experts. The task force, supported by AVS, has already drafted a curriculum which is expected to be finalized in early 1985. Other activities needed to upgrade vsc training at the nation's eight model family planning clinics are expected to be consolidated in a proposal for AVS funding in mid-1985.

B. Research and Evaluation

Though not funded under the mission agreement, the status of AVS's follow-up study of female BAVS clients should nevertheless be mentioned, as the study's results will directly benefit the mission-funded service program. At year's end, focus group interviews have been completed and survey staff have been trained and are ready to be fielded at nine of the 32 BAVS clinics which offer female vsc services. The final report is expected to be available in June/July 1985. Plans are also underway for a follow-up survey of male BAVS clients.

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Table # 1: Summary of BAVS Outputs, January-December 1984

I. SERVICES:

A. Sterilizations requested:

| | |
|-----------|---------------|
| 1. Male | 68,267 |
| 2. Female | <u>46,827</u> |
| 3. Total | 115,094 |

B. Sterilization Requestors rejected and percent rejected

| | | |
|-----------|--------------|--------------|
| 1. Male | 7,503 | 11.0% |
| 2. Female | <u>5,274</u> | <u>11.3%</u> |
| 3. Total | 12,777 | 11.1% |

C. Sterilizations Performed

| | |
|-----------|---------------|
| 1. Male | 60,764 |
| 2. Female | <u>41,552</u> |
| 3. Total | 102,316 |

D. Follow-up Rate:

| | |
|-----------|------------|
| 1. Male | 84% |
| 2. Female | <u>91%</u> |
| 3. Total | 87% |

E. Temporary Methods Provided:

| | |
|--------------------|---------|
| 1. IUDs | 229 |
| 2. OC(cycles) | 8,790 |
| 3. Condoms(pieces) | 752,903 |
| 4. Foam(vials) | 129 |
| 5. Foam(tablets) | 248 |

F. Number of Clinics:

| | |
|---|----|
| 1. Opened during the period | 6 |
| 2. Total Operational at the end of the period | 34 |

II. TRAINING

A. Physicians

| | |
|---------------------------|-----|
| 1. BAVS VSC Comprehensive | 55 |
| 2. BAVS IUD | 15 |
| 3. BAVS VSC Refresher | 11 |
| 4. GOB Refresher | 234 |

(more)

| | |
|----------------------------|-----|
| B. Paramedics | 65* |
| C. Counselors | 4 |
| D. Accountants | 8 |
| E. Administrative Officers | 7 |
| F. Field Agents | 254 |

III. CONFERENCE/WORKSHOPS:

| | |
|-------------------------|---|
| Annual Medical Workshop | 1 |
|-------------------------|---|

*19 trained in IUD

GN/ts:ab
130185

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Table #2 : Yearly moving average of BAVS VSC Performance
January 1983 through December 1984

| | Vasectomy | Tubectomy | Total |
|----------------|-----------|-----------|-------|
| January 1983 | 1975 | 3529 | 5504 |
| February 1983 | 1907 | 3415 | 5322 |
| March 1983 | 1755 | 3265 | 5020 |
| April 1983 | 1623 | 3129 | 4752 |
| May 1983 | 1584 | 3041 | 4625 |
| June 1983 | 1536 | 2960 | 4496 |
| July 1983 | 1521 | 2955 | 4476 |
| August 1983 | 1554 | 2902 | 4456 |
| September 1983 | 1615 | 2880 | 4495 |
| October 1983 | 1850 | 2922 | 4772 |
| November 1983 | 2287 | 3073 | 5360 |
| December 1983 | 2521 | 3177 | 5698 |
| January 1984 | 2930 | 3357 | 6287 |
| February 1984 | 3282 | 3551 | 6833 |
| March 1984 | 3585 | 3654 | 7239 |
| April 1984 | 3841 | 3724 | 7565 |
| May 1984 | 4093 | 3743 | 7836 |
| June 1984 | 4419 | 3693 | 8112 |
| July 1984 | 4857 | 3839 | 8696 |
| August 1984 | 5194 | 3898 | 9092 |
| September 1984 | 5422 | 3929 | 9351 |
| October 1984 | 5554 | 3862 | 9416 |
| November 1984 | 5227 | 3611 | 8838 |
| December 1984 | 5063 | 3463 | 8526 |

Table #3 BAVS VSC PERFORMANCE SINCE JANUARY 1979

| M o n t h | Procedures | Y e a r s | | | | | |
|-----------|------------|--------------|--------------|--------------|--------------|--------------|---------------|
| | | 1979 | 1980 | 1981 | 1982 | 1983 | 1984 |
| January | Vasectomy | 106 | 158 | 218 | 1616 | 1334 | 6242 |
| | Tubectomy | <u>1054</u> | <u>2155</u> | <u>2638</u> | <u>3831</u> | <u>3152</u> | <u>5308</u> |
| | Total: | 1160 | 2313 | 2856 | 5447 | 4486 | 11550 |
| February | Vasectomy | 33 | 191 | 270 | 2061 | 1250 | 5478 |
| | Tubectomy | <u>865</u> | <u>3590</u> | <u>3134</u> | <u>5032</u> | <u>3665</u> | <u>5999</u> |
| | Total: | 898 | 3781 | 3404 | 7093 | 4915 | 11477 |
| March | Vasectomy | 120 | 187 | 253 | 3047 | 1225 | 4856 |
| | Tubectomy | <u>2063</u> | <u>2594</u> | <u>3395</u> | <u>5394</u> | <u>3586</u> | <u>4825</u> |
| | Total: | 2183 | 2781 | 3648 | 8441 | 4811 | 9681 |
| April | Vasectomy | 100 | 140 | 344 | 2746 | 1158 | 4232 |
| | Tubectomy | <u>1223</u> | <u>2319</u> | <u>2602</u> | <u>4042</u> | <u>2417</u> | <u>3250</u> |
| | Total: | 1323 | 2459 | 2946 | 6788 | 3575 | 7482 |
| May | Vasectomy | 253 | 108 | 519 | 1684 | 1222 | 4242 |
| | Tubectomy | <u>1641</u> | <u>1622</u> | <u>2826</u> | <u>3482</u> | <u>2424</u> | <u>2660</u> |
| | Total: | 1894 | 1730 | 3345 | 5166 | 3646 | 6902 |
| June | Vasectomy | 278 | 155 | 641 | 1608 | 1032 | 4937 |
| | Tubectomy | <u>1923</u> | <u>2295</u> | <u>3042</u> | <u>2941</u> | <u>1968</u> | <u>1367</u> |
| | Total: | 2201 | 2450 | 3683 | 4549 | 3000 | 6304 |
| July | Vasectomy | 647 | 220 | 1055 | 1665 | 1483 | 6749 |
| | Tubectomy | <u>3017</u> | <u>2726</u> | <u>1810</u> | <u>1866</u> | <u>1806</u> | <u>3556</u> |
| | Total: | 3664 | 2946 | 2865 | 3531 | 3289 | 10305 |
| August | Vasectomy | 213 | 151 | 957 | 1343 | 1733 | 5792 |
| | Tubectomy | <u>1310</u> | <u>1439</u> | <u>2743</u> | <u>2950</u> | <u>2318</u> | <u>3027</u> |
| | Total: | 1523 | 1590 | 3700 | 4293 | 4051 | 8799 |
| September | Vasectomy | 340 | 406 | 2911 | 2217 | 2951 | 5695 |
| | Tubectomy | <u>2248</u> | <u>3706</u> | <u>4337</u> | <u>3032</u> | <u>2772</u> | <u>3138</u> |
| | Total: | 2588 | 4112 | 7248 | 5249 | 5723 | 8833 |
| October | Vasectomy | 547 | 543 | 3687 | 3215 | 6042 | 7618 |
| | Tubectomy | <u>2735</u> | <u>3656</u> | <u>4266</u> | <u>5131</u> | <u>5623</u> | <u>4827</u> |
| | Total: | 3282 | 4199 | 7953 | 8346 | 11665 | 12445 |
| November | Vasectomy | 251 | 374 | 2252 | 1861 | 7104 | 3185 |
| | Tubectomy | <u>2719</u> | <u>3064</u> | <u>3262</u> | <u>3406</u> | <u>5219</u> | <u>2201</u> |
| | Total: | 2970 | 3438 | 5514 | 5267 | 12323 | 5386 |
| December | Vasectomy | 160 | 188 | 1402 | 914 | 1720 | 1758 |
| | Tubectomy | <u>2169</u> | <u>2274</u> | <u>2836</u> | <u>1922</u> | <u>3174</u> | <u>1394</u> |
| | Total: | 2327 | 2462 | 4238 | 2836 | 4894 | 3152 |
| TOTAL | Vasectomy | 3048 | 2821 | 14509 | 23977 | 30254 | 60,764 |
| | Tubectomy | <u>22965</u> | <u>31440</u> | <u>36891</u> | <u>43029</u> | <u>38124</u> | <u>41,552</u> |
| | Total: | 26013 | 34261 | 51400 | 67006 | 68378 | 102,316 |

