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INTERNATIONAL POSTPARTUM PROGRAM

Annual Progress Report

1973

Contract No. AID/csd-2155

The Population Council
245 Park Avenue
New York, New York 10017

March 29, 1974

1973 ANNUAL PROGRESS REPORT

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I. INTRODUCTION

This is the sixth annual progress report submitted to USAID under this grant, AID/csd-2155. It covers the period of January 1, 1973, through December 31, 1973. It is our intention to submit a final substantive report on the entire project in August 1974, followed by the last annual progress report in March 1975.

The year 1973 was the eighth year of operation of the Internationa Postpartum Program, 1966 and 1967 having been supported entirely with non-AID funds. During these years the postpartum approach to family planning has been demonstrated through Council-supported programs in over 250 hospitals in 21 countries. Hospital-based maternity-centered family planning programs have become an important part of many national family planning programs. Of the countries having had Council-supported postpartum programs, 13 now have multi-hospital national networks. In addition to these countries there are another 15 to 20 countries with postpartum programs in varying stages of development.

Having demonstrated the acceptability of the postpartum concept to maternity patients, to the hospitals and to the local governments, it was decided that the demonstration project should be brought to a close. Therefore, in 1971 the Council began work to discontinue its support to these programs, while making a concerted effort to see that they would be continued with local or other international assistance. The success of this "spin-off" effort is discussed in Chapter II of this report, but the devolution from 112 hospitals in 12 countries in January 1972 to 34 hospi-

pitals in two countries in January 1974 shows its extent. Of the approximately 250 hospitals ever supported by the Council, including the 125 Indian hospitals which were supported under nesa-391, only eight have discontinued their postpartum services.

International financial and technical assistance for postpartum programs now comes from many sources in addition to the Population Council and the Agency for International Development. These include the United Nations Fund for Population Activities, the World Health Organization, the World Bank, Church World Service, OXFAM, Pathfinder Fund, the International Division of Planned Parenthood Federation of America, The International Planned Parenthood Federation and several bilateral governmental assistance programs.

Hospitals in the Council's International Postpartum Program, excluding the 125 hospitals in India to which the Council provided only equipment, have provided contraceptive services to approximately 1.2 million women between January 1966 and December 1974. This is equivalent to 33.2 percent of all obstetric and abortion cases in the affiliated hospitals. Fifty-nine percent of all the acceptors were women who had recently delivered in the hospitals, the remainder being women who had delivered more than three months previously or who learned about the program indirectly. Of the 1.2 million acceptors, 48 percent accepted an IUD, with 16 percent or 202,411 having the insertion prior to departure from the hospital. The second largest number of acceptors, representing 35 percent of all acceptors.

The effects of the Council's planned phase out of support for postpartum programs began to become apparent in 1972 and were seen most

dramatically in 1973:

Table I-1

Total Program:
Total Obstetric and Abortion Cases,
Total Acceptors and Direct Acceptors, 1971-1973

	Ob and Ab Caseload	Total Acceptors(1)	Direct Acceptors(1)
1971	690,423	231,738	142,981
1972	628,350	228,118	140,599
1973	339,684	105,603	66,451

The total direct expenditure for support of postpartum programs in 1973 was down to $953,000 from $1.2 million in 1972 and $1.4 million in 1971. (See Appendix A: Table 2 for detailed breakdown of sources of support and totals for entire period since 1966.)

Although the annual expenditure has decreased, the average cost per acceptor and per ob/ab per case has increased. It can be seen from Table I-2 on page five, when comparing identical hospitals in 1972 and 1973, rather than all hospitals reporting in each year, the direct cost

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(1) Technical Note: In this and prior reports, two measures of acceptance have been used: direct acceptance rate and total acceptance ratio. A direct acceptor is defined as a woman who, within three months of her hospitalization as an obstetric or abortion patient, accepts a contraceptive method. The "direct rate" is the ratio of such acceptors to the current period's obstetric and abortion cases. The total acceptors figure includes direct acceptors and indirect acceptors (who are women who have not been obstetric and abortion patients in the last three months). The "total acceptance ratio" is the ratio of all acceptors in the period to the obstetric and abortion caseload for that period. For consistency with previous reports, the terms "direct acceptance rate" and "total acceptance ratio" will be continued in this report.

We also use the term "immediate acceptors" for women who accept a method before leaving the hospital.

per acceptor has increased 45 percent or from $6.20 to $9.01. This is a result of the decrease in acceptors at the same time there was an increase in cost. The decrease in acceptors of 32,614 is almost wholely attributable to the mid-1973 spin-off of most of the Thai hospitals which reduced Thailand's total acceptors by 29,657 persons. The total budgeted for all hospitals in 1973 increased 11 percent or $94,013 over 1972. $27,000 of this increase was a result of the Council's having provided funds in 1973 for contraceptives in Brazil, whereas in 1972 this cost came from another source. The remainder is attributable mainly to increased budgets in Colombia and Venezuela due to local annual inflation levels of nearly 20 percent in Venezuela and 35 percent in Colombia. These factors, combined with the loss of the 29,657 acceptors in Thailand where the cost per acceptor was the lowest at $2.33, account for the increased average cost per acceptor.

Viewed another way, the most expensive programs in terms of cost per acceptor (Nigeria, Brazil, Venezuela and Colombia) accounted for only 46 percent of all acceptors in 1972, whereas their acceptors represented 56 percent in 1973. Consequently, budgets for these same programs increased from 78 percent of all programs in 1972 to 87 percent in 1973.

In addition to site visits by Council staff to every country in which postpartum programs were supported, a major activity of the Program in 1973 was the extensive field trips of Petra Reyes to assess and assist the information and education components of programs in six countries. Detailed information on her activities is contained in Chapter IV of this report. Perhaps the most significant finding of her analysis has been the importance of good planning and management to the success of I and E pro-

Table I-2 Caseload, Acceptors and Cost of Only Those Hospitals Active in Both 1972 and 1973

		Ob & Ab	Total Acceptors	Budgeted Amount	Cost per Ob & Ab	Cost per Acceptor
Thailand	1972	102,320	62,640	$133,088	$1.30	$2.12
	1973	57,608	32,983	76,960	1.34	2.33
Ghana	1972	28,899	7,160	38,851	1.34	5.43
	1973	28,864	7,397	37,415	1.30	5.06
Nigeria	1972	33,748	5,235	83,705	2.48	15.99
	1973	34,225	5,321	96,687	2.83	18.17
Brazil	1972	2,237	4,977	13,261	5.93	2.66
	1973	2,217	3,738	40,452	18.25	10.82
Vene-	1972	150,725	32,970	407,742	2.71	12.37
zuela	1973	152,707	33,703	491,655	3.22	14.59
Mexico	1972	11,918	5,232	16,747	1.41	3.20
	1973	11,648	6,135	14,130	1.21	2.30
Colombia	1972	61,653	20,003	164,230	2.66	8.21
	1973	52,593	16,326	194,338	3.70	11.90
TOTAL	1972	391,500	138,217	857,624	2.19	6.20
	1973	339,862	105,603	951,637	2.80	9.01
Percent change	72/73	-13.2%	-23.6%	+11.0%	+27.9%	+45.3%

grams. Seemingly more important than I and E content or methods, is the program leadership and the manner in which staff are supervised. It should be noted, however, that programs which presented family planning messages as information, with little attempt to appeal to the client's emotions, generally had low levels of success.

Throughout 1973 Dr. Castadot has been helping Fonds Medical de Coordination (FOMECO) to prepare for a seminar, "Naissances Désirables: Un Programme Postpartum", to be held in Kinshasa in early March 1974, which will expose Francophone Africans to the concept of maternity-based family planning services. In June 1974, the Council will publish "Contraception and Fertility Change in the International Postpartum Program" by Irving Sivin. This is a presentation of the findings from the international

II. SPIN-OFF PLANS AND PROGRESS

Since 1966, over 270 hospitals and clinics located in 21 countries have been associated in the Population Council's International Postpartum Program. The postpartum approach to the delivery of family planning services has now been widely accepted as an important element of a national family planning strategy. The Council believes there is, therefore, little need for further demonstration of the postpartum concept. Consequently, a major concern during 1972 and 1973 has been to assist Council-supported programs to secure alternative financial support with the objective of full integration into their respective national programs.

Table II-1 on the next page, shows the countries and hospitals in the Postpartum Program at the beginning and end of 1973. Actually, the decline began in 1972; there were 115 hospital programs on January 1, 1972, 58 on January 1, 1973, and only 34 on January 1, 1974.

Alternative funding and technical assistance for programs formerly supported through the Council's International Postpartum Program is being provided from a variety of sources. Internationally, assistance is coming from WHO, PAHO, UNFPA, World Bank, Pathfinder, OXFAM, Church World Service, FPIA, IPPF and governmental foreign assistance agencies, including Norway, the United Kingdom, Sweden and the United States.

For hospitals discontinued in 1973, funding comes from several sources. Local voluntary family planning associations took over funding for the hospital programs in Brazil and Mexico. Local, state or national governments took over funding for the programs discontinued by the Council

Table II-1 Number of Council-Supported Programs in 1972, 1973 and 1974, by Country

	Number of Hospitals[a][b]		
	January 1, 1972	January 1, 1973	January 1, 1974
Brazil	1	1	0
Colombia	26	9	0
Ghana	3	3	0
Honduras	2	0	0
Hong Kong	9	0	0
Indonesia	26	0	0
Iran	1	0	0
Mexico	4	3	0
Nigeria	4	3	2
Philippines	2	0	0
Thailand	15	13	0
Venezuela	22	26	32[c]
TOTAL	115	58	34

(a) P.C. also provided partial assistance to Hospital Materno Infantil in Honduras, supporting only one nurse and one clerk in 1973 in order to ease the transition to other funding.

(b) P.C. supported a mobile training team for four months in Indonesia, but provided no funds for family planning services.

(c) In addition to 17 central hospitals there are 14 satellite clinics included in IPP support of the AVPF program. The MCP in Caracas is supported separately.

in Ghana, Nigeria and 11 of the Thai hospitals. 1974 support of the discontinued programs in Colombia will come from AID funds made available to the Council for the regular program of support in Colombia. Other foreign assistance will support the two Bangkok hospitals (from OXFAM for Women's and probably also from OXFAM for Chulalongkorn).

The remaining programs should be phased out during 1974. It is expected that the state government will take over the Lagos Island Maternity Hospital. The UNFPA has been approached for support of the program in Ibadan, Nigeria, and also for all of the hospitals in Venezuela, with funding anticipated to begin the first of 1975. Thus, as of December 31, 1974, the Postpartum Program as an international demonstration project will have come to an end, and postpartum family planning services will have been institutionalized in hospitals around the world.

It is encouraging to note that only eight of the 238 hospitals in 21 countries phased out so far have discontinued their family planning services. Moreover, now over 700 hospitals in these same developing countries have postpartum programs, with an estimated expansion by 1975 to at least 1,200 hospitals. [See Table II-2.] This does not include an estimated 1,695 United States hospitals which offer family planning services, but it is not known how many of these could be called "postpartum programs." 926 of them have "case-finding" and routine education of patients.*

During 1973 the establishment and expansion of non-Council funded

* Gentry, John T., Arnold D., Kaluzny and James E. Veney: "A Comparative Analysis of Factors Influencing the Implementation of Family Planning Services in the United States." American Journal of Public Health, Volume 64, No. 4, pp. 376-389, April 1974.

postpartum programs continued. Most of the countries in which the Council formerly supported postpartum programs have already extended, or are attempting to find funding for the extension of postpartum services into other hospital facilities. These countries include India, Pakistan, Hong Kong, Indonesia, Philippines, Thailand, Iran, Colombia, Honduras, Venezuela, Mexico, Ghana and the United States. In addition, many other countries have developed, or are developing, postpartum family planning programs supported by their governments, universities or private associations.