BANGLADESH
Table #4 VSC NATIONAL PERFORMANCE SINCE 1980
(Including BAVS and Other NGOs)

| Month | Procedures | 1980 | 1981 | 1982 | 1983 | 1984 |
|-----------|------------|----------------|----------------|----------------|----------------|---------------|
| January | Vasectomy | 1,744 | 1,313 | 3,789 | 5,300 | 22,650 |
| | Tubectomy | <u>17,973</u> | <u>20,996</u> | <u>18,477</u> | <u>24,402</u> | <u>37,094</u> |
| | Total: | 19,717 | 22,309 | 22,266 | 29,702 | 59,744 |
| February | Vasectomy | 2,340 | 2,455 | 5,821 | 5,689 | 22,314 |
| | Tubectomy | <u>24,370</u> | <u>24,779</u> | <u>27,823</u> | <u>29,585</u> | <u>43,528</u> |
| | Total: | 26,710 | 27,234 | 33,644 | 35,274 | 65,842 |
| March | Vasectomy | 2,440 | 1,332 | 6,860 | 7,067 | 22,799 |
| | Tubectomy | <u>22,156</u> | <u>19,576</u> | <u>31,251</u> | <u>29,794</u> | <u>37,436</u> |
| | Total: | 24,596 | 20,908 | 38,111 | 36,861 | 60,235 |
| April | Vasectomy | 1,015 | 2,074 | 8,591 | 4,426 | 20,316 |
| | Tubectomy | <u>13,146</u> | <u>21,284</u> | <u>28,335</u> | <u>19,938</u> | <u>27,805</u> |
| | Total: | 14,161 | 23,358 | 36,926 | 24,364 | 48,121 |
| May | Vasectomy | 231 | 3,133 | 7,015 | 4,502 | 21,201 |
| | Tubectomy | <u>2,480</u> | <u>19,491</u> | <u>28,540</u> | <u>17,970</u> | <u>23,136</u> |
| | Total: | 2,711 | 22,624 | 35,555 | 22,472 | 44,337 |
| June | Vasectomy | 675 | 3,395 | 8,723 | 3,484 | 19,950 |
| | Tubectomy | <u>7,600</u> | <u>16,175</u> | <u>25,296</u> | <u>12,438</u> | <u>10,061</u> |
| | Total: | 8,275 | 19,570 | 34,019 | 15,922 | 30,011 |
| July | Vasectomy | 1,132 | 2,647 | 8,470 | 4,006 | 28,732 |
| | Tubectomy | <u>13,777</u> | <u>7,736</u> | <u>12,531</u> | <u>12,217</u> | <u>25,434</u> |
| | Total: | 14,909 | 10,383 | 21,001 | 16,223 | 54,166 |
| August | Vasectomy | 1,260 | 3,509 | 5,892 | 5,641 | 29,786 |
| | Tubectomy | <u>10,333</u> | <u>13,235</u> | <u>22,082</u> | <u>18,381</u> | <u>23,140</u> |
| | Total: | 11,593 | 16,744 | 27,974 | 24,022 | 52,926 |
| September | Vasectomy | 3,655 | 6,552 | 11,397 | 10,147 | 33,699 |
| | Tubectomy | <u>24,134</u> | <u>11,175</u> | <u>25,631</u> | <u>20,951</u> | <u>28,528</u> |
| | Total: | 27,789 | 17,727 | 37,028 | 31,098 | 62,227 |
| October | Vasectomy | 3,011 | 9,138 | 17,106 | 21,205 | 46,411 |
| | Tubectomy | <u>20,643</u> | <u>19,815</u> | <u>37,578</u> | <u>41,194</u> | <u>42,196</u> |
| | Total: | 23,654 | 28,953 | 54,684 | 62,399 | 88,607 |
| November | Vasectomy | 1,503 | 4,754 | 10,718 | 29,136 | 24,098 |
| | Tubectomy | <u>14,599</u> | <u>13,194</u> | <u>24,766</u> | <u>41,476</u> | <u>22,122</u> |
| | Total: | 16,102 | 17,948 | 35,484 | 70,612 | 46,220 |
| December | Vasectomy | 1,098 | 3,744 | 4,333 | 14,928 | |
| | Tubectomy | <u>14,210</u> | <u>15,752</u> | <u>17,923</u> | <u>22,171</u> | |
| | Total: | 15,308 | 19,496 | 22,256 | 37,099 | |
| TOTAL: | Vasectomy | 20,104 | 44,046 | 98,715 | 115,511 | |
| | Tubectomy | <u>185,421</u> | <u>203,208</u> | <u>300,233</u> | <u>290,517</u> | |
| | Total: | 205,525 | 247,254 | 398,948 | 406,048 | |

Table: #5

BAVS Performance and Follow-up by Month for
January 1984 to December 1984 for all clinics

| Month | V a s e c t o m y | | | T u b e c t o m y | | | T o t a l | | |
|--------------------|-------------------|---------------|--------------|-------------------|---------------|--------------|----------------|---------------|--------------|
| | Performance | Follow-up | R a t e | Performance | Follow-up | R a t e | Performance | Follow-up | R a t e |
| January '84 | 6,242 | 5,582 | 89.4% | 5,308 | 4,693 | 88.4% | 11,550 | 10,275 | 88.9% |
| February '84 | 5,478 | 4,750 | 86.7% | 5,999 | 5,550 | 92.5% | 11,477 | 10,300 | 89.7% |
| March '84 | 4,856 | 4,214 | 86.8% | 4,825 | 4,328 | 86.6% | 9,681 | 8,542 | 88.2% |
| April '84 | 4,232 | 3,715 | 87.8% | 3,250 | 2,982 | 91.7% | 7,482 | 6,697 | 89.5% |
| May '84 | 4,242 | 3,585 | 84.5% | 2,660 | 2,353 | 88.4% | 6,902 | 5,938 | 86.0% |
| June '84 | 4,937 | 4,012 | 81.3% | 1,367 | 1,537 | 112.4%* | 6,304 | 5,549 | 88.0% |
| July '84 | 6,749 | 5,971 | 88.5% | 3,556 | 3,342 | 94.0% | 10,305 | 9,313 | 90.4% |
| August '84 | 5,772 | 4,801 | 83.1% | 3,027 | 2,754 | 91.0% | 8,799 | 7,555 | 85.8% |
| September '84 | 5,695 | 4,405 | 77.3% | 3,138 | 2,738 | 87.2% | 8,833 | 7,143 | 80.9% |
| October '84 | 7,618 | 6,286 | 82.5% | 4,827 | 4,195 | 86.9% | 12,445 | 10,481 | 84.2% |
| November '84 | 3,185 | 2,428 | 76.2% | 2,201 | 1,922 | 87.3% | 5,386 | 4,350 | 80.8% |
| December '84 | 1,758 | 1,204 | 68.4% | 1,394 | 1,195 | 85.7% | 3,152 | 2,399 | 76.1% |
| TOTAL 1984: | 60,764 | 50,953 | 83.9% | 41,552 | 37,589 | 90.5% | 102,316 | 88,542 | 86.5% |

*Note: Total number of follow-up visits reported is greater than total reported VSC procedures because it includes 2nd and sometimes 3rd follow-up visits for the same client. Follow-up figures for July to December '84 period includes only 1st follow-up.

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Table# 6

BAVS Performance and Follow-up by Month for January 1984 to December 1984 for all clinics.

| Clinics | V a s e c t o m y | | | T u b e c t o m y | | | T o t a l | | |
|-----------------|-------------------|-----------|---------|-------------------|-----------|---------|-------------|-----------|---------|
| | Performance | Follow-up | R a t e | Performance | Follow-up | R a t e | Performance | Follow-up | R a t e |
| 1. Barisal | 1,508 | 1,292 | 80.3% | 2,495 | 2,185 | 87.6% | 4,003 | 3,477 | 86.8% |
| 2. Bhola | 1,545 | 1,493 | 96.6% | 797 | 782 | 98.1% | 2,342 | 2,275 | 97.1% |
| 3. Brahmanbaria | 1,238 | 656 | 52.9% | 1,149 | 1,073 | 93.4% | 2,387 | 1,729 | 72.4% |
| 4. Bogra | 2,806 | 2,424 | 86.4% | 1,739 | 1,521 | 87.5% | 4,545 | 3,945 | 86.8% |
| 5. Chandpur | 574 | 537 | 93.5% | 730 | 698 | 95.6% | 1,304 | 1,235 | 94.7% |
| 6. Chittagong | 1,079 | 814 | 75.4% | 441 | 344 | 78.0% | 1,520 | 1,158 | 76.2% |
| 7. Comilla | 2,036 | 1,542 | 75.7% | 657 | 596 | 90.7% | 2,693 | 2,138 | 79.4% |
| 8. CBVP | 2,045 | 1,079 | 52.8% | N.A. | N.A. | N.A. | 2,045 | 1,079 | 52.8% |
| 9. Cox's Bazar | 33 | 32 | 96.9% | 192 | 179 | 93.2% | 225 | 211 | 93.8% |
| 10. Dhaka | 2,263 | 1,717 | 75.9% | 4,199 | 3,688 | 87.8% | 6,462 | 5,405 | 83.6% |
| 11. Dinajpur | 985 | 888 | 90.2% | 870 | 833 | 95.7% | 1,855 | 1,721 | 92.8% |
| 12. Faridpur | 2,329 | 2,280 | 97.9% | 1,500 | 1,484 | 98.9% | 3,829 | 3,764 | 98.3% |
| 13. Gaibandha | 658 | 482 | 73.3% | 1,071 | 877 | 81.9% | 1,729 | 1,359 | 78.6% |
| 14. Joypurhat | 2,991 | 2,813 | 94.1% | 480 | 463 | 96.4% | 3,471 | 3,276 | 94.4% |
| 15. Jessore | 2,459 | 2,129 | 86.6% | 1,140 | 1,077 | 94.5% | 3,599 | 3,206 | 89.1% |
| 16. Khulna | 1,560 | 1,370 | 87.8% | 2,288 | 2,005 | 87.6% | 3,848 | 3,375 | 87.7% |
| 17. Kishoregonj | 1,655 | 1,648 | 99.6% | 1,022 | 1,020 | 99.8% | 2,677 | 2,668 | 99.7% |
| 18. Kushtia | 3,031 | 2,800 | 92.4% | 2,580 | 2,267 | 87.9% | 5,611 | 5,067 | 90.3% |
| 19. Mymensingh | 3,266 | 3,030 | 92.8% | 4,079 | 3,826 | 93.8% | 7,345 | 6,856 | 93.3% |
| 20. Naogaon | 4,445 | 4,240 | 95.4% | 1,455 | 1,379 | 94.8% | 5,900 | 5,619 | 95.2% |
| 21. Narail | 1,031 | 766 | 74.3% | 109 | 89 | 81.6% | 1,140 | 855 | 75.0% |
| 22. Natore | 2,732 | 2,503 | 91.6% | 1,343 | 1,273 | 94.8% | 4,075 | 3,776 | 92.7% |
| 23. Nilphamari | 929 | 476 | 51.2% | 126 | 55 | 43.7% | 1,055 | 531 | 50.3% |
| 24. Noakhali | 1,561 | 1,335 | 85.5% | 650 | 601 | 92.5% | 2,211 | 1,936 | 87.6% |
| 25. Narsingdi | 3,222 | 2,475 | 76.8% | 505 | 441 | 87.3% | 3,727 | 2,916 | 78.2% |
| 26. Pabna | 2,404 | 1,843 | 76.7% | 1,693 | 1,415 | 83.6% | 4,097 | 3,258 | 79.5% |
| 27. Perojpur | 1,051 | 880 | 83.7% | 434 | 342 | 78.8% | 1,485 | 1,222 | 82.3% |
| 28. Rajshahi | 951 | 781 | 82.1% | 1,572 | 1,362 | 86.6% | 2,523 | 2,143 | 84.9% |
| 29. Rangpur | 1,676 | 1,571 | 93.7% | 1,198 | 1,157 | 96.6% | 2,874 | 2,728 | 94.9% |
| 30. Serajgong | 716 | 650 | 90.8% | 974 | 823 | 84.5% | 1,690 | 1,473 | 87.2% |
| 31. Sylhet | 2,018 | 1,599 | 79.2% | 1,051 | 821 | 78.1% | 3,069 | 2,420 | 78.9% |
| 32. Tangail | 2,072 | 1,624 | 78.4% | 1,358 | 1,249 | 91.9% | 3,430 | 2,873 | 83.8 |
| 33. Tongi | 1,001 | 546 | 54.5% | 1,655 | 1,545 | 93.3% | 2,656 | 2,091 | 78.7% |
| 34. Ulipur | 894 | 815 | 91.2% | N.A. | N.A. | N.A. | 894 | 815 | 91.2% |
| TOTAL: | 60,764 | 51,130 | 84.1% | 41,552 | 37,470 | 90.2% | 102,316 | 88,600 | 86.6% |

Note: The following follow-up figures are not available:

i) Sylhet: September 1984

ii) Narail: September and December 1984

iii) Gaibandha: October 1984

iv) Nilphamari: July and August 1984

Table: #7 BAVS mortality investigations and Summary
of findings January to December 1984

| Name of Client/Sex | Name of BAVS Clinic | Date of Operation | Date of Death | Probable Cause(s) of Death | Findings |
|------------------------------|---------------------|-------------------|---------------|---|----------------------|
| Ruma Ali (Male) | Mymensingh | 24 Jan'84 | 29 Jan'84 | 1. Cardiac arrest 2. Pulmonary embolism 3. Jarcotic poisoning (crude opium)/ food poisoning 4. Septicaemia 5. Secondary Haemorrhage | Non attributable |
| Iman Ali (Male) | Chandpur | 6 Feb'84 | 19 Feb'84 | 1. Post-operative peritonitis following resection of gangrenous volvulus. | Nonattributable |
| Abdul Wahab (Male) | Khulna | 20 Mar'84 | 30 Mar'84 | 1. Shock due to myocardial infarction | Non attributable |
| Abdur Rahman Sheikh (Male) | Khulna | 30 May'84 | 8 Jun'84 | 1. Poisoning due to adulterated liquor. | Case not yet closed. |
| Mofiz Khan (Male) | Pirojpur | 26 Jul'84 | 16 Aug'84 | 1. Shock due to perforation of gastic ulcer and acute bacillary dysantray | Non attributable |
| Rahima Alias Felany (Female) | Rajshahi | 13 Oct'84 | 25 Oct'84 | 1. Septicaemia due to secondary infection. 2. Pernicious Malaria | Case not yet closed. |

TABLE: # 8 CLINIC WISE MONTHLY COMPLICATIONS STATISTICS
(JANUARY TO DECEMBER 1984)