Table II-2 Summary of Spread of Postpartum Programs in Countries Which Have Had Hospitals Funded by the International Postpartum Program (IPP), as of January 1, 1974

	Number of Hospitals and Satellite Clinics			
	Currently funded by IPP	Formerly funded by IPP	Present number with Postpartum Programs[a]	Estimated number when expansion completed
Asia				
Bangladesh		0[b]	43	197
Hong Kong		10	45	45
India		124	368 +	600
Indonesia		26	86 +	146
Iran		1	12	12
Japan		1	1 +	1 +
Pakistan		1	16	16
Philippines		2	2 +	25
Singapore		1	2	2
Thailand		16	87	87
Turkey		1	1	1

(continued on next page)

Table II-2 continued

	Number of Hospitals and Satellite Clinics			
	Currently funded by IPP	Formerly funded by IPP	Present number with Postpartum Programs	Estimated number when expansion completed
Africa				
A.R.E.		2	6	6
Ghana		3	2	2 +
Nigeria	2	5	3	3
Latin America				
Brazil		1		
Chile		1	0 +	0 +
Colombia		27	27	97
Honduras		2	2	2
Mexico		5	19 +	19 +
Puerto Rico		1	8	56
Venezuela	32	1	32 +	32 +
North America				
U.S.		7	7 + (d)	7 +
21 Countries	34	238 (e)	769 + (e)	1,356 +

(a) A "+" indicates an additional but unknown number of hospitals which have postpartum programs.

(b) Bangladesh is included because it was part of Pakistan when there was a Council funded program there (non-IPP funds).

(c) There are 60 Christian hospitals in Indonesia and 244 Christian hospitals in India with postpartum programs.

(d) See text about 926 U.S. hospitals which have "case-finding" and routine education.

(e) Only four hospital programs and four satellite clinics have discontinued their postpartum family planning services since the start of the program in 1966.

III. EVALUATION

A. Service Statistics 1973

As a consequence of the planned spin-off of programs, both the number of countries and the number of hospitals in the Postpartum Program dropped sharply in 1973. The number of patients, acceptors and acceptance ratios all fell. For all units reporting to the Postpartum Program in any given year, whether or not currently funded by the Population Council, (and in 1972 and 1973 a few continued reporting even though no longer funded) acceptance ratios had gone up from a low value of 27.5 percent in 1969 (not shown) to 36.3 percent in 1972 (See Table III-1). The acceptance ratio fell to 33.4 percent in 1973, still an impressive figure.

Table III-1 Total Acceptance Ratios* 1970-1973, for Total Program (All Reporting Units and Countries (All Institutions Until Funding Ceased)

	1970	1971	1972	1973
Total Program	27.8%	33.6%	36.3%	33.4%
Thailand	44.3%	54.1%	56.5%	57.3%
Ghana	10.5%	13.0%	24.8%	25.6%
Nigeria	8.9%	14.0%	15.5%	15.5%
Brazil	--	178.7%	222.5%	168.6%
Colombia	24.8%	28.5%	33.8%	31.0%
Venezuela	15.6%	18.1%	21.9%	22.1%
Mexico	22.5%	28.2%	43.9%	52.7%

* The total acceptance ratio is the total number of acceptors in the calendar year divided by the total number of obstetrical and abortion cases served by the hospitals in the same year, expressed as a percentage.

Even quarter by quarter in 1973 acceptance ratios declined among reporting units, so that by the last quarter of the year the acceptance ratio for reporting units was running at a level of 27.7 percent. In 1974 we expect acceptance ratios to fall even further, perhaps going below 25 percent.

The apparent deterioration in Total Program performance is, however, nothing more than a reflection of the changed composition of the institutions and countries remaining in the Program subsequent to the substantial spin-off in 1972-1973. The remaining institutions continue to operate at substantially the same level in 1973 as they had in 1972, with the exception of Mexico and Brazil.

That the fall in acceptance ratios is a simple artifact is demonstrable if one looks at the Program in Venezuela which had the same ratio of 22 percent in 1972 and 1973. In 1972 the in-patient (ob/ab) caseload in Venezuela represented one-fourth (24 percent) of the entire in-patient caseload in the Postpartum Program, but in 1973 it represented 45 percent of the in-patient caseload. As this country now represents a greater proportion of the Program's target population, the overall acceptance ratio in the Program has approached that of Venezuela (22 percent). Indeed, a single hospital in Venezuela, the Maternidad Concepcion Palacios, which is the world's largest maternity hospital, accounts for 40 percent of the Venezuelan postpartum program caseload. In 1972 it represented nine percent of the caseload in the entire program; in 1973, its importance had risen to 17 percent. Hence, the acceptance ratio of 15 percent for this one hospital weighted heavily (one-sixth) in the acceptance ratio for the entire Program.

As stated above, the countries with continued Council funding in 1973 recruited approximately the same percentages of acceptors in 1973 as all hospitals in these countries in 1972. Those institutions that were actually funded during 1973 (as opposed to those reporting activities) had an overall acceptance ratio of 31 percent and a direct acceptance rate of 19 percent (see Table III-2). Of the 106,000 acceptors at funded institutions, about half (48.3 percent) accepted IUD's and about one-third accepted Orals (35.2 percent). Fully one-eighth (12.8 percent) of the acceptors were sterilized (see Table III-3).

For the seven countries participating in the Postpartum Program in 1973, there is an indication of a decline in both the median age of acceptance and in the median number of living children of acceptors. At the same time there is no indication of a change in either the age or number of children of women in the ob/ab in-patient population, Colombia excepted. The profile of the acceptor has thus moved closer to that of the patient (see Table III-4).

How this has been accomplished is shown in Table III-5. The strongest improvements in recruitment have taken place among women with three children (1971 to 1973 median increase in acceptance ratio of 13 percent) and among women with two children (1971 to 1973 median increase of 11 percent). The recruitment of women giving birth for the first time remains well below that of higher parity women.

Table III-2 Basic Service Statistics 1973 by Country, and for Total Program[a]

COUNTRY	OB & AB	OB	AB	TOTAL ACCEPTORS	DIRECT ACCEPTORS	TOTAL ACC. RATIO	DIRECT ACC. RATI
Thailand	57,608	52,064	5,544	32,983	18,880	57	33
Ghana	28,864	23,825	5,039	7,397	3,096	26	11
Nigeria	34,225	30,980	3,245	5,321	1,965	16	06
Brazil	2,217	2,101	116	3,738	817	169	37
Colombia	52,593	42,454	10,139	16,326	13,929	31	27
Venezuela	152,707	129,909	22,798	33,703	19,629	22	13
Mexico	11,648	9,374	2,274	6,135	6,135	53	53
Total Program	339,862	290,707	49,155	105,603	64,451	31	19

[a] Data in Tables III-2 through III-5 cover only those periods during which the institutions received Council funding.

Table III-3 Total Acceptors and Percentage Distribution in 1973 of Acceptors by Method for Each Country, and for Total Program

COUNTRY	TOTAL ACCEPTORS	IUD	IMMEDIATE IUD	PILL	STERIL.	INJECTABLE	ALL OTHERS
Thailand	32,983	53.8	18.7	14.9	30.0	1.2	0.1
Ghana	7,397	16.0	0.0	69.4	6.8	1.2	6.7
Nigeria	5,321	44.8	0.5	51.6	1.4	2.1	0.2
Brazil	3,738	45.9	0.6	36.9	1.9	0.0	15.3
Colombia	16,326	58.5	38.2	35.2	4.5	0.3	1.5
Venezuela	33,703	50.4	3.7	40.5	6.1	0.0	3.1
Mexico	6,135	23.4	23.2	59.5	2.9	14.2	0.0
Total Program	105,603	48.3	14.3	35.2	12.8	1.4	2.3

Table III-4 Median Age, Median Number of Living Children for Obstetric and Abortion Cases, All Acceptors (Excluding Sterilization Cases) by Country 1971, 1972 and 1973

	Median Age OB & AB			Median Age All Acceptors			Median Living Children OB & AB			Median Living Children All Acceptors		
COUNTRY	1971	1972	1973 (a)	1971	1972	1973 (a)	1971	1972	1973 (a)	1971	1972	1973 (a)
Thailand	26.0	26.0	26.0	28.0	27.4	27.3	2.1	2.1	2.1	3.0	2.8	2.7
Ghana	24.9	24.6	24.8	28.6	27.7	27.9	2.0	1.9	2.0	3.0	3.0	3.2
Nigeria (b)	29.3	26.7	26.3	31.0	32.4	31.8	3.3	2.8	2.8	4.1	4.4	4.2
Brazil	25.4	25.2	24.6	28.8	27.7	27.7	2.1	2.1	1.7	3.2	3.1	2.9
Colombia	25.0	24.4	23.9	26.4	25.1	24.3	2.4	2.2	2.0	3.1	2.6	2.3
Venezuela	24.7	24.6	24.6	26.0	25.5	24.9	2.8	2.7	2.7	3.7	3.4	3.2
Mexico	27.4	26.9	27.8	29.6	27.5	27.1	3.3	3.4	3.5	4.3	4.0	3.8

(a) 1973 figures for first semester only.
(b) Data for Nigeria in 1972 and 1973 excludes Lagos Island Hospital.

Table III-5 Total Acceptance Ratios (as Percent of Ob/Ab) by Number of Living Children at Acceptance, by Country, 1971 through 1st Half 1973

COUNTRY		TOTAL	NUMBER OF LIVING CHILDREN					
			0-1	2	3	4	5	6+
Thailand	1971	54	23	49	70	92	97	85
	1972	56	25	50	75	98	101	87
1st half	1973	61	27	54	83	100	106	87
Ghana	1971	13	7	14	17	18	18	20
	1972	25	15	26	36	37	33	35
1st half	1973	27	14	29	37	41	37	38
Nigeria[a]	1971	16	13	10	16	13	22	27
	1972	23	5	11	20	32	42	58
1st half	1973	25	6	16	25	35	34	63
Brazil	1971	178	78	162	267	254	288	313
	1972	223	114	222	347	319	340	346
1st half	1973	217	106	243	318	313	476	379
Colombia	1971	30	19	31	35	46	36	33
	1972	34	25	39	44	47	42	38
1st half	1973	33	25	41	45	43	38	35
Mexico	1971	34	18	28	30	39	40	47
	1972	43	26	44	47	49	53	46
1st half	1973	47	31	54	56	49	46	54
Venezuela	1971	18	8	17	20	23	22	24
	1972	22	12	23	24	26	27	26
1st half	1973	23	13	26	27	28	28	28

(a) Data for Nigeria in 1972 and 1973 exclude Lagos Island Hospital.

B. Special Studies

1. Performance Incentives in Thailand

Beginning in January 1972, monthly salary supplements were made for the regular staff of the 11 Ministry of Health hospitals in the Progr Shown below in U.S. dollars is the schedule of the monthly supplementary payments in each hospital, which were based on the number of new acceptor the methods adopted, and whether or not the acceptors had had recent deliveries (direct acceptors or not).

Table III-6 Basis for Incentive Payments by Type of Acceptor

Method	Direct	Indirect
IUD	$1.50	$0.75
Pill	.50	.25
Tubal ligation	3.75	3.75
Vasectomy	--	2.50

In addition, a monthly bonus was available for each hospital achieving a direct acceptance rate of 40 percent or more. The bonus was $75 for direct acceptance rate between 40-59 percent, $100 for a direct acceptance rate between 60-74 percent and $125 per month for a higher rate. The distribution of the supplementary payments to the staff was determined in Thailand rather than by New York. The only fixed salary was that of the clerk who tabulated the monthly performance.

As detailed in the 1972 Annual Report, the incentive scheme produced no clear, positive results that year. Pill acceptance rates fell in the second half of 1972, partially as a result of the unfavorable experience with Norlestrin, introduced in April 1972. In the first half of 1973 there is an indication of a rebound in pill acceptance rates. In

the provincial hospitals and in the MCH units, sterilization acceptance rates advanced about three percentage points in the first half of 1973 from the last half of 1972; but the "control group" of Bangkok hospitals showed a similar change. IUD insertion rates continued to decline in the provincial hospitals, bounced back somewhat in the MCH units, and remained unchanged from the second half of 1972 in Bangkok. Overall, therefore, the assessment made in the 1972 Annual Report would seem valid. The changed payment scheme did not influence acceptance rates in a noteworthy manner.

Unfortunately, from this study we can draw no clear inference concerning the effect of monetary incentive payments. Reports from Thailand indicate that there was considerable local option in the participating hospitals regarding the administration of the incentive scheme. It may not have been uniformly promoted by the local project directors and the bonus payments may not have been large enough to have acted as institutional incentives.