| Clinics | Jan | | | Feb | | | March | | | April | | | May | | | June | | | July | | | August | | | Sept. | | | October | | | Nov. | | | Dec. | | | T o t a l | | |
|-----------------|-----|----|----|-----|----|----|-------|---|----|-------|---|---|-----|----|----|------|---|----|------|----|----|--------|---|---|-------|---|---|---------|---|---|------|---|---|------|----|----|-----------|--------|-------|
| | M | F | T | M | F | T | M | F | T | M | F | T | M | F | T | M | F | T | M | F | T | M | F | T | M | F | T | M | F | T | M | F | T | M | F | T | Male | Female | Total |
| 1. Barisal | 2 | - | 2 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 2 | 2 | - | - | - | - | - | - | - | 1 | 1 | - | - | - | 2 | 3 | 5 | | | | |
| 2. Bhola | - | - | - | 2 | 1 | 3 | - | 1 | 1 | - | - | - | 4 | 1 | 5 | 1 | - | 1 | 2 | - | 2 | - | 1 | 1 | - | - | - | - | - | - | 2 | - | 2 | 11 | 4 | 15 | | | |
| 3. Brahmanbaria | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | | | |
| 4. Bogra | - | - | - | - | - | - | 1 | - | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | - | 1 | | | | |
| 5. Chandpur | - | - | - | - | - | - | - | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | 1 | 1 | | |
| 6. Chittagong | 1 | - | 1 | - | - | - | - | - | - | - | - | - | - | - | - | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | 2 | 3 | | | |
| 7. Comilla | 2 | 1 | 3 | - | 1 | 1 | - | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | 1 | - | 1 | 1 | - | - | - | 2 | 5 | 7 | | | |
| 8. C.B.V.P. | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | | | |
| 9. Cox's Bazar | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | | | |
| 10. Dhaka | - | - | - | - | 2 | 2 | - | 1 | 1 | - | 3 | 3 | - | 6 | 6 | - | - | - | 4 | 4 | - | - | - | 1 | - | 1 | - | 1 | 1 | - | - | - | 2 | 2 | 1 | 19 | 20 | | |
| 11. Dinajpur | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | | | |
| 12. Faridpur | 1 | 2 | 3 | - | 1 | 1 | - | - | - | - | 2 | 2 | - | 1 | 1 | - | - | - | - | - | - | - | - | 1 | - | 1 | - | - | - | - | - | - | - | 2 | 6 | 8 | | | |
| 13. Gaibandha | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | 1 | - | - | - | - | - | - | 1 | 1 | - | - | - | - | - | - | - | - | 1 | 1 | - | 3 | 3 | | |
| 14. Joypurhat | - | - | - | - | - | - | - | - | - | - | 1 | - | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | - | 1 | | | |
| 15. Jessore | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | - | 1 | - | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | 1 | 1 | 2 | | | |
| 16. Khulna | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | | | |
| 17. Kishoregonj | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | | | |
| 18. Kushtia | 2 | - | 2 | - | - | - | - | - | - | 1 | 1 | 2 | - | - | - | 3 | 1 | 4 | 4 | 1 | 5 | - | - | - | - | - | 1 | - | 1 | 1 | - | 1 | - | 1 | 1 | 12 | 3 | 15 | |
| 19. Mymensingh | - | 2 | 2 | - | - | - | 2 | - | 2 | - | - | - | - | - | - | 1 | 1 | - | - | - | - | - | - | - | - | 1 | - | 1 | - | - | - | - | - | - | 3 | 3 | 6 | | |
| 20. Naogaon | - | 3 | 3 | 2 | 3 | 5 | - | - | - | - | - | - | - | 2 | 2 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | 1 | 2 | 9 | 11 | | |
| 21. Narail | - | - | - | - | - | - | - | - | - | - | 1 | 1 | - | - | - | 1 | - | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | 1 | 1 | - | 1 | 4 | |
| 22. Natore | - | 2 | 2 | 1 | - | 1 | - | - | - | - | - | - | - | - | - | - | 1 | 1 | 1 | - | 1 | - | 1 | - | 1 | - | - | - | - | - | - | 2 | 2 | - | 2 | 5 | 7 | | |
| 23. Nilphamari | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | | |
| 24. Noakhali | - | - | - | - | - | - | - | - | - | - | 1 | 1 | - | - | - | 1 | 3 | 4 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | 4 | 5 | | | |
| 25. Norsingdi | - | - | - | - | - | - | 1 | - | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | - | 1 | | | |
| 26. Pabna | 1 | - | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | - | 1 | - | - | - | 1 | 1 | - | - | - | - | - | - | 2 | 1 | 3 | - | - | | |
| 27. Perojpur | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | | |
| 28. Rajshahi | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 4 | 4 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | 1 | - | 5 | 5 | | |
| 29. Rangpur | 1 | 1 | 2 | 1 | - | 1 | - | 3 | 3 | - | - | - | - | - | - | 1 | - | 1 | 1 | - | 1 | - | 1 | - | 1 | - | 1 | - | 1 | 1 | - | - | - | 4 | 4 | 8 | | | |
| 30. Serajgonj | - | - | - | - | - | - | 1 | - | 1 | - | - | - | 1 | - | 1 | - | - | - | 1 | - | 1 | - | - | - | 1 | - | 1 | - | 1 | 1 | - | - | - | 4 | 1 | 5 | | | |
| 31. Sylhet | - | - | - | - | - | - | - | - | - | - | - | - | 1 | - | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 | - | 1 | | | |
| 32. Tangail | - | - | - | - | 8 | 8 | - | 1 | 1 | - | - | - | - | - | - | - | - | - | - | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | 10 | 10 | | | |
| 33. Tongi | - | 2 | 2 | - | 1 | 1 | - | 1 | 1 | - | - | - | 1 | 1 | - | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 6 | 6 | | | |
| 34. Ulipur | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | | |
| TOTAL: | 10 | 13 | 23 | 6 | 17 | 23 | 5 | 9 | 14 | 1 | 6 | 7 | 6 | 13 | 19 | 5 | 5 | 10 | 11 | 14 | 25 | 3 | 5 | 8 | 3 | 1 | 4 | 1 | 4 | 5 | 1 | 5 | 6 | 4 | 6 | 10 | 56 | 98 | 154 |

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M= Male
F= Female
T= Total

Table # 9 : Summary of Activities Funder under the
"Consultants and Training" Budget line
between 01 January and 31 December 1984

| Date | Amount | P u r p o s e |
|------------------|--------------------------|---|
| February 1984 | \$ 1,288 (Tk.29,500) | Attendance in the Fifth International WFVSC conference held in the Dominican Republic (Mr. Syed Mansur-ul Haq). |
| February 1984 | \$ 2,543 (Tk.58,421) | Participation of two BAVS staff (Ms.Nadira Mallik and Mr.Zafarullah) in "Approaches to Evaluation" project workshop in Bangkok. |
| July'84 & Dec'84 | \$ 862 (Tk.20,000) | BAVS compensation study (Rahman Rahman and Haq) |
| September 1984 | \$ 4,893 (Tk.115,011) | Study tour for 4 BAVS Physician in Indonesia and Thailand |
| November 1984 | \$ 3,674 (Tk.92,768) | Attendance in International Population Conference, Mexico (Dr. Azizur Rahman, President, BAVS). |
| December 1984 | \$ 464 (Tk.11,000) | Consultancy on consolidation of BAVS Branch Accounting and Headquarters Manual (Mr. Syed Ahmed). |
| December 1984 | \$ 464 (Tk.11,000) | Expenditure for Task force for development of Model Clinic curriculum. |

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Table #10 Financial Status of USAID Cooperative Agreement #388-0050-A-1014-06 to AVS as of 01 January 1985.

| Budget Line ⁸ | Total amount obligated by USAID to AVS as of 01 November 1984 | Expenditures and sub-obligations as of 01 January 1985 | Balance as of 01 January 1985: (9) |
|--------------------------------------|---|--|------------------------------------|
| 1. Subgrants | 6,003,800 | a) 3,507,082 ¹ b) 4,622,203 ² | 1,381,597 ⁶ |
| 2. Consultants and Training | 150,000 | 95,333 | 54,667 |
| 3. Administrative Costs ⁷ | 210,450 | 88,810 | 121,640 |
| 4. Accounting and Audit | 63,300 | 8,268 | 55,032 |
| 5. Vehicles | 40,000 | 39,064 | 936 |
| Total: | \$6,467,550 | a) 3,738,557 ³ b) 4,853,678 ⁴ | 1,613,872 ⁵ |

1. This figure represents cumulative AO disbursements for all bilateral subgrants through 01 January 1985.
2. This figure represents cumulative sub-obligations for all bilateral subgrants through 01 January 1985.
3. This figure represents total cumulative disbursements (line #1) and expenditures under budget lines #2-5.
4. This figure represents total cumulative expenditures under budget lines #2-5 and total cumulative sub-obligations under budget line #1.
5. This figure represents the total amount available to expend and sub-obligate as of 01 January, 1985.
6. This figure represents the total amount available to be sub-obligated for bilateral subgrants as of 01 January, 1985.
7. "Local travel" and "bank charges" budget lines have been subsumed under "Administrative Costs" as of Amendment Six (29 August 1984).
8. AVS may reallocate funds among budget lines upto to 15% of each line item without amending the agreement.
9. Balances in lines #2 and #3 are not yet final as of 1 January, 1985.

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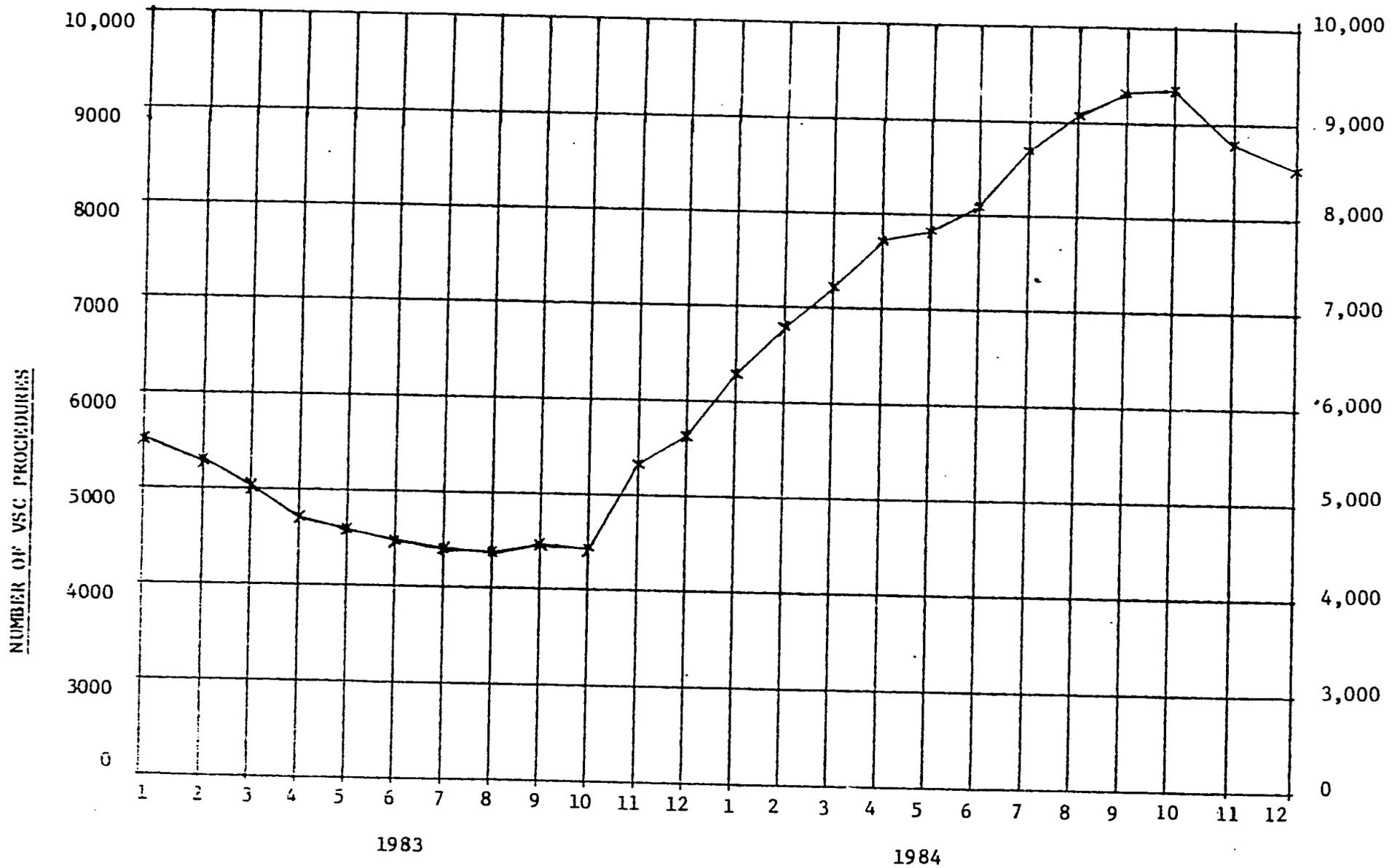
Table #11 : BAVS Expenditures, performance, and cost per-case, 1983-1985