2. The Pacientes Visitantes Program, Hospital Materno Infantil, Honduras

In 1972 a study was initiated to determine the joint effects of peer level motivation and improved access to supply sources on pill continuation rates. The setting for this study, Hospital Materno Infantil in Tegucigalpa, had had high acceptance ratios from the moment it joined the International Postpartum Program in the last quarter of 1969 (average ratio 60 percent). The principal method accepted was the pill. Reports on the number of cycles distributed at the clinic each month indicated that continuation rates were low. An opportunity was grasped to recruit

Table III-7 Thailand MOPH: Acceptance Ratios 1970-1973 (1st half), by Administrative Unit and Method

Method & Unit	1970	1971	1972 1st Half	1972 2nd Half	1973 1st Half	1st Half 1973 Ob/Ab
All Methods						
8 Provincial	54.6	65.8	78.2	68.7	70.3	19,408
2 MCH*	94.6	97.1	91.4	86.2	90.6	3,270
3 MCH*	112.4	159.7	144.7	106.8	114.2	6,736
3 Bangkok Hospital	31.7	32.5	33.1	29.3	34.5	30,561
Sterilization						
8 Provincial	8.4	10.3	14.0	15.4	18.6	
2 MCH*	32.5	41.7	43.8	36.2	36.0	
3 MCH*	21.9	33.7	37.9	33.5	36.1	
3 Bangkok Hospital	5.2	6.4	7.6	8.7	11.7	
Pill						
8 Provincial	8.9	15.1	15.7	12.0	12.2	
2 MCH*	12.4	17.4	16.2	14.7	16.2	
3 MCH*	9.6	40.2	36.8	17.9	25.8	
3 Bangkok Hospital	6.4	7.2	6.9	6.1	7.1	
IUD						
8 Provincial	37.1	40.4	48.5	41.3	39.6	
2 MCH*	49.7	37.8	31.3	35.1	38.6	
3 MCH*	80.9	85.8	70.0	55.4	63.1	
3 Bangkok Hospital	18.7	18.9	18.6	14.5	14.6	

* In 1971 and for the first half of 1972, the Khon Kaen MCH unit reported acceptors recruited by a mobile unit touring the province. Thereafter, the reports from Khon Kaen include only acceptors at the basic MCH facility. The very sharp drop in acceptance rates at the three MCH units in the second half of 1972 is, therefore, but an artifact of reporting. To obtain a better indication of the trend, data from the other two MCH units, Yala and Rajaburi, are shown separately.

satisfied acceptors, using them as home visitors and as pill depots operating within designated geographic areas. Thus, access to supply sources should be improved and the home visits of the pacientes visitantes should, in theory at least, reinforce contraceptive continuation by reassuring the acceptors and providing them with additional information from their peers. Information on the operation of the program was to be based on the redemption of coupons. Postpartum acceptors were given numbered coupons before discharge from the hospital. The coupons could be redeemed with the pacientes visitantes or at the family planning clinic.

The operation and consequently the evaluation of this project was seriously impaired during most of 1973 because of funding problems. It had been anticipated that PAHO would support the Postpartum Program at Hospital Materno Infantil after the "spin-off" from the Population Council. When the anticipated 1973 support did not materialize, the Population Council, using both AID and Council funds, resumed partial support of the clinical services in the latter part of the year. In the first quarter of 1973 the acceptance ratio, perhaps because of the absence of funding, reached its lowest point ever attained since records were first kept. Only in the fourth quarter of 1973 did the Postpartum Program return to its former acceptance levels.

Despite these great constraints, some limited inferences may be permitted as to the operation of the system. After acceptance of the initial cycle at the hospital's clinic, acceptors could redeem numbered coupons for pills either at the Postpartum clinic or with the pacientes visitantes. As shown in Table III-8 below, during the course of 1973

Table III-8 Honduras Pacientes Visitantes Program, 1973. Number of Coupons Redeemed and Estimated Percent Continuing

	Coupons Redeemed By:			Estimated Percent Continuing:	
	Pacientes Visitantes	Clinic	Total	a) Of all Referred Women	b) Of Contacted Women
January	5	34	39	21%	40%
February	11	27	38	21	54
March	NA	NA	NA	NA	NA
April	45	15	60	20	41
May	56	19	75	23	44
June	98	20	118	29	48
July	80	26	106	42	59
August	147	24	171	43	61
September	111	22	133	26	44
October	186	26	212	33	47
November	144	13	157	25	38
December	167	33	200	28	40

the number of coupons redeemed at the clinic averaged 23 per month in the first half year (five months reported) and 24 per month in the second half year. On the other hand, redemption of coupons with the pacientes visitantes averaged 95 per month. Starting from nil in December 1972, redemptions from January through June 1973 averaged 43 per month, and more than tripled to 139 per month in the last half of the year. This tripling of use of the pacientes visitantes was at no apparent sacrifice to the redemptions at the clinic which continued to honor an average of 24 coupons presented monthly throughout the year.

Unfortunately, from the records available, further precise quantification is unavailable. Nevertheless, the evidence suggests that both total continuation and second cycle continuation rates are extremely low. Therefore it would seem that the high acceptance rates at the hospital are essentially not backed up by good continuation, though possibly they are increasing. It is hoped that the assured funding in 1974 (Council funds) will permit continuous operation of the program and a more definitive evaluation of this project.

3. The Indonesian Mobile Training Team

The Mobile Training Team (MTT) in Indonesia was created under the auspices of the National Family Planning Coordination Board (BKKBN) with technical and financial assistance from the Population Council. Funding for the project ceased as of June 31, 1973.

Primarily an educational experiment, the program's objective was to provide in-hospital family planning training to members of the obstetrical staff of the Postpartum hospitals, including professional, paramedical and support levels.

Upon termination of the Population Council grant, the MTT was dissolved. Training of the hospital Postpartum clinic staff is now being provided by provincial training centers under BKKBN guidance.

During the operations of the MTT program, the attention of official agencies was drawn to the widespread need for family planning training of the paramedical and auxiliary staff as well as of the medical staff. The training department within BKKBN, in recognizing the need for an integrated multi-faceted national training program, has suggested that it would eventually organize its own mobile team for the expanded Postpartum Program in the country, now in 62 hospitals.

An extensive account of the Mobile Training Team project was given in the 1973 Semi-Annual Report of the International Postpartum Program.

IV. INFORMATION AND EDUCATION

A. Overview of 1973 Activities

Beginning in 1972 and continuing through 1973, the Council gave special attention to the educational aspects of the postpartum concept. A health educator, Petra Reyes, was hired for the following tasks:

(1) To obtain an overview of how education, information and training activities were being conducted in a sample of postpartum hospitals;

(2) To document any seemingly effective educational strategies that were associated with contraceptor success;

(3) To provide technical assistance to some of the postpartum programs for the purpose of improving existing educational activities and to document the possible role and functions of a short-term educational consultant in such an endeavor.

The health educator observed the educational activities of 22 postpartum hospitals in six countries - Nigeria, Indonesia, Venezuela, Colombia, Honduras and Thailand. The hospitals in each geographic area were chosen to give a balance of programs with relatively higher and lower contraceptive acceptance rates. Three of the programs included were large maternity hospitals with annual ob/ab caseloads ranging from 22,000 to 56,000, located respectively in Nigeria, Colombia and Venezuela. The other institutions selected were either smaller maternity hospitals including three MCH centers in Thailand, or general hospitals, all with ab/ob caseloads ranging from 1,500 to 7,000 per year.

The duration and extent of observations by the health educator were determined by a variety of circumstances, including the availability of program staff, patient load at the time, and in some cases, the existence of a translator. Therefore, the length of stay at each hospital ranged from one day to two months, with the average being about five days.

While it was not possible to carry out a systematic study under these circumstances, sufficient observations were collected to permit identification of certain patterns in the provision of information and education in the postpartum program. Observations, descriptive of the form and context of postpartum education programs, are briefly stated below. A more detailed descriptive presentation is being prepared.

(1) Irrespective of hospital size or ob/ab caseload, the programs were found to adhere to a common sequence of providing the patients with family planning communication, which follows the maternity care cycle and reflects the common organization of the obstetric program. Large hospitals, generally characterized by shorter patient stay and greater turnover, have more difficulty in managing motivational coverage of the patient at all the points of maternity cycle care. One of the major differences found among hospitals is the emphasis placed on family planning which in turn is reflected by the intensity of motivational activities.

(2) Two basic patterns of staff utilization for patient education were observed - i.e., the use of existing hospital staff and that of "special motivators." No conclusions could be drawn

in regard to the greater effectiveness of one pattern over the other. The observations did identify relative advantages and disvantages of each pattern, as well as managerial problems inherent in each of the two staffing approaches for achieving motivational coverage.

(3) The observations of family planning communications activities served to document a variety of educational approaches, but did not result in the identification of any particular strategies which could be directly related to contraceptive acceptance rates. From the information collected it appears, however, that there is a relationship between patient motivation activities and general program effectiveness. While little variation was found among the hospitals in use of maternity cycle care as contact points for family planning motivation, there were noticeable differences in the communication content provided to the women. The more successful programs were found to offer a coherent planned educational strategy, combining instruction with emotional appeal, and offering a broader spectrum of topics related to MCH.

(4) As a final point it should be noted that many factors other than the educational input influence patient response to family planning. Although an educational component can be identified as an aspect of each service program, the effect of educational activities themselves could not be isolated from the staff who perform them, nor from the total context of the services.

The major technical assistance activities were carried out in Nigeria at one of the large maternity hospitals. In order to improve the existing patient motivation program, the health educator attempted to train the chief nurse-midwife in supervision, training methods and management of the motivators. Assistance was also given with clinic management, operational evaluations of educational activities and the development of motivational content.

In Colombia, the health educator visited postpartum hospitals under the auspices of ASCOFAME and the Ministry of Health. On the basis of these observations, assistance was then given to the central organizations in regard to identified problems relating to patient education efforts. The health educator gave guidance to both agencies in curriculum development for the training of physicians and auxiliary personnel in patient education.

Assistance in Indonesia primarily involved guidance of the Mobile Training Team, and secondarily included some assistance to two of the hospitals in matters relating to the deployment of motivational staff for increased patient coverage.

This experience involving the use of a short-term consultant suggests the following concl:

(1) To improve existing information and education activities, the organizational framework which sustains these activities had to be given equal attention. Problems requiring assistance with educational activities were difficult to separate from other problems in program management.

(2) While program staff may ask for assistance and be willing to work with an outside consultant to improve educational activities, lack of encouragement or indifference on the part of the Program Director will negate the effort.

(3) Obvious difficulties or inadequacies of the educational activities may be indicators of more serious management problems which cannot be solved by a short-term consultant.

(4) Guidance with educational activities should be offered in conjunction with other programmatic assistance during the developmental stages of a program.

(5) A consultant combining interest and skill in both education and management seems to be required.

B. Conclusions Regarding Information, Education and Training Programs

No one educational approach may be recommended for all hospitals. Since each situation encompasses a variety of differing conditions and constraints, there is potential utility for a variety of educational approaches. As an integral part of the total program management, different staffing patterns, educational methods and program strategies must be selected and combined to best meet the educational requirements for each particular hospital. Although the specifics of educational program design may not be prescribed, certain principles can be advanced as seeming to have general applicability.

1. Leadership

Programs relatively successful in terms of contraceptor recruitment tend to have program directors who:

-- are involved daily in the program's services;

-- participate actively in planning and evaluating all aspects of the program;

-- actively interpret the program's objectives and activities to other physicians and staff;

-- involve themselves in supervising staff performance.

2. Supervision and Training

All of the better programs have an adequately functioning system of training and supervision, including most of the following:

-- initial training or job-specific inservice training early in the program;

-- recurring inservice training;

-- clearly defined job descriptions and assignments;

-- job performance evaluation, emphasizing educational and interview methods and individual achievement in terms of referrals, appointments and acceptors;

-- frequent supervisory contacts, including staff meetings in which problems, approaches and performance are discussed.

3. Planning

The better performing programs tend to reflect (conscious) planning in terms of:

-- general program organization;

-- staff assignments;

-- educational content;

-- clear objectives for each contact in the cycle of maternity care.

Although planning needs to be detailed, the well-functioning programs were not static in design but showed evidence of redesign and adaptation to new circumstances or understandings.

4. 100 Percent Coverage

Almost without exception, one element in the better programs is the commitment and effort to reach every obstetric and abortion case with family planning information. The program designs, including staff assignments, educational methods and record systems, incorporate this objective and work together to ensure its achievement.

5. Broad Message Content

Present in many of the better programs, but not universal, was an integrated educational message combining family planning with other concerns for the health of the mother and her child.

6. Informational and Emotional Messages

Programs relying almost completely on the provision of factual information seem to be less successful than those which also use some emotive content. A locally determined balance between the two extremes seems to be indicated.

7. Varied Approach

The better performing programs have a greater variety of educational approaches, including one-to-one interviews, small group talks, pamphlets and, occasionally, film and broadcast systems. More than one category of personnel are often involved in the educational program and patients are usually contacted by program personnel several times in a number of different settings, including clinics, labor room, wards and at home.

8. Teaching

All of the hospitals visited were teaching institutions. The better programs revealed a tendency to utilize medical, nursing and

midwifery students in the family planning activities. The program directors and their staff saw training of these students as an essential part of their family planning responsibilities. The presence of students encouraged role-modeling behavior and was an added stimulus to the staff's desire to perform well.

9. Educational Effectiveness and Management

Perhaps the most striking observations in this overview of hospitals is of the tremendous influence of managerial factors on the educational program. Proper planning, organization, supervision and evaluation activities seem more important than the specific types of personnel used to provide I & E services, or than the educational messages and methods used. Program personnel perform their educational functions in response to the manner in which they and the program are managed. The patients, in turn, are affected by their whole hospital experience. The credibility of the educational program may be enhanced or negated by the ways in which they are treated and by what they sense to be the attitudes of the whole hospital staff.

A. Sub-grants Under AID/csd-2155

1. Colombia

History

1973 was a transition year for the postpartum program in Colombia From 1968 through 1972 the Council had annually supported, through the Colombian Association of Medical Schools, 23 to 26 hospital-based postpartum programs. On January 1, 1973, the non-university hospitals were incorporated into the Ministry of Health's national family planning program. The remaining eight university hospitals plus one new university hospital remained in the Council-supported ASCOFAME program. During the year plans were developed for these programs, in 1974, to become more closely identified with the universities' teaching and research programs. The postpartum family planning services will provide the teaching and research setting for this expanded activity. In 1974, the program will not be considered by ASCOFAME or the Council as primarily a family planning service program and will not, therefore, be supported from Postpartum Program funds. The Council will support it under its Latin American regional program funding.

The hospitals included in the 1973 program are as follows:

Instituto Materno Infantil	U. Nacional	Bogota
Hospital San Jose	U. del Rosario	Bogota
Hospital Infantil	U. del Rosario	Bogota
Hospital San Juan de Dios	U. Industrial de Santander	Bucaramanga

Hospital U. Evaristo Garcia	U. del Valle	Cali
Clinica Rafael Calvo	U. de Cartagena	Cartagena
Hospital U. de Caldas	U. de Caldas	Manizales
Hospital San Vicente de Paul	U. de Antioquia	Medellin
Hospital U. San Jose	U. del Cauca	Popayan

Program

There was a change in the central direction of the program in 1973, with the appointment in May of a new Director, Dr. German Riano Gamboa, a Coordinator of Education, Dr. Jorge Chavez Rosero and an Administrator, Mr. Luis Felipe Rojas. Three of the hospital program directors also changed in the year. The total personnel employed in the program were:

Central Office	4
Program Directors	9
Physicians (part-time)	17
Motivators	13
Secretaries	9
Nurses (part-time)	11
Total	63

Patient education for family planning continued, as it has in the past, with primary focal points being the postpartum wards, postpartum clinics and family planning clinics. Work was started in late 1973 to give more attention to prenatal clinics and well-baby clinics, while also seeking to increase the return rates to postpartum clinics.

The central office makes supervisory visits to the hospitals, sponsors biannual meetings of the program directors, provides training courses for the hospital program personnel, and assists in designing, supporting and publishing the findings of research projects within the programs. This

latter activity produced a large number of studies started or completed during the year.

1973 saw increasing cooperation between ASCOFAME and the Ministry of Health programs. They have organized a training center for MOH and ASCOFAME postpartum personnel within one of the ASCOFAME hospitals. They have also cooperated in curriculum development for other courses, and have sought to further coordinate their educational activities.

The Council sent Petra Reyes, the Postpartum Program's health educator, to Colombia in July to assess these education and training activities, including the patient education programs, and to assist in planning and evaluation, when requested. This assignment was received quite well by ASCOFAME and the MOH, both programs using her expertise.

Service Statistics

With the major reduction in the number of hospitals from 1972 to 1973 because the non-university hospitals became a part of the MOH family planning program, there was a corollary drop in obstetric and abortion (ob/ab) caseload and in acceptors. The total acceptance ratio declined three points while the direct acceptance rate increased two points.

Table V-1 Colombia: Basic Service Statistics, 1971-1973 for Country, and for 9 University Hospitals, 1972-1973

		Ob/Ab	Total Acceptors	Direct Acceptors	Total Acceptance Ratio (as%)	Direct Acceptance Rate (as%)
Colombia	1971	120,103	34,261	22,848	29	19
	1972	92,451	31,239	22,680	34	25
	1973	52,593	16,326	13,929	31	27
9 University	1972	45,358	15,356	11,694	32	25
9 University	1973	52,593	16,326	13,929	31	27

A comparison of the 1972 and 1973 performance of only the nine university hospitals shows a different picture: for the nine hospitals, the total ob/ab caseload increased primarily as a result of changes in the largest hospital, Instituto Materno Infantil, which went from 20,000 in 1972 to 24,000 in 1973. The total acceptance ratio declined only one point, while the direct acceptance rate increased two points.

It is expected that the performance of these university hospitals may improve in 1974. There was a delay of two to three months in starting three of the programs in 1973 and some readjustments were necessary due to the change of directors in the central office and within three of the hospitals. With the intensified supervisory program and training activities in the last part of 1973, and with the programs operating for a full 12 months, next year may show more improvement.

Looking at only the nine university hospitals in 1972 and 1973 (see Table V-2) one sees a significant improvement in total IUD acceptance which is accounted for mainly by the doubling of the immediate IUD insertions. This, in turn, was the result of the increased proportion of all acceptors in 1973 from Instituto Materno Infantil who were primarily immediate IUD acceptors. In 1972 they represented only 13 percent of all acceptors, whereas in 1973 they were 34 percent of all acceptors. The presence and improvement in this one large hospital dominates the program's service statistics now that the number of hospitals has been reduced so drastically.

The percentage of women accepting the pill is down, as are "other methods", while sterilizations have increased. In terms of program effectiveness, that is, continuation of use and births prevented, this change in

method mix probably represents an improvement.

Table V-2 Colombia: Number of Acceptors by Method, 1972-1973, for Country, and for 9 University Hospitals

		Total Acceptors	Total IUD	Immediate IUD	Pill	Sterilization	Inj.	All Other
All hospitals	1972	31,239	12,620	4,158	16,806	937	281	594
9 University	1972	15,356	7,617	2,902	6,802	476	107	353
9 University	1973	16,326	9,551	6,236	5,747	735	49	245
IMI	1972	3,990	3,069	1,338	772	0	43	106
	1973	5,547	5,135	4,248	228	37	14	113

Spread and Spin-off

The political and ideological climate supporting family planning activities has never been better in Colombia. On June 4, 1973 the President issued a decree creating a cabinet level Council on Ecology and Population. The Colombian bishops, speaking for the Colombian Roman Catholic hierachy, in a widely distributed but as yet unpublished document, have given their approval to all forms of fertility control except abortion and sterilization procedures.

It was this very favorable situation which allowed the MOH to take over the 15 non-university hospital postpartum programs on January 1, 1973. Five more hospitals were added to the MOH program, bringing the national total of hospital-based postpartum family planning programs to 29, including the nine ASCOFAME programs. It should be noted, however, that the government's program did encounter some difficulties in getting started in 1973. There were administrative problems caused by a lack of staff, inadequate organization and delayed funding from the government. The latter problem was resolved in part with financial assistance from PAHO/AID. It is

expected that in 1974 the UNFPA will provide support through PAHO for the government's postpartum program. If financial support can be assured, there are plans to expand the program to 97 hospitals in the next two years.

The ASCOFAME university hospital postpartum program will be broadened in 1974, with increased emphasis on research, teaching of students and training for their own and MOH staff. In addition, they began in late 1973 to add laparoscopic sterilizations to their procedures, with assistance from the Association for Voluntary Sterilization.

In 1974 it is expected that they will begin the study of vacuum aspiration techniques in relation to incomplete abortions, assisted by the Pathfinder Fund and the International Fertility Research Program of North Carolina University.

Indications are that the postpartum program in Colombia has played an important role in legitimizing family planning in the country. This is not to say family planning would otherwise not have been accepted, but that its acceptance has perhaps been accelerated. Certainly, the support of the Colombian Association of Medical Schools, under the direction of the deans of the medical schools, has helped in the medical profession's acceptance of family planning. The influence of this association within the government is more difficult to ascertain, but there is some indication of a positive impact. In any case, it appears likely that postpartum family planning services will continue to be offered in Colombian hospitals. Also, it is ASCOFAME's plan to work toward the time in the near future when postpartum family planning can be discontinued as a special program and will become a routine part of normal obstetrical care.

2. Ghana

History

Although the National Family Planning Program was not launched in Ghana until May 1970, postpartum services began in 1969 with Council support for a clinic in the Korle Bu hospital, the teaching hospital of the University of Ghana Medical School, which has an annual ob/ab caseload of 14,500. In July 1971, postpartum family planning services were started in the two largest hospitals outside Accra: at Komfo Anokye in Kumasi (11,000 ob/ab cases annually), and Effia Nkwanta in Sekondi (4,000 ob/ab cases annually). The National Family Planning Program regards these three programs as demonstration and training centers for the entire national program. The hope was expressed that through their participation in the International Postpartum Program the selected hospitals would gain useful experience in the delivery of hospital-based family planning services and also serve as centers for the training of personnel, medical and paramedical, required for the National Family Planning Program.

Program

The services provided at Korle Bu remain the same as in 1972, including three half-day clinics per week, daily education on the wards, and follow-up by three fieldworkers of patients who accepted clinic appointments, but who did not return to keep them. The Chairman of the Department, Professor Bentsi-Enchill, supervises the program, but has delegated overall administration to Professor Ampofo, and daily clinic administration to the nurse-midwives. Besides the Director and Co-director, other gynecologists in the department assist in clinics as needed, and are paid on a sessional basis.

There is one full-time nurse-midwife who is in charge of the clinics and educational program, assisted by four part-time nurses and three full-time fieldworkers-motivators. The clerk and cleaner are full-time.

In Kumasi, the postpartum program at Komfo Anokye Hospital continues under the direction of Dr. Agble, with the part-time assistance of three gynecologists, five nurses and a secretary, as well as six full-time fieldworkers, a clerk and a cleaner. In addition, other doctors and nurses helped in various ways. The work of the fieldworkers was hampered in late 1973 by a severe shortage of gasoline. In addition, Dr. Agble reports that sterilization operations have been limited by the lack of adequate operating room and bed space.

Effia Nkwanta Hospital in Sekondi has continued to operate under the direction of Dr. Bart-Plange, with the assistance of Dr. Lassey. There is one full-time nurse-midwife, three part-time family planning nurses, four full-time fieldworkers-motivators and a full-time clerk. Whereas the facilities in Kumasi are very crowded and inadequate, the outpatient obstetric and family planning clinic in Sekondi is spacious and convenient for both staff and patients.

Service Statistics

The 1973 combined total acceptance ratio for all three Ghanian hospitals was 26 percent, up one point over 1972 and the highest level reached since the program started in 1969. Shown on the next page (Table V-3) are results of the three programs since 1969. It should be recalled that only Korle Bu was in the program before July 1971.

Table V-3 Ghana: Basic Service Statistics, 1971-1973

		Ob/Ab	Total Acceptors	Direct Acceptors	Total Acceptance Ratio (as%)	Direct Acceptance Rate (as%)
Ghana	1969	3,841	185	89	5	2
	1970	12,205	1,279	476	11	4
	1971	19,536	2,543	1,098	13	6
	1972	28,889	7,160	3,708	25	13
	1973	28,864	7,397	3,096	26	11

Although the total acceptance ratio increased in 1973, the direct acceptance rate declined slightly from its peak of 13 percent in 1972 to 11 percent in 1973. This may be due to the shift from IUD to the pill, since women may be delaying pill acceptance until prolonged lactation is completed. The program directors have no other explanation to offer. Total IUD acceptance has declined from 94 percent of the 185 acceptors in 1969 to 16 percent in 1973, with a rise in pill acceptance of from 7 percent to 69 percent of all acceptors.

It will be recalled from previous reports that the early 1972 death of a woman in Komfo Anokye Hospital, following an operation to remove an IUD which perforated the uterus, resulted in wide-spread negative publicity regarding the IUD. Table V-4 on the next page shows the trend since 1971 in each of the hospitals. It will be seen that, although the percent of acceptors choosing the IUD has declined in 1972 in Komfo Anokye and Korle Bu, and increased slightly in Effia Nkwanta, the actual number of IUD acceptors has increased overall. That is, the IUD has not necessarily decreased in popularity, but other methods are now also being accepted.