| Y e a r | Expenditures (Taka) | % Change | Total VSC Performance | % Increase | Cost per Case (Taka) | % Decrease |
|---------|---------------------------|------------------|--------------------------|--------------------|-------------------------|---------------|
| 1983 | 26,943,727 ⁽¹⁾ | - | 68,378 | - | 394 | - |
| 1984 | 37,635,903 ⁽²⁾ | 40% | 102,316 | 50% ⁽⁴⁾ | 368 | 7% |
| 1985 | 37,132,096 ⁽³⁾ | (1%) Decrease | 110,000 | 8% | 338 | 8% |

- (1) Total expenditures reported under 400-049-2SB and 391-2SB (January'83) only), BGD-20-SV-3-B (Feb'83-Dec'83), BGD-29-SV-1-B (Aug'83 - Dec'83) and BGD-03-CO-8-A.
- (2) Total expenditures reported under BGD-20-SV-3-B, BGD-29-SV-1-B through Oct'84 and projected expenditures for November-December 1984 plus actual expenditures for BGD-03-CO-8-A through November'84 and projected expenditures for December'84.
- (3) Actual budgetted amount under BGD-03-CO-9-B.
- (4) If there were no increase in the number of BAVS clinics, performance would have increased 25% from 66,130(actual) to 83,000 (projected), i.e., "new" clinics' performance was factored-out of total 1983 and 1984 performance to analyze performance trends using a constant 24-clinic system assumption.

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Figure #1 : Yearly Moving Average of total BAVS VSC Performance
January 1983 thru December 1984



MALE: — x — x — x

FEMALE: - - o - - o - - o

Figure #2 : Yearly Moving Average of BAVS Male and Female VSC Performance: January 1983 through December 1984

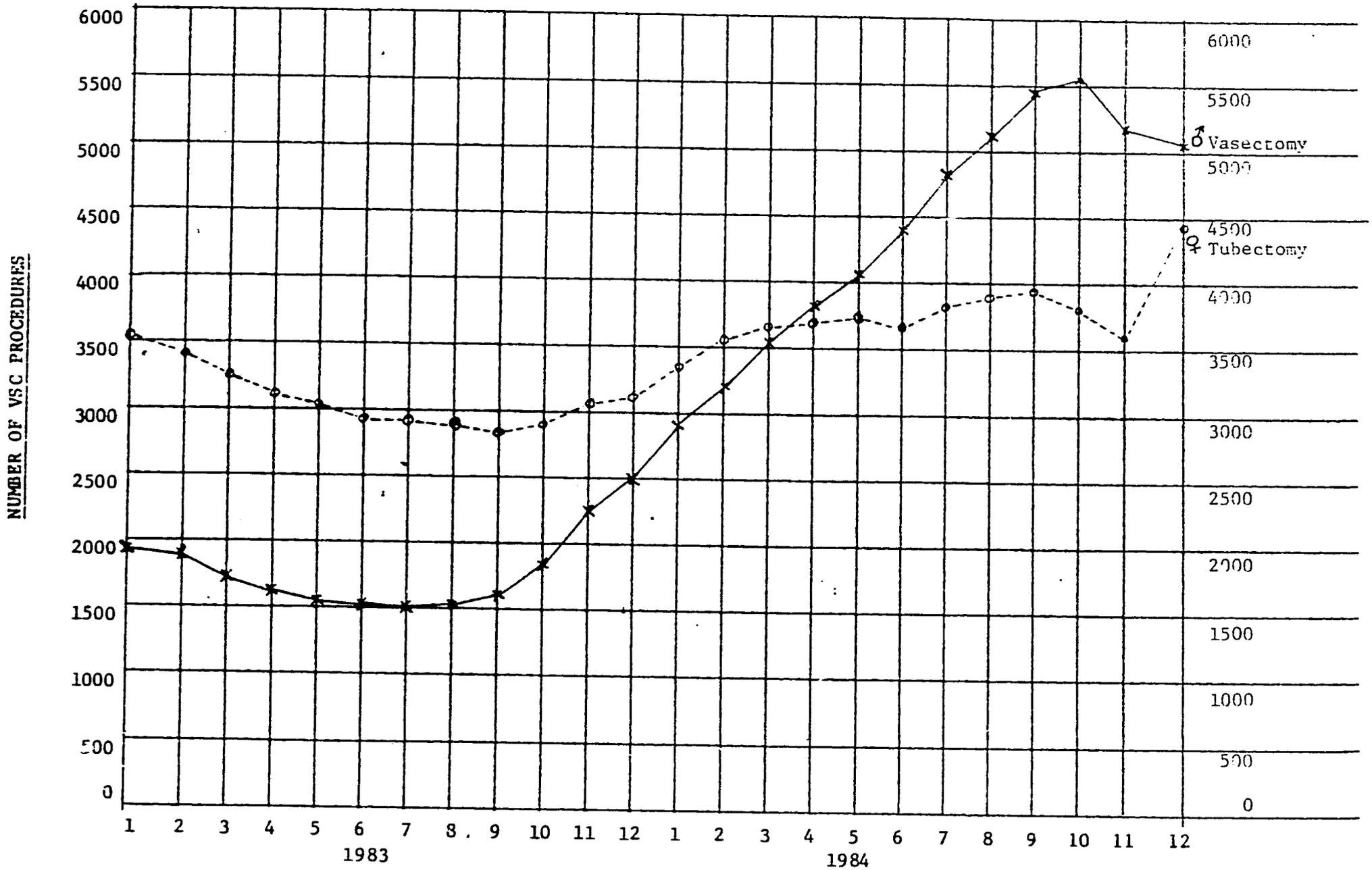
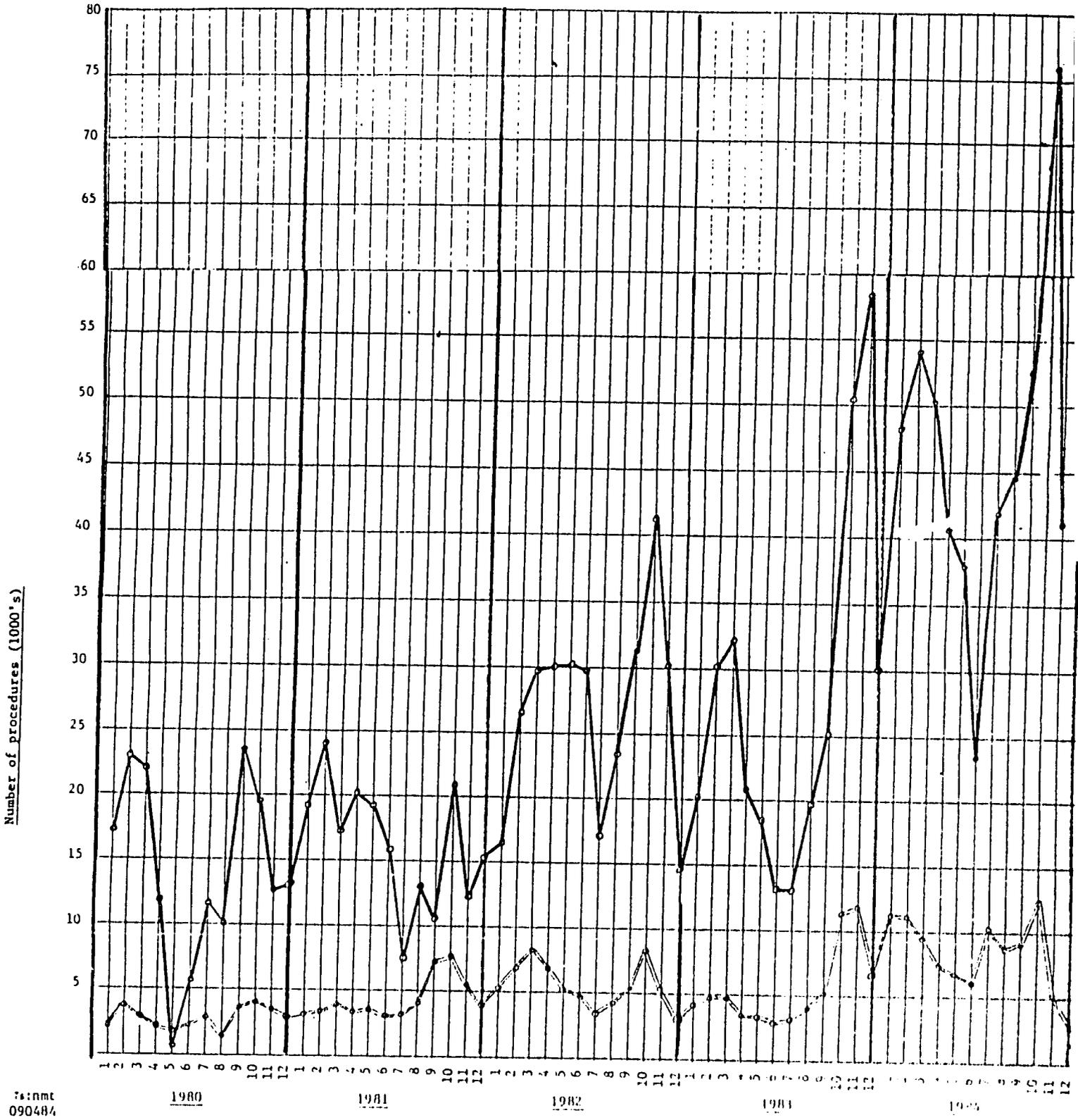