The oral contraceptive is the most popular method, ranging from

89 percent of all acceptors in Komfo Anokye, to 61 percent in Korle Bu and 38 percent in Effia Nkwanta.

Table V-4 Ghana: Number and Percent of IUD and Pill Acceptors, 1971-1973 for Country, and for Individual Hospitals

		Total Acceptors	IUD Acceptors	IUD as % of Acceptors	Pill Acceptors	Pill as % of Acceptors
Ghana	1971	2,543	958	38	817	32
	1972	7,160	1,311	18	4,933	69
	1973	7,397	1,181	16	5,130	69
Korle Bu	1971	1,521	690	45	584	38
	1972	3,313	886	27	2,207	67
	1973	3,035	846	28	1,856	61
Komfo Anokye	1971	386	172	45	49	13
	1972	2,648	150	6	2,305	87
	1973	3,116	123	4	2,822	89
Effia Nkwanta	1971	636	96	15	107	17
	1972	1,199	275	23	421	35
	1973	1,196	212	18	452	38

Spread and Spin-off

The National Family Planning Program reports its satisfaction with the postpartum program in terms of its demonstration and training value. Consequently, in 1973 WHO and the UNFPA were approached with a request to both continue the programs in the three hospitals and to assist in developing a national postpartum element to the National Family Planning Program. The proposed expansion is intended to extend postpartum services into existing health facilities throughout Ghana and to establish a MCH-based family planning service within the Ministry of Health. For 1974, the NFPP is continuing to support, from its own budget, the programs in Effia Nkwanta and Komfo Anokye. Until other arrangements can be made, however, postpartum

services in the Korle Bu Hospital have been temporarily suspended. It is hoped that the anticipated WHO/UNFPA assistance will enable Korle Bu, as the primary teaching hospital in Ghana, to resume its proper training and service role.

3. Nigeria

History

The postpartum program in Nigeria began in 1969 with the opening of services in the Lagos Island Maternity Hospital (LIMH). This is the largest maternity hospital in West Africa, with 22,500 obstetric and abortion cases annually. In 1970 the University College Hospital (UCH) in Ibadan joined the program. The hospital is associated with a major Nigerian medical school and has only 3,000 cases annually. Inalende Maternity Center was also associated with the UCH program, but the program there was discontinued in 1972. The UCH postpartum clinic staff also provided part-time assistance for a clinic at Adeoyo State Hospital, but in 1973 this tie was cut and Adeoyo used its own personnel to staff its clinic.

Program

Professor O. A. Ojo, director of the postpartum program at UCH, is an extremely able and active person. In addition to his duties as Chairman of the Department of Obstetrics, he has developed, with Ford Foundation assistance, a family planning training program for medical and paramedical staff in Nigeria. Also, he is co-director of the WHO Regional Clinical Research Center located in the UCH. He is assisted in the postpartum program by a well-trained staff consisting of a varying number of gynecologists who are paid sessional fees; a full-time nursing sister who administers many of

the clinic, ward and field activities; two full-time nurse-midwives; three full-time junior social workers; a part-time clerk; part-time secretary and full-time cleaner.

Motivational talks are provided daily on the wards and in the obstetrical outpatient clinics. Family planning clinics are held five days a week, 8:00 a.m. to 5:00 p.m. The three social workers have, according to Dr. Ojo, contributed to a reduction in the high rate of defaulters through diligent home follow-up.

Because of the very low acceptance levels at Adeoyo State Hospital in 1972, it was arranged in 1973 for Dr. Adenuga, the program director, to hire his own staff, rather than depend upon the part-time services of UCH staff. With the planned take-over of funding by the Western State Ministry of Health in 1974, he decided to utilize existing staff for part-time work in the postpartum family planning program, rather than hire full-time staff whom the MOH would not be able to support. This has included the following part-time staff: two physicians, two nursing sisters, three nurse-midwives, six motivators and a clerk. Mrs. Delano, the chief nurse-midwife in the UCH postpartum program, has continued to lend assistance in planning the Adeoyo program and in helping to prepare their reports.

The postpartum program at Lagos Island Maternity Hospital continues under the direction of Dr. A. A. Lakeru, with the following full-time staff: three nurse-midwives, 15 motivators, one secretary, one clerk, and a messenger-cleaner. The postpartum family planning clinic is held daily, six days a week, from 8:00 a.m. to 2:00 p.m. Motivational talks are given in the daily ob/gyn outpatient clinic, on the wards and to those attending the

postpartum clinic. In addition, an attempt is made to follow up at home every patient delivered at the hospital. In fact, fewer than half are contacted because of inadequate addresses, change of residence or "not at home". However, between 70 and 75 percent of the inpatients are contacted on the wards, a rather remarkable figure in view of the average post-delivery hospital stay of eight hours.

The postpartum program at Lagos Island Maternity Hospital has continued to encounter difficulties in increasing its acceptance rates. The acceptance levels in the larger maternity hospitals of the International Postpartum Program have tended to be lower than in the smaller hospitals, but even among the seven hospitals in the Program with a caseload of 20,000 or over, LIMH has the lowest acceptance rates. Factors reported by the director as contributing to this are the short hospitalization after delivery (average eight hours), a reported resistance among Yoruba women against contraception in the first 40 days postpartum, a strong taboo against sexual relations for 40 days postpartum, polygamy, and the common use of lactation as a contraceptive. Other contributing factors, of perhaps equal importance, are: the postpartum clinic at LIMH is physically separated from the hospital; its staff are not hospital staff; hospital staff contribute very little to family planning activities; the postpartum program director has very little time for the program; there are seldom doctors available for consultation by the program midwives; and finally, supervision/training of the staff has in the past been inappropriate and/or minimal. The latter situation may change somewhat as a result of the late-1973 training in the United States of the chief midwife. Also, after April 1974 the program will become part

of the regular hospital program under the direction of the MCH section of the Lagos State Ministry of Health, which may help to get other staff involvement.

Service Statistics

In the three Nigerian hospitals supported by the Council in 1973 - UCH, Adeoyo, and LIMH - there were 34,225 obstetric and abortion cases. The total acceptors were equivalent to 16 percent of these cases, or 5,321 women. Of the acceptors, 1,965 were direct acceptors, accepting within three months after delivery. These figures represent a small increment in total acceptors compared with 1972, but a stabilization of the acceptance rates.

University College Hospital, with the smallest annual obstetric/abortion caseload, has by far the highest total acceptance ratios in the Nigerian hospitals. Its direct acceptance rate is also the highest, with 16 percent of all its ob/ab cases accepting.

There may be some difference in education and income of patients between UCH and the other two hospitals, but other program factors are probably more important in explaining the different acceptance levels. Internationally the Postpartum Program has had better success in the smaller hospitals, indicating the possibility of difficulties in organization, management and communication in large hospitals. In Nigeria, however, the size factor has been exacerbated by differences in leadership and staff. The UCH postpartum program has in its Director, Dr. Ojo, an outstanding administrator who gives considerable attention to the everyday details of his program. His chief midwife, who was trained in family planning at Downstate Medical Center, exhibits a similar leadership ability, both in her organizational and role-

modeling behavior. Neither LIMH nor Adeoyo has these advantages.

Table V-5 Nigeria: Basic Service Statistics, 1971-1973 for Country, and for Individual Hospitals

		Ob/Ab	Total Acceptors	Direct Acceptors	Total Acceptance Ratio (as%)	Direct Acceptance Rate (as%)
Nigeria	1970	29,648	2,629	1,145	9	4
	1971	32,445	4,522	1,572	14	5
	1972	33,748	5,235	1,876	16	6
	1973	34,225	5,321	1,965	16	6
Lagos Island	1970	20,989	865	448	4	2
	1971	20,927	2,185	1,059	10	5
	1972	23,966	2,995	1,421	13	6
	1973	22,439	2,636	1,259	12	6
Univ.(Ibadan)	1970	2,491	1,413	392	57	16
	1971	2,519	2,044	396	81	16
	1972	2,784	2,116	438	76	16
	1973	3,064	2,309	497	75	16
Adeoyo State	1970	4,853	324	288	7	6
	1971	5,675	208	73	4	1
	1972	6,428	115	15	2	0.2
	1973	8,722	376	209	4	2

Adeoyo State Hospital is much larger, over-crowded, under-staffed and has, until 1973, been dependent for educational and clinical services upon periodic visits by the UCH nursing and motivator staff. In 1973 the Director, Dr. Adenuga, began using staff of Adeoyo on a part-time basis for educational and clinical duties. His direct acceptance rates increased from 0.2 percent in 1972 to 2.4 percent in 1973, and the total acceptance more than doubled from 1.8 percent to 4.3 percent. However, this is still far below the rates experienced at UCH, also located in Ibadan.

Lagos Island Maternity Hospital is triple the size of Adeoyo, with 22,439 ob/ab cases annually. As pointed out earlier, the average patient

stays only eight hours after delivery, giving little time for educational contacts. The general antepartum clinic has over 700 patients daily, giving a rather chaotic atmosphere for group or individual talks. Dr. Lakeru, the postpartum program director, has little time for daily involvement in his program and depends heavily on his three nurse-midwives for clinical service and the 15 lay-motivators for patient education.

For the country as a whole, the pill has constituted more than half of all acceptors in both 1972 and 1973 (55 percent and 52 percent, respectively), with the IUD representing 41 percent in 1972 and 45 percent in 1973. This is a shift since 1970 when the IUD was more popular, representing 70 percent of all acceptors. There is, however, considerable variation among the three reporting hospital programs.

Table V-6 Nigeria: Number and Percent of IUD and Pill Acceptors, 1970-1973 for Country, and for Individual Hospitals

		Total Acceptors	IUD Acceptors	IUD as % of Acceptors	Pill Acceptors	Pill as % of Acceptor
Nigeria	1970	2,629	1,849	70	652	25
	1971	4,522	2,303	51	2,024	45
	1972	5,235	2,134	41	2,858	55
	1973	5,321	2,383	45	2,744	52
Lagos Island	1970	865	219	25	548	63
	1971	2,185	493	23	1,576	72
	1972	2,995	594	20	2,252	75
	1973	2,636	466	18	2,020	77
Univ.(Ibadan)	1970	1,413	1,282	91	101	7
	1971	2,044	1,528	75	437	21
	1972	2,116	1,435	68	587	28
	1973	2,309	1,588	69	681	29
Adeoyo State	1970	324	321	99	3	1
	1971	208	198	95	10	5
	1972	115	96	83	19	17
	1973	376	329	88	43	11

In 1973 IUD acceptors represent 88 percent of all acceptors at Adeoyo, 69 percent at UCH, and only 18 percent at LIMH. In all three hospitals, virtually all other acceptors choose the pill. Only in UCH were ther any immediate IUD insertions, a total of 25 cases in 1973. In this regard, it is reported by the program directors that the women strongly resist the idea of immediate insertions, there being almost a taboo against it. However, since most deliveries are conducted by midwives, none of whom have be trained in immediate postpartum insertions, it is doubtful if the concept has been adequately tested.

Spread and Spin-off

Because of the federal system of government in Nigeria, each separate state is responsible for its own health services, including family planning. As of this date there is no plan for the extension of postpartum family planning services into other hospitals in any Nigerian state except for Lagos State. There, they will take over support of the program in LIMH on April 1, 1974 and plan to offer similar services in all other Lagos State maternity centers. The Western State plans to take over support of the program at Adeoyo State Hospital on January 1, 1974, but has not expressed an intention to offer family planning in any other hospitals.

Only the program at UCH has not yet secured future funding and is being continued in 1974 as part of the International Postpartum Program. Since it is a federal institution, it cannot get support from Western State. Dr. Ojo, the Director, has applied to the UNFPA for financial assistance, but does not expect to receive it until January 1975. The Federal Ministry of Health has approached WHO about the possibility of its assistance in

developing a national maternity-centered family planning program, but planning has not progressed very far.

It is likely that in Nigeria, perhaps also in most of West Africa, the postpartum concept will have to be expanded to include a greater than three-month period and to encompass child care, as well. It seems that the desire for large families, polygamy, prolonged lactation, and male attitudes of progeny as indicative of their virility, all contribute to relatively low acceptance of contraception early in the postpartum period. Add to this a relative lack of official government support for family planning, and we have some explanation for Nigeria's low acceptance of postpartum family planning. Only the exceptional program at UCH in Ibadan indicates its possibilities when there is a well-trained staff with good leadership.

4. Thailand

In 1973 the Population Council supported Chulalongkorn Hospital for the full year, Women's Hospital for the first six months, and the eight Ministry of Health hospitals and three MCH centers also for six months. (Funding for Siriraj ended in 1972 and for Vajira in 1971.)

The programs of these hospitals will be described below, but we include here some remarks about the service statistics for these hospitals which may be affected by the following general considerations, regardless of any programmatic factors.

First, immediate postpartum acceptances have always been an important part of the Thai programs. The direct acceptance rates are high in Thailand, and in various hospitals 70 percent to 100 percent of the direct acceptors are immediate acceptors. Immediate acceptance ratios have been

quite steady in the past three years because the decline in immediate IUD acceptances has been offset by the increase in immediate sterilizations. (See Tables V-7 and V-8.)

Part of the decline in the number of postpartum clinic acceptances may be due to the increase in the number of alternative family planning clinics, or possibly to a slight decline in the ob/ab caseloads. Also, Thailand's national family planning program has always placed heavy emphasis on pill acceptances, but it was seriously affected in early 1972 by consumer disaffection with the pill, reportedly the result of the switch to Norlestrin, and has only begun to recover from this. In addition, there has been a proliferation of distribution points for the pill, and these factors may explain some of the decrease in pill acceptances even in the Council's postpartum programs. Finally, beginning with the Bangkok hospital programs, emphasis on IUD insertions, which used to account for at least 60 percent of all acceptors, has been shifted in the last two years to sterilizations. Added impetus for these procedures comes from the UNFPA which pays the hospitals $7.50 for a tubal ligation and $2.50 for a vasectomy. The cost to patients has been significantly reduced, from perhaps as high as $40 for a tubal ligation to $7.50.

Spread and Spin-off

The four Bangkok hospitals began their postpartum programs in 1966; in March 1969 eight MOH hospitals and three MCH centers were added. Since then the policy of the MOH has been to extend the postpartum concept to the 76 other Ministry hospitals, but the actual number which are currently implementing this policy is unknown.

Table V-7 Thailand: Basic Service Statistics 1971-1973 (Including Immediate Acceptance Ratios) for Country, and for Individual Hospitals

		Ob/Ab	Total Acceptance Ratio (as%)	Direct Acceptance Rate (as%)	Immediate Acceptance Ratios (as%) IUD	Steril.	Pills
Chulalongkorn	1971	18,120	48.7	27.0	17.3	8.6	0
	1972	18,051	45.6	27.6	15.5	12.1	0
	All 1973	17,316	45.0	27.5	10.4	17.1	0
Somdet	1971	3,183	38.2	25.4	12.6	10.5	0
Sriracha	1972	3,382	40.4	25.2	13.7	9.8	0
(Dec.'73 est.)	All 1973	2,985	28.8	16.1	0.9	13.9	0
Women's	1971	24,476	25.7	18.6	10.9	2.2	0.6
(Support	1972	24,487	25.1	18.3	10.0	2.9	0.8
ended 6/73)	All 1973	23,216	25.0	17.8	8.0	4.7	0.1
8 MOH	1971	34,422	66.1	32.1	14.5	9.8	3.8
	1972	37,030	73.5	40.1	19.1	13.2	1.0
(1st 6 mos.)	1973	19,408	70.3	38.2	12.9	16.5	0.6
3 MCH	1971	11,136	160.1	64.9	17.2	32.2	2.5
	1972	13,567	126.3	60.1	13.7	34.2	0.4
(1st 6 mos.)	1973	6,736	114.2	61.0	12.8	34.2	0
All Thailand	1971[1]	122,716	54.1	27.2	11.6	9.3	NA
	1972[2]	117,024	56.5	31.2	12.7	12.5	NA
	1973[3]	57,608	57.3	32.9	10.1	14.3	0.2

1. 1971 figures also include Vajira and Siriraj (Siriraj support ended 12/71)
2. 1972 figures also include Vajira (Vajira support ended 12/72).
3. 1973 figures include only the above hospitals for the periods indicated.

Table V-8 Thailand: Number of Acceptors by Method 1971-1973 (Including Immediate Acceptors) for Country, and for Individual Hospitals

		Ob/Ab	Total Acceptors	Direct Acceptors	Immediate Postpartum Acceptors IUD	Steril.	Pills	Clinic Acceptors All Other IUD	All Other Pills	Injectables
Chulalongkorn	1971	18,120	8,825	4,894	3,142	1,562	0	3,450	342	329
	1972	18,051	8,229	4,988	2,796	2,180	0	2,626	269	358
	All 1973	17,316	7,791	4,765	1,807	2,958	0	2,178	545	303
Somdet	1971	3,183	1,217	857	401	335	0	425	52	0
Sriracha	1972	3,382	1,365	851	462	332	0	489	82	0
(Dec.'73 est.)	All 1973	2,985	861	482	28	414	0	342	77	0
Women's	1971	24,476	6,296	4,560	2,660	537	154	954	1,799	127
(Support	1972	24,487	6,139	4,491	2,446	708	186	966	1,645	152
ended 6/73)	All 1973	23,216	5,805	4,127	1,860	1,100	16	940	1,660	182
8 MOH	1971	34,422	22,746	11,037	4,983	3,361	1,305	8,930	3,918	15
	1972	37,030	27,232	14,866	7,081	4,882	360	9,540	4,790	5
(1st 6 mos.)	1973	19,408	13,647	7,423	2,510	3,201	108	5,173	2,245	1
3 MCH	1971	11,136	17,827	7,229	1,916	3,586	279	7,647	4,199	0
	1972	13,567	17,134	8,152	1,852	4,640	49	6,678	3,687	0
(1st 6 mos.)	1973	6,736	7,695	4,106	859	2,302	0	3,394	1,007	0
All Thailand	1971[1]	122,716	66,392	33,424	14,234	11,459	NA	23,915	NA	770
	1972[2]	117,024	66,073	36,568	14,886	14,602	NA	21,428	NA	687
	1973[3]	69,661	35,799	20,903	7,064	9,975	124	12,027	5,534	486

1. 1971 figures also include Vajira and Siriraj (Siriraj support ended 12/71).
2. 1972 figures also include Vajira (Vajira support ended 12/72).
3. 1973 figures include only the above hospitals for the periods indicated.

Council funding for all Thai hospitals ended in 1973. OXFAM will undertake the support of Women's Hospital and it is expected that they will also include Chulalongkorn and Somdet Sriracha. There will be no outside funding needed for the 11 Thai governmental hospitals (except for sterilizations, mentioned earlier) as the postpartum family planning functions will be absorbed by existing personnel.

4a. Women's Hospital (Bangkok)

History

This hospital became a member of the International Postpartum Program in December 1965. It is the largest of the four maternity services in Bangkok and has an annual ob/ab caseload of approximately 24,000. The inclusion of this hospital and the three other large maternity hospitals in the postpartum program means that almost all women who have supervised obstetrical care in Bangkok receive family planning education and services should they so desire.

Program

There were no new programmatic innovations in 1973. Immediate postpartum IUD insertions were performed each morning, at the rate of approximately 40 per week. The family planning clinic for outpatients was open on weekdays; IUD insertions and all IUD follow-up cases were handled in three sessions, and other conventional methods were serviced in two sessions. Information and education were given by a variety of specially trained paramedical personnel, using fairly standard informational materials and content, supplemented by movies, tape recorders with a loud speaker, and posters.

The program at Women's Hospital has been well integrated into the ob/gyn service and has yielded a satisfactory return with relatively small input and finances. Its influence has extended to the provinces because of its training program for physicians and midwives from several provincial health centers.

Service Statistics

In spite of the fact that Council support ended in mid-year, acceptance ratios are essentially unchanged from the previous two years. As in other Thailand hospitals, the drop in immediate IUD insertions is offset by the rise in sterilizations, and at this hospital there are no changes in clinic statistics. (See Tables V-7 and V-8.)

Spin-off

Since the end of Council funding in June, OXFAM is providing support for all family planning activities at this hospital, which includes the postpartum approach.

4b. Chulalongkorn Hospital (Bangkok)

History

The Family Planning Research Unit at Chulalongkorn Hospital has been partially supported by the Council since 1966. The program began in November 1965 with major emphasis on IUD insertions and by the end of 1973 there had been over 65,000 acceptors. Since January 1971 the Postpartum Program has included the Sriracha Hospital, a satellite hospital of Chulalongkorn. The combined family planning activities of these two hospitals reach over 20,000 women each year.

Program

The postpartum program at Chulalongkorn has been run on similar lines for the last few years. The clinic is open every afternoon; every morning, including weekends and holidays, immediate IUD insertions are offered. Information and educational activities for the postpartum patients include a talk on the public address system on the postpartum wards and visits by staff nurses to the bedside. In addition, there is a daily talk in the antenatal clinic.

Training activities go beyond those for the postpartum patients. They include six hours for third-year medical students and 12 hours for fourth-year students; student nurses receive two to four hours of introduction to family planning. In addition, doctors, nurses and social workers from the Bangkok Ministry of Public Health, trainees from Vietnam, and local leaders of the Planned Parenthood Association of Thailand receive instruction and training.

Activities of Chulalongkorn Hospital also include the operation of a mobile clinic (supported by IPPF) which makes a five- to six-day trip to the provinces twice a month.

As the postpartum program moves steadily on, the attention of its director, Dr. Aree Somboonsook, has turned to the development of the WHO Clinical Research Center which began its operations in April 1972. There are several projects currently under study, one of which concerns about 150 abdominal tubal ligations performed immediately postpartum. Its applicability in rural hospitals is being considered. A report of this project is not yet available, but it represents sharply increased interest in Thailand on

sterilization procedures.

Service Statistics (See Tables V-7 and V-8.)

The ob/ab caseload has decreased four percent but Total and Direct acceptance ratios at Chulalongkorn have remained steady in the past year (at 45 percent and 28 percent, respectively), as is true in most of the Thailand programs. All Direct acceptors are immediate acceptors. Among these acceptors there has been a shift from IUD acceptance, which is almost offset by an increase in sterilization acceptance rates. For those who come to the family planning clinic, where sterilizations are not done, IUD acceptances have also decreased considerably, but this is not compensated for with a corresponding increase in pill acceptances.

In the satellite clinic of Somdet Sriracha, immediate IUD acceptances have dropped almost to zero, with only a moderate increase in the number of immediate sterilizations; in the clinic, IUD acceptances have dropped 30 percent but pill acceptances, never numerous, have remained essentially the same. Reasons for the changes in numbers of acceptances are not apparent.

Spin-off

The postpartum program at Chulalongkorn is continuing. Negotiations with OXFAM have progressed to the point where it is expected that funding for the Postpartum Program will be continued by them in 1974. WHO is providing financial and technical assistance to institutions as part of their program of "Clinical Research Center" in family planning.

4c. Thailand Ministry of Health (MOPH)
(8 provincial hospitals and 3 MCH centers)

History

Support for these two groups of hospitals began in March 1969, under two separate grants, but these were combined under the MOPH in 1972 and 1973. In 1972 an incentive scheme of salary supplements to the regular staff was the major programmatic innovation. The new payment scheme could not be shown to have influenced acceptance ratios significantly, perhaps due to a variety of confounding factors (see the chapter on evaluation where this is discussed further, Section III B). In any event, this method of payment will not be continued in 1974 when these hospital programs are re-integrated into the provincial hospital system as it would be difficult administratively or financially to continue an incentive scheme for all the 87 provincial hospitals. Furthermore, and more importantly, in Thailand family planning is considered a regular part of maternity care and the responsibility of all those involved in this care, not something that should be dependent upon supplementary payments or incentives.

Program

The most valuable reports about these programs in 1973 come from the IPP health educator who made site visits to the three MCH Centers. Some of her most pertinent observations are given here.

(1) A very important characteristic that contributes to the organization and functioning of the services is the basic teaching/training commitment. It leads to an unusual degree of integration with the service component, and because students

are utilized to provide patient care, the teaching responsibility extends to the staff. Each staff nurse and midwife carries a supervisory responsibility toward the student. It seems that both in-patients and out-patients receive good care from the paramedical staff, with considerable individual attention. The training commitment also extends to field training for midwifery students, refresher courses for practicing midwives, and basic training for other community health workers, thereby creating an outreach component into the wider community.

(2) Integration of family planning with other MCH services is the most recognized characteristic of the Centers. The philosophy of integration is actively taught to the midwifery students through participation and demonstration. Moreover, there is a linkage between the care rendered at the Centers and follow-up care in the community which is achieved through public health nursing. In short, the Centers have made the services accessible,acceptable, comprehensive and coordinated, and have achieved a remarkable continuity of care.