Figure #3

BAVS: _____
NATIONAL: _____

VSC Performance by Month between January 1980 and December 1984 for BAVS
Relative to the National Program (GOB Plus NGOs minus BAVS)



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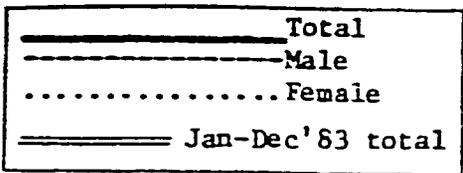
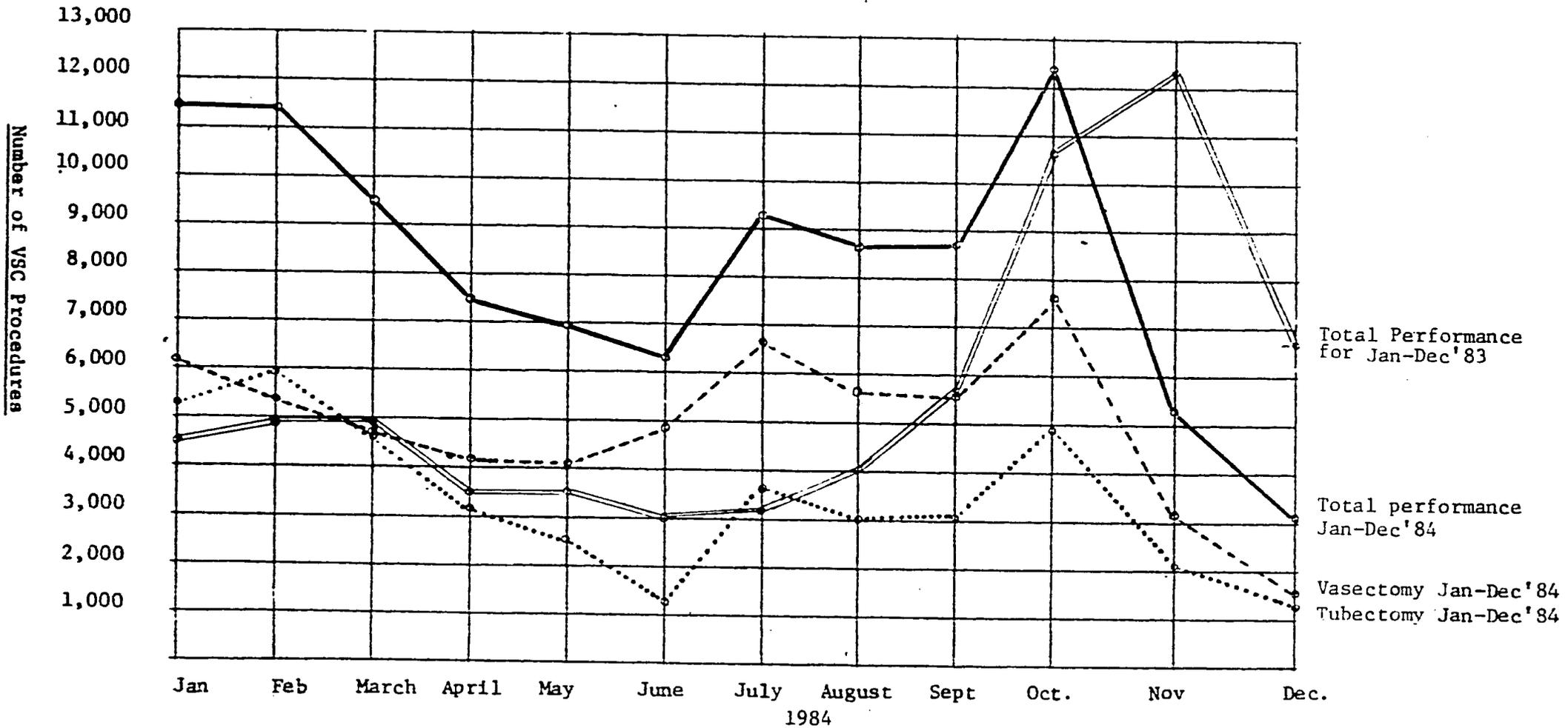


FIGURE # 4: Vasectomy, Tubectomy, and Total BAVS Performance by Month, Jan'84-Dec'84 with total BAVS Jan-Dec'83 performance shown for comparison



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100185

124

Figure #5 Total Vasectomy and Tubectomy Acceptance in the BAVS Program 1979 - 1984