(3) Patient educational responsibilities are shared by all MCH staff including students, and are carried out as an integral part of the care and services rendered. Thus, various staff members within any one of the many patient care settings help with the family planning communication

and the general patient education.

(4) The MCH centers have developed a systematic approach to patient education so that patients receive meaningful combinations of messages. Patients are exposed to a sound system approach, one-to-one interaction, and planned discussion among patients. Mass media communications are used outside the MCH setting. This integrated approach leads to some of the highest acceptance ratios in the whole International Postpartum Program.

Service Statistics

Both groups of MOPH hospitals have maintained their very high acceptance ratios in 1973, at least until the end of Population Council support and reporting requirements (Table V-7). Immediate acceptances in the three MCH centers show no change in IUD and sterilization ratios, but the eight MOH hospitals show some trade-off of IUD's for sterilizations. (Table V-7). The clinic activities in these hospitals apparently maintain the level of IUD acceptances, but pill acceptances have declined somewhat in the MOH hospitals, and declined considerably in the MCH centers. (Table V-8). This may be because of the increased number of pill distribution points or because there is still a fear of some adverse reactions from the pill.

Spread and Spin-off

As mentioned previously, the postpartum concept is being integrated into all the provincial hospitals, without supplementary payments, and without provision for extra personnel. Rather, family planning is integrated into the total maternity care package.

These 11 hospitals will continue without the special supplementary payments, and the activities of the Program will be handled exclusively by the regular hospital personnel. They will not receive special support for postpartum activities, except for sterilization supplements from the UNFPA.

5. Venezuela

The Council has two grantees in Venezuela - the Maternidad Concepcion Palacios Hospital (MCP) and the postpartum program of the Venezuela Family Planning Association (AVPF). These will be discussed separately.

5a. Maternidad Concepcion Palacios (MCP)

History

The MCP hospital has participated in the Population Council Postpartum Program since 1966. In the early years it was a demonstration to legitimize postpartum family planning as the responsibility of ob/gyn specialists. The first Population Council involvement with MCP was in 1966 through a series of non-AID bio-medical grants establishing the cytology laboratory for a study of the possible carcinogenic effects of oral contraceptives and IUDs, and it established Pap smear screening in the family planning clinic. This proved to be a very important factor in gaining the acceptance of family planning by the medical profession. The major thrust of the later postpartum grants has been to provide ward motivation and additional doctor hours to those already being paid from the MCP budget. Ford Foundation grants for professional training in family planning have been most important in strengthening the teaching

aspects of the program.

Program

The family planning program, although in existence for over eight years, still meets resistance among some physicians, nurses and auxiliaries, even though there has been some attempt to conduct informal educational sessions on family planning after working hours for nurses and other interested hospital staff.

Patient stay, for normal deliveries, is usually 24 hours, frequently with two women per bed. There are 12 motivators who attempt to talk with these women, a total of about 135 new obstetrical and 30 new abortion cases each day. The 12 motivators reach about 80 percent of the newly delivered women; 100 percent coverage is prevented because of the short stay at the hospital and only one-half day's work on Saturday and the numerous holidays.

The motivators not only give talks in the clinic and on the hospital wards, but also take medical histories and conduct patient interviews; home visits are usually made only to follow-up positive Pap smears or for special studies such as those for the Copper-T and post-abortion IUD insertions.

Training of the motivators receives considerable attention here. The focus at MCP is on educational methods, interviewing and simple counseling skills. Job descriptions are written and serve as a basis for supervision and performance evaluation. Quantitative evaluation is based on motivator-specific appointment slip returns. Qualitative evaluation is carried on by the two supervising motivators and a family planning

coordinator. Criteria include the manner of relating to patients, eliciting of questions, appropriateness of messages, etc. Frequent staff meetings and one-to-one sessions are used to change motivator approaches or to improve necessary skills. The educational topics and motivational messages have been standardized in a motivator's guide; fortunately this is very similar to the content to that of the AVPF, since a large number of patients receive motivation from both groups at one time or another.

In 1971 it was felt that one reason for the relatively low level of new acceptors at MCP was that there was not enough physician staff to provide the services at the MCP clinic, and consequently the Council provided funding for 12 additional physician-hours daily. Even with this assistance, the present use of physician time at MCP makes it difficult to increase the new patient load at the clinic because of the increasing number of revisit and annual check-up cases which also must be seen by the physicians. There were 8,500 new acceptors in 1973, but also 37,000 revisit cases, 90 percent of whom came for IUD checks.

To make it easier for recently delivered women to receive contraceptive services, a referral system was instituted in 1972. When a woman on the postpartum wards requests consultation on family planning and then decides she would like a family planning clinic appointment, she is given a choice of the MCP clinic or an AVPF clinic nearer her home. As Table V-9 shows, of the 41,169 consultations in 1973, 43 percent were referred to the MCP clinic. Of those who received referral slips to the MCP clinic, about one-third returned to become direct acceptors (5,754 in 1973). Although the number is unknown, it is likely that some of the later

(indirect) acceptors had also received a motivational consultation as a patient at MCP. Accurate statistics are not yet available, but if the same percentage of the referrals to the AVPF clinics also became acceptors, the motivators at MCP might be justified in claiming credit for 8,000 or more new patients at AVPF clinics in 1973. Statistics on referrals will become available as the AVPF computerized service statistics program becomes operational. This is provided for under another Council grant to the AVPF, AID/csd-2897.

Table V-9 Venezuela: Referrals to MCP and AVPF Clinics

	1972	1973
MCP Ob/Ab Caseload	58,737	58,086
Number of Consultations	28,373	41,169
Referred to MCP clinic	15,873	17,764 (43%)
Referred to AVPF clinics	12,500	23,405 (57%)
Returned with slips to MCP	NA	4,072
Direct Acceptors at MCP	5,680	5,754 (33% of referrals?)
Total New Acceptors at MCP	8,726	8,446 (48% of referrals?)

Service Statistics

The caseload at MCP and the total number of acceptors have remained essentially the same in the past year (see Table V-10 and V-11) and, therefore, the total acceptance ratio remains at 14.5 percent. This is still primarily an IUD program, and although the number of IUD acceptances remains at 6,800, there has been a considerable increase in the number of immediate IUD insertions, all from the non-septic abortion caseload.

The number of sterilizations has remained close to 1,000 for the year, but an important development is the rise of immediate sterilizations after delivery and before hospital discharge, from 260 in 1972 to 866 in 1973. Immediate postpartum sterilizations are not done in any of the other Council-supported postpartum hospitals in Venezuela.

Table V-10 Venezuela: Basic Service Statistics, 1971-1973 for Country, MCP, and AVPF Clinics

		Ob/Ab	Total Acceptors	Direct Acceptors	Total Acceptance Ratio (as%)	Direct Acceptance Rate (as%)
Venezuela	1971	150,469	27,243	15,662	18.1	10.4
	1972	150,725	32,970	19,060	21.9	12.6
	1973	152,707	33,703	19,629	22.1	12.9
MCP	1971	58,359	7,357	4,135	12.6	7.1
	1972	58,737	8,573	5,552	14.6	9.5
	1973	58,086	8,446	5,754	14.5	9.9
AVPF (31 clinics)	1971	92,109	19,886	11,527	21.5	12.5
	1972	91,988	24,397	13,508	25.3	14.5
	1973	94,621	25,257	13,875	26.7	14.7

Table V-11 Venezuela: Number of Acceptors by Method, 1971-1973, for Country, MCP, and AVPF Clinics

		Total	All IUD	Imm. IUD	Pill	All Steril.	Imm. Steril.	All Other
Venezuela	1971	27,243	14,803	98	9,603	1,904	0	933
	1972	32,970	16,913	844	13,115	1,932	260	1,010
	1973	33,703	16,986	1,243	13,636	2,042	866	1,039
MCP	1971	7,357	5,570	0	728	1,029	0	30
	1972	8,573	6,877	589	807	1,039	260	150
	1973	8,446	6,813	740	647	971	866	35
AVPF	1971	19,886	9,143	98	8,875	875	0	993
(31	1972	24,397	10,036	255	12,308	893	0	1,160
Clinics)	1973	25,257	10,173	503	12,989	1,071	0	1,024

Acceptance rates at MCP have never been high, but Table V-12 shows that although the median age of the ob/ab caseload has remained the same for the past three and one-half years, the median age of acceptors has steadily declined. The table also shows something that is probably unique in the Council Postpartum Program - the median age of the acceptors is now almost the same as that for the caseload, whereas usually it has been higher by a couple of years.

Table V-12 MCP: Median Age of Ob/Ab Cases and All Acceptors (except Sterilizations)

		Ob/Ab	All Acceptors
1970	Semester 1	24.2[a]	25.1
	Semester 2	24.4[a]	25.0
1971	Semester 1	24.2	24.8
	Semester 2	24.2	24.7
1972	Semester 1	24.3	24.4
	Semester 2	24.3	24.6
1973	Semester 1	24.2	24.3
	Semester 2	Not Available	

[a] The 1970 figures are estimates based on 1971 Ob/Ab distributions.

Spin-off

Future funding for MCP is still uncertain. One can look forward to the time when MCP will become a part of a unified health services which include family planning, but because it is extremely unlikely that alternative financing for MCP could begin before January 1975, the Council is continuing its support in 1974, with a gradual reduction in the number of physician-hours and no reduction in the motivator time. It is possible that within another year there will be a National Health Service which will consolidate Health, Municipality and Social Security Services. In other words, planning at the federal level includes the Maternidad, but this cannot be assured in 1974.

5b. Venezuela Family Planning Association (AVPF)

History

The Population Council supports only a part of the many activities of the AVPF, an affiliate of IPPF, founded in 1966. The professional staff has grown from an executive director and two other physicians in 1967 to 18 professionals on the Central Office staff in 1973, with 20 others who perform technical and clerical functions. From the beginning, it has been engaged in varied and extensive efforts to develop political, professional and financial support for family planning.

It has been responsible for the development of a country-wide network of family planning clinics, and it has been the policy of the Association to render family planning services provisionally until such services are incorporated into the National Health Service, as proposed by the Health Ministry in 1968. At the present time the AVPF is responsible for all except two of the 139 family planning facilities in Venezuela. For most of these, the AVPF provides personnel and contraceptive supplies. All but five operate in state-owned facilities, rent-free.

During 1973 a total of 31 facilities were supported by Population Council funds, 17 in hospital clinics and 14 in associated satellite clinics of various types. There may be other postpartum programs in some or all of the other 13 hospital-based facilities in the AVPF system.

The AVPF now carries out its own training programs for the 450 medical and paramedical personnel who staff its 137 clinics. It also trains volunteer community workers who attempt to inform and educate various groups in the community or in industrial settings. The Association also

holds seminars for university-level professors and students who are involved in the fields of population studies and family planning.

With the prospect that the Venezuelan government is moving toward assuming more coordination of family planning within its overall health care system, the AVPF has turned its attention toward improving its monitoring and evaluation of program activities to provide data needed for evaluation and policy decisions.

In the past year a grant from the Council (non-postpartum) supported the creation of a Research and Evaluation Unit. The principal first year goals were to establish a Caracas Metropolitan Area computerized service statistics program that would provide rapid feedback and management information for the administrators of the Venezuelan family planning clinics. It is this system that will provide follow-up data on the appointments given at the MCP when it becomes operational in 1974 or early 1975. The research unit was also funded to undertake several rapid feedback studies on clinic management. The unit is headed by Dr. Gonzales-Cerutti who received a Council fellowship to study at the University of Michigan.

Program

Population Council support for the AVPF Postpartum Program provides for personnel, contraceptives and Central Office administration and supervision for family planning clinics in 31 locations in government facilities. Each facility is staffed with one or more "teams" consisting of a physician, nurse, motivator, and sometimes clerical assistance. The clinics are open two or more hours each day depending on caseload requirements.

Training (mentioned earlier) and supervision are provided from the AVPF Central Office. One of the most important developments in the past year, however, has been the addition of nine regional coordinators, based in the field, employed either part-time or full-time to supervise program and clinic activities in the States where they live. The medical coordinators work under the administrative direction of the State Health Department but receive technical direction and supervision from the AVPF. The supervisors have been able to give extensive training to doctors in the rural health centers.

Service Statistics (See Tables V-10 and V-11)

The number of acceptors in the AVPF clinics has increased four percent over the last year, resulting in very slight increase in the acceptance ratios. Although the absolute number of new IUD acceptors has remained the same, the number of Immediate IUD insertions has doubled, from 250 to 500 in 1973. The number of sterilizations shows a 20 percent increase over the previous year, but there are still no immediate sterilizations done in the AVPF postpartum facilities.