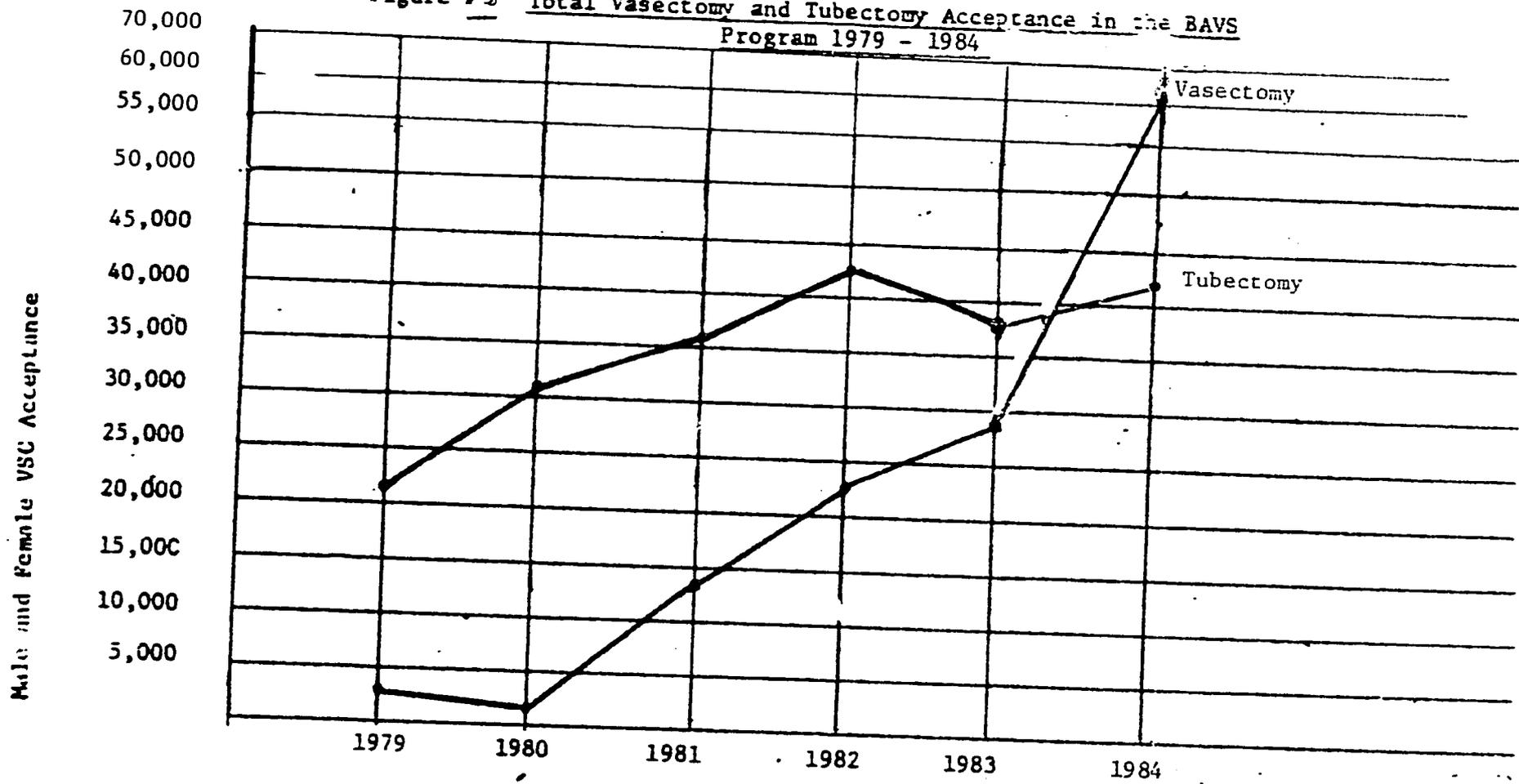
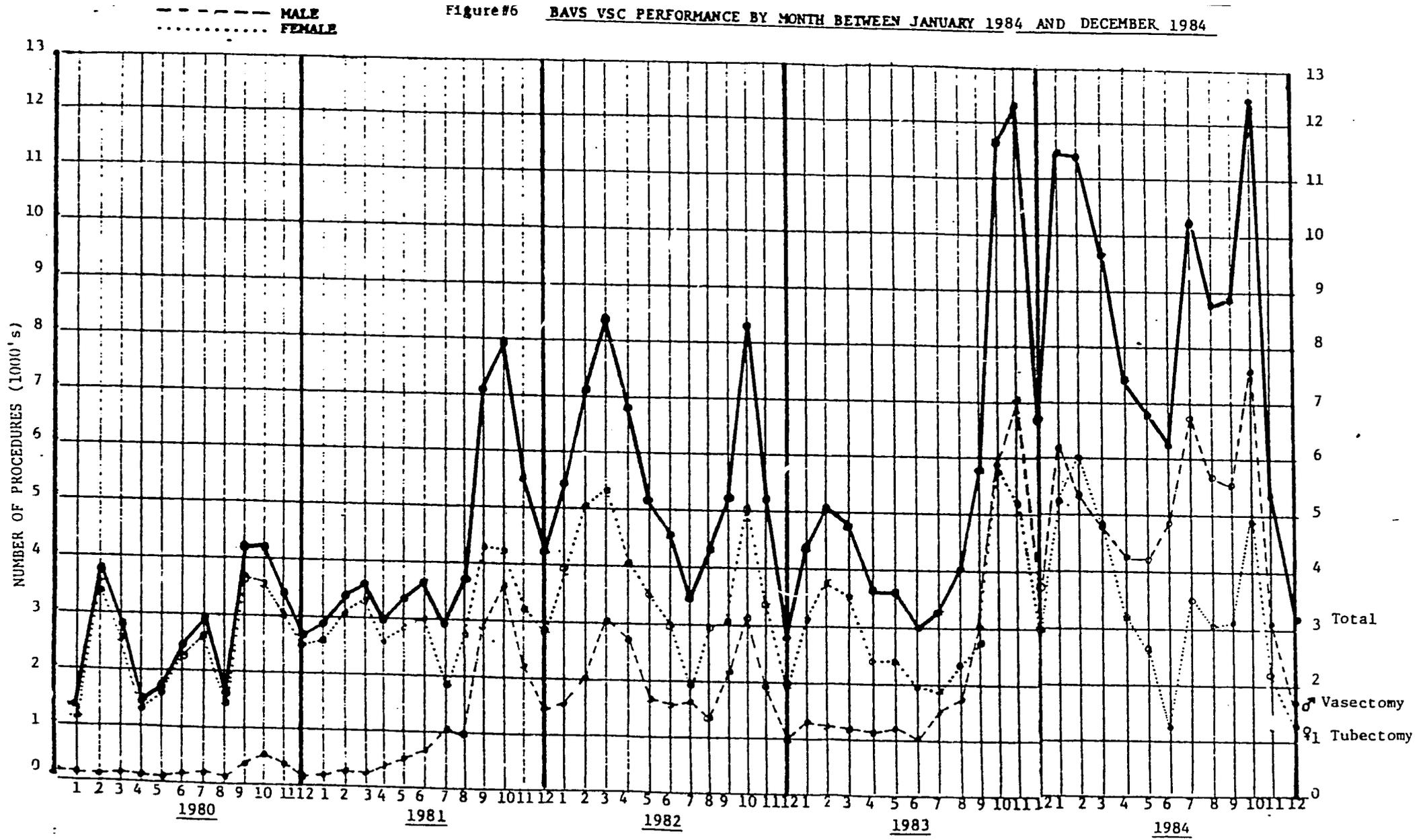


Figure #6 BAVS VSC PERFORMANCE BY MONTH BETWEEN JANUARY 1984 AND DECEMBER 1984



APPENDIX B

MAJOR EQUIPMENT ITEMS SHIPPED IN 1984

| <u>Item</u> | <u>Average Unit Price</u> | <u>Quantity Shipped</u> | <u>Total Cost</u> |
|---------------------------|-------------------------------|-----------------------------|-------------------|
| Air conditioner | \$ 514 | 8 | \$ 4,112 |
| Anesthesia cylinders | 383 | 6 | 2,298 |
| Anesthesia machine | 3,060 | 6 | 18,360 |
| Aspirator, electric | 601 | 24 | 14,424 |
| Aspirator, manual | 160 | 16 | 2,560 |
| Autoclave, large (8080) | 1,115 | 5 | 5,575 |
| Autoclave, small (8020) | 717 | 6 | 4,302 |
| Insufflator | --- | 0 | --- |
| Lamp, OR, ceiling | 273 | 4 | 1,092 |
| Lamp, OR, emergency | 1,072 | 4 | 4,288 |
| Lamp, OR, floor | 248 | 34 | 8,432 |
| Laparoscope system (110V) | 4,980 | 1 | 4,980 |
| Laprocator system | 3,221 | 1 | 3,221 |
| Microscope | --- | 0 | --- |
| Medical kit #1 | 137 | 253 | 34,661 |
| Medical kit #2 | 221 | 12 | 2,652 |
| Medical kit #3 | 144 | 6 | 864 |
| Medical kit #5 | 65 | 83 | 5,395 |
| Medical kit #6 | --- | 0 | --- |
| Model, training, female | 252 | 1 | 252 |
| Model, training, male | 606 | 1 | 606 |
| Resuscitator, demand | 229 | 19 | 4,351 |
| Resuscitator, manual | 121 | 17 | 2,057 |

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APPENDIX B - (continued)

| <u>Item</u> | <u>Average Unit Price</u> | <u>Quantity Shipped</u> | <u>Total Cost</u> |
|-----------------------------|-------------------------------|-----------------------------|-------------------|
| Scale | 137 | 10 | 1,370 |
| Sterilizer | 3,153 | 4 | 12,612 |
| Sterilizer, drying | --- | 0 | --- |
| Sterilizer, large | 3,152 | 4 | \$12,608 |
| Sterilizer, portable | --- | 0 | --- |
| Stretcher | 435 | 11 | 4,785 |
| Table, exam | 414 | 8 | 3,312 |
| Table, instrument (Mayo) | 158 | 8 | 1,264 |
| Table, operating, hydraulic | 2,490 | 1 | 2,490 |
| Table, operating, manual | 1,039 | 35 | 36,365 |
| Teaching attachment | --- | 0 | --- |
| Typewriter | 856 | 1 | 856 |
| Washing machine | 547 | 1 | 547 |
| <u>TOTAL</u> | | | <u>\$200,691</u> |

APPENDIX C

WORLD FEDERATION MEMBERS

AUSTRALIA

* Australian Association for Voluntary Sterilization (AAVS)

BANGLADESH

* Bangladesh Association for Voluntary Sterilization (BAVS)

BRAZIL

* Associacao Brasileira de Entidades de Planejamento Familiar (ABEPF)

Centro Materno Infantil Planejamento Familiar (CMI/PF)

COLOMBIA

* Asociacion Pro-Bienestar de la Familia Colombiana (PROFAMILIA)

DOMINICAN REPUBLIC

* Asociacion Dominicana Pro-Bienestar de la Familia (PROFAMILIA)

EGYPT

* Egyptian Fertility Care Society (EFCS)

EL SALVADOR

* Asociacion Demografica Salvadorena (ADS)

EUROPE

* Federation Europeen pour le Droit a la Sterilisation Volontaire (FESV)

FRANCE

* Association Nationale pour l'Etude de la Sterilisation Volontaire (ANLSV)

GREAT BRITAIN

* Vasectomy Advancement Society of Great Britain (VASGB)

GUATEMALA

* Asociacion Pro-Bienestar de la Familia de Guatemala (APROFAM)

HONDURAS

* Asociacion Hondurena de Planificacion de la Familia (ASHONPLAFA)

INDIA

* National Association for Voluntary Sterilization of India (NAVS)

INDONESIA

* Indonesian Association for Secure Contraception (PKMI)

International Federation for Family Health (IFFH)

IRAQ

* The Iraq Family Planning Association (IFPA)

ITALY

* Associazione Italiana per la Sterilizzazione Volontaria (AS.STER)

APPENDIX C - (continued)

JORDAN

- * Jordan Family Planning and Protection Association (JFPPA)

KENYA

- * Family Planning Association of Kenya (FPAK)

KOREA

- * Korean Association for Voluntary Sterilization (KAVS)

LEBANON

- * Lebanon Family Planning Association (LFPA)

NEPAL

- * Family Planning Association of Nepal (FPAN)

NETHERLANDS

- * Population Services Europe (PSE)

PAKISTAN

- * Pakistan Society for Planned Parenthood (PSPP)

PANAMA

- * Asociacion Panamena para el Planeamiento de la Familia (APLAF)

PHILIPPINES

- * Philippine Association for the Study of Sterilization (PASS)

REGIONAL ARAB

- * Regional Arab Federation for Voluntary Fertility Care (RAF)

REGIONAL ASIA

- * Asian Regional Association for Voluntary Sterilization (ARAVS)

REPUBLIC OF CHINA (TAIWAN)

- * Association for Voluntary Sterilization of the Republic of China (AVSRC)

ST. LUCIA

- * St. Lucia Family Planning Association (SLFPA)

SIERRA LEONE

- * Association for the Management of Infertility and Fertility (AMIF)

SOUTH AFRICA

- * Association for Voluntary Sterilization of South Africa (AVSSA)

SRI LANKA

- * Sri Lanka Association for Voluntary Surgical Contraception (SLAVSC)

SUDAN

- * Sudan Fertility Control Association (SFCA)

SYRIA

- * Syrian Fertility Control Society (SFCS)

APPENDIX C - (continued)

THAILAND

* Thai Association for Voluntary Sterilization (ATSV)

TUNISIA

* Tunisian Association for Voluntary Sterilization (TFIA)

TURKEY

* Turkish Fertility and Infertility Association (TFIA)

UNITED STATES

* Association for Voluntary Sterilization (AVS)

Population Dynamics (PD)

Population Institute (PI)

NORTH YEMEN

* Yemen Family Planning Association (YFPA)

SOUTH YEMEN

* Yemeni Council for Family Care (YCFC)

* Voting Members

APPENDIX D

AVS STAFF FUNDED WITH AID DOLLARS
(As of December 31, 1984)

HEADQUARTERS (New York Office)

EXECUTIVE DIVISION

Executive Director.....Hugo Hoogenboom*
Executive Assistant.....Deborah Autorino
Secretary..... Vacant

FINANCE AND ADMINISTRATION DIVISION

Director of Finance and Administration.....George Woodring*
Assistant to the Director.....Andrea P. Mejia

Finance Department

Finance Manager.....Danny Queri*
Senior Secretary.....Patrica Moore-Barrington*
Senior Finance Officer.....Ramesh Chadha*
Financial Control Officer.....P. Thomas Mathew*
Bookkeeper.....Rupert Falcon*

Administration Department

Assistant Director for Administration.....Sophia LaRusso*
Administrative Assistant.....Lorraine Parent-Bendiks*
Personnel Officer.....Marilyn Riedlinger*
Personnel Assistant.....Helen Epps*
Clerk Typist.....Laura Finver-Harman

Travel Coordinator.....Lorraine Logan*
Administrative Secretary.....Sandra Patterson

Receptionist.....Suzanne Joyner*
Mail Specialist.....Kenneth Browne*
Word Processor/Secretary.....Ida LoGuidice

Data Processing Department

Manager, Data Processing & Budget Officer.....Katherine Kendall
Administrative Secretary.....Shirley Wilson
Computer Programmer/Operator.....Dana Evans
Computer Programmer/Operator.....Peggy Grosser

Library Services Department

Manager, Library Services.....William Record*
Typist (Bilingual)/Clerk.....Maria Canosa*
File Clerk/Typist.....Esther Sonneborn

APPENDIX D - (continued)

Publications Department

Publications Manager.....Pamela Harper*
Production Assistant.....Vacant
Secretary.....Vacant

MEDICAL DIVISION

Medical Director.....Douglas Huber, M.D.*
Assistant Director.....Betty Gonzales Sansoucie*
Executive Secretary.....Ruth Burns
Coordinator for Technology and Training.....Vacant
Research Associate.....Sawon Hong
Senior Secretary.....Barbara Lockett

INTERNATIONAL DIVISION

Director, International Division.....Terrence Jezowski
Executive Secretary.....Josephine Osmani
Program Development Manager.....Javed Ahmad
Medical and Program Adviser.....Zein El-Abidin Khairullah, M.D

Program Department

Deputy Director.....Lynn Bakamjian
Administrative Assistant.....Mildred Rondon

Program Manager (Anglophone Africa).....Joseph Dwyer
Senior Secretary (Anglophone Africa).....Laurel Rapkin
Program Manager (Francophone Africa/Middle East)...Beverly Ben Salem
Senior Secretary (Francophone Africa/Middle East)...Robert Flora
Grants Officer (Sub-Saharan Africa).....Nancy Kish

Program Manager (Asia).....P.E. Balakrishnan
Senior Secretary (Asia).....Francoise Hurtault
Grants Officer (Asia/Middle East).....Alison Ellis

Program Manager (Central America/Mexico).....Roberto Chavez
Bilingual Secretary (Central America/Mexico).....Leda Massih
Program Manager (South America/Caribbean).....Sylvia Marks
Senior Secretary (South America/Caribbean).....Vacant
Grants Officer (Latin America/Caribbean).....Cynthia Steele Verme
Grants Officer (South America/Caribbean).....Vacant
Equipment Services Manager.....Clifford Pauling
Senior Secretary.....Diahann Stokes
Equipment Officer.....Syed Jafri
Equipment Assistant.....Lorrie Fritz

APPENDIX D - (continued)

AFRICA-MIDDLE EAST REGIONAL OFFICE

Director.....Fathi Dimassi
Assistant Director.....Phyllis Butta
Program Monitor.....Vacant
Program Officer.....Margaret Duggan
Program Officer.....Mongi Gadhoom
Program Officer.....Rafik Staali
Program Officer.....Vacant
Administrator/Accountant.....Mohamed Hafsa
Translator.....Arbi Haddad
Documentalist.....Odile Sassi
Secretary.....Therese Laatar
Typist.....Yamina Maiza
Typist.....Khedija Mediouni
Driver.....Nabil Chekir
Housekeeper.....Khedija Essaihi
Housekeeper.....Cherif Saidi

ASIA REGIONAL OFFICE

Director.....Russell P. Vogel
Assistant Director.....Farruk Ahmed Chaudhuri
Assistant Director.....Gary William Newton
Senior Program Officer.....Abul Quasem Bhuyan
Program Officer.....Dr. Rezaul Haque
Program Officer.....Dr. Sadia Afroz Chaudhuri
Program Officer.....Ahmed Al-Kabir
Junior Program Officer.....Tulshi Das Saha
Program Monitor.....Dewan Mokbul Hossain
Assistant Program Monitor/Librarian.....Asaduzzaman
Chief, Administration & Personnel.....Anthony Gomes
Executive Secretary.....Subash Chandra Saha
Administrative Officer.....Abdul Wadud
Secretary.....Ruhul Amin
Typist.....Nazneen Margub Taufiq
Typist.....Anowara Begum
Driver.....Dulu Miah
Driver.....Abdul Jalil
Messenger.....Abdul Kader
Messenger.....Sirajul Islam
Guard.....Abu Taher
Guard.....Ali Ashraf
Guard.....William D'Cruze
Guard.....Akkas Ali
Guard.....Altaf Hossain
Guard.....Md Moslem

APPENDIX D - (continued)

SOUTH AMERICA REGIONAL OFFICE

Director.....Fernando Gomez
Program Officer.....Bjorn Holmgren
Administrative Secretary.....Gloria Perdomo
Messenger.....Miguel Hernandez

*Employees funded through private and AID dollars