Spread and Spin-off

The situation with the AVPF is similar to that of the Maternidad. The Council continued its support into 1974, with the expectation that alternative sources of funding soon will become available.

Late in 1973, CORDIPLAN (the official planning agency for the government) submitted a request to the UNFPA for funds for a "program of education, orientation and family planning" which would involve additional assistance from UNDP, the Ford Foundation and the Population Council. The

Ministry of Health (MSAS) and personnel from AVPF and Maternidad Concepcion Palacios (MCP) all helped to plan the Government's request. This plan, a part of the national five year plan (1975-1979), would include the study of population dynamics, training of necessary personnel for the execution of education and family orientation activities, and the operation of family planning services - all along the lines of a suggestion for a Unified Health Service originally proposed in 1968.

The request was submitted to the UNFPA before the election of the new president, Carlo André Pérez, but since Señor Pérez was outspokenly in favor of family planning during the campaign, it is expected that his interest will continue after he takes office. More recently there are hints that the UN request may be withdrawn and funding provided from the national budget. The new President also indicated that the universities would not lack for funds, so these statements open up the possibilities of studies, training and development of Venezuelan self-sufficiency in population planning and family planning services. Thus it is expected that the government will continue to develop its interest and commitment in population planning.

This is especially important because it is obvious that outside donor agencies cannot be expected to continue their assistance at the present level for an indefinite period and therefore successful local financing is of paramount importance. The Fundacion Paternidad Responsible (FPR) proposed a mass media campaign as a means of gaining and mobilizing public support, but this will have to be coupled with an intensive campaign of face-to-face contacts with key individuals and groups to enlist other organized action.

Meanwhile, the AVPF is awaiting the decision of the new government

as to the form in which the family planning program will function. Important contacts have been made with personnel connected with the government and there are good perspectives for the absorption by the Ministry of Health of one or all parts of the family planning services of the country.

B. Council-Supported Latin American Programs (non-AID Funds)

1. Brazil

History

The Sociedade Civil Bem Estar Familiar no Brasil (BEMFAM), an IPPF affiliate, has played an important pioneering role in Brazil, leading the government and the people to recognize the population problem. During the past two years BEMFAM action seems to have been very successful and it is presently operating 67 clinics.

In late 1970 the first postpartum program grant to the Universidade Minas Gerais in Belo Horizonte was approved (using non-AID funds) as an exception to the Council policy against further expansion of the postpartum demonstration. This exception was made because of the advantage of introducing the hospital postpartum approach in a Federal University important in the Brasilian health and political structure. At that time, BEMFAM was already operating a clinic at the University but the productivity was not high and was fraught with difficulties such as the absence of a motivation program, low patient attendance and irregular physician attendance. Support for a postpartum program was recognized as an opportunity for an organized motivational program for family planning in an important Brasilian medical school teaching hospital. In the first year the very high total acceptance ratio indicated that this program had an unusual impact on the total community of Belo Horizonte.

In the first two years of the postpartum program, Council funds covered only those supplementary activities related to the postpartum program ($13,261 in 1972). BEMFAM provided funds for its general family

planning clinic operation, including contraceptives for its own clients and for postpartum patients.

In 1973 BEMFAM requested that the Council take over funding of the whole operation (postpartum program plus general BEMFAM family planning clinic), partly because of the inconvenience of a separate reporting and accounting system. Therefore the budget for 1973 covered all personnel at the clinic as well as contraceptive supplies ($40,452). Beginning in 1974, BEMFAM absorbed the whole program after Council support ended.

Program

Until recently the family planning clinic, located in the Hospital do Cruz Vermelha, was the only public family planning service in Belo Horizonte. It is one of the most active clinics in the entire BEMFAM operation. In the mornings, the services are provided for direct acceptances from the Maternity Hospital, and in the afternoons the clinic has been crowded with indirect acceptors from the other larger maternity hospitals and the general population of Belo Horizonte for whom no other services were available. When BEMFAM opened another clinic in Belo Horizone in late 1972, the number of indirect acceptors at the University clinic dropped steadily each quarter.

The doctor responsible for the service took a maternity leave of absence in September 1973 and as a result there was only one doctor in the last quarter. There were also other problems in the Maternity Service and Medical School in late 1973, and in December 1973 and January 1974, all medical school clinics were closed. With reorganization,

expansion is expected in 1974. In spite of these problems, the number of direct acceptors remained the same in Q4 1973.

The medical faculty at the University of Minas Gerais continues its training in family planning as a part of the two-year postgraduate course in obstetrics/gynecology in which each resident spends two months in the family planning clinic. The training also usually includes one month with BEMFAM in Rio. For the graduate students, there are lectures and observations in the family planning clinic.

Service Statistics (See Table V-13)

The number of obstetrical cases (2,200) and direct acceptance rates (37 percent) have remained steady since 1972. As mentioned above, the number of indirect acceptors has dropped steadily, probably because of the opening of another clinic in Belo Horizonte. There were about 1,000/Q in 1972, but only 320 by Q4 1973.

The Direct Acceptance rate remained at 37 percent in 1973, and even rose to 40 percent in Q4, although it was a period during which the clinic was faced with many problems. Method acceptances for the year were colored by the clinic problems in Q4. In this quarter there were no immediate IUD acceptances, and sterilizations, which had been increasing, were reduced by half. These reductions were compensated for by an increase in Other Method acceptors.

Spread and Spin-off

BEMFAM already supports postpartum programs at several university maternity hospitals, but the extent of its current activities in this aspect of family planning is not available to us. The concept

Table V-13 Brazil: Universidade Federal de Minas Gerais
Basic Service Statistics 1971-1973
Including Immediate Acceptances

		Total	Immediate Direct	Other Direct	Total Direct	Indirect
Ob and Ab	1971	2,445				
	1972	2,237				
	1973	2,217				
Acceptance Ratios (as % of Ob/Ab)	1971	178.7			42.8	135.9
	1972	222.5	(very low)		37.1	185.4
	1973	168.6			36.9	131.8
Acceptors (all methods)	1971	4,368	60	986	1,046	3,322
	1972	4,977	66	763	829	4,148
	1973	3,738	93	724	817	2,921
IUD	1971	1,972	13	441	454	1,518
	1972	1,995	20	257	277	1,718
	1973	1,716	23	230	253	1,463
Pill	1971	2,168	--	476	476	1,692
	1972	2,611	--	398	398	2,213
	1973	1,381	--	312	312	1,069
Sterilization	1971	47	47	--	47	--
	1972	45	45	--	45	--
	1973	70	70	--	70	--
Other Methods	1971	181	--	69	69	112
	1972	326	1	108	109	217
	1973	571	--	182	182	389

of a family planning policy for Brazil is being considered by governmental and other sources, primarily due to the work of BEMFAM through its educational and service assistance activities. It is hoped that in the near future there will be a semi-officialization of BEMFAM's program beyond its official accreditation as a "public utility" in Brazil.

Population Council support ended December 31, 1973 and BEMFAM will resume its support of the postpartum clinic. The Council will continue to consider support for research, evaluation or training activities in the medical school setting, including at this University.

2. Mexico

History

In 1973 the Population Council (using non-AID funds) supported the same three hospitals as in the previous year - the University hospitals at Guadalajara, Durango and Toluca. Because of the late 1972 FEPAC agreement with the Gulf coast state of Veracruz to open 18 family planning clinics in the Civil hospitals there, and its plans for similar expansion with other hospital systems in other states, FEPAC wished to use the three Population Council-supported postpartum programs as training centers for personnel who would be working in the new projects. The Schools of Medicine agreed to include postpartum observation and practice in the curricula of interns and residents.

A major development in the past year has been made possible because of UNFPA support to the MCH Division of the Ministry of Health. With these funds the government has trained state coordinators and they have begun to take responsibility for hospital and health center family

planning clinics. Eventually the government, through the MCH Division, will take over all the family planning services in the MOH-supported hospitals and health centers. When this occurs, it is FEPAC's policy to establish new clinics where there are no health services (see Durango, below).

Program

The postpartum program at Guadalajara is by far the largest of the three Council-supported Mexican programs. It has a very complete family planning program including postabortion service, and in 1973 the hospital established within its regular budget a full-time position for the Director. It offers training to medical interns and residents, and in 1974 physicians from the Ministry of Health clinics in Veracruz will come here for further training.

The postpartum program at Toluca, although much smaller than at Guadalajara, is also used for area training, and coordinates its activities with the University of Toluca's program for rural community medicine. It has particular interest in developing a program for tubal ligations which in the latter part of 1973 had reached 25 per month.

In Durango, however, it was necessary for FEPAC to revise its plan in October when the postpartum program was turned over to the State Health Ministry for incorporation into its general health program, with the understanding that the postpartum family planning services would continue using the same FEPAC system. As a result of this, FEPAC was able to open a new family planning center (not postpartum) in an area of Durango which previously had received no family planning services,

and it plans to open another center in 1974.

At the Medical School in Durango Dr. Rivera Damm has established a collaborative effort with Downstate Medical College, in which three of his nurses will be trained in Brooklyn, and then will return to train auxiliary nurses in family planning in the 24 coastal health centers. At Durango they are also trying the immediate postpartum distribution of pills, a demonstration effort stimulated by FEPAC, although not carried out under FEPAC auspices.

In its postpartum programs FEPAC continues to use the same educational approach as previously. Information is given first to groups and then on an individual basis, by both the social worker and the physician. Audio-visual material for motivation includes two films developed by FEPAC, on family planning and on contraceptive methods. The patient is encouraged to attend the follow-up clinic for a gynecological postpartum check and a Papanicolaou test which cannot be done in the immediate puerperium.

In an effort to improve its supervision of the new hospital programs for the Veracruz hospitals, a seminar was held in July 1973 which brought to light several problem areas, and permitted the development of supervisory procedures in order to increase the efficiency of all its service programs.

Service Statistics

These are shown in Tables V-14 and V-15. The statistics for Mexico are unique in that in each of the three Council-supported postpartum programs, almost all acceptors are Immediate acceptors, regardless

of method accepted. The Total Acceptance ratios shown in Table V-14 are, therefore, also Immediate Acceptance ratios, and as such are some of the highest in the Postpartum Program.

Service statistics at Guadalajara, the largest hospital, have shown steady improvement since the beginning. In 1972 about 50 percent of the ob/ab caseload accepted a contraceptive method; in the last two quarters of 1973, 70 percent of the women accepted, and all of these were acceptances before hospital discharge. In 1973 about 20 percent of the postpartum patients had immediate IUD insertions; about 40 percent accepted the pill and another seven percent received Depo-provera. This is approximately the same method mix as a year ago, but the percentage of caseload accepting has risen significantly.

The sterilization program at this hospital began to accelerate in late 1973. Training in sterilizations will be offered in Guadalajara to physicians from other cities in the country, with a view to initiating pilot programs in voluntary sterilization, using male as well as female methods

At Toluca, which has a much smaller caseload of about 2,400 per year, there also has been increasing emphasis on sterilizations, with a corresponding decrease in reliance on injectables.

In the first three quarters of 1973, before being absorbed into the governmental program, Durango put increasing emphasis on a demonstration distribution of pills immediately postpartum. This helped to increase the acceptance ratios, in spite of a decrease to almost zero of IUD insertions, and a drop in injectables to one-third of their 1972

Table V-14 Mexico: Basic Service Statistics, 1971-1973, for Country, and for Individual Hospitals

		Ob/Ab	Total Acceptors	Direct Acceptors	Total Acceptance Ratio (as%)	Direct Acceptance Rate (as%)
Mexico	1971	14,330	4,043	Almost	28.2	same
	1972	11,918	5,232		43.9	
	1973	11,648	6,135	all	52.7	
						as
				acceptors		
Civil de	1971	6,352	1,802		28.4	
Guadalajara	1972	7,818	3,819	are	48.8	Total
	1973	7,699	4,870		63.3	
				immediate		
Mujer	1971	2,248	453		20.2	acceptance
(Toluca)	1972	2,339	559	direct	23.9	
	1973	2,575	550		21.4	
				acceptors		ratios
Durango	1971	764	277		36.3	
	1972	1,761	854	in these	48.5	
	1973	1,374	715	hospitals	52.0	

(1) 1971 figures for Mexico include Hospital de la Mujer in Mexico City and Hospital de la Mujer in Tijuana. The program in Mexico City was discontinued March 31, 1971 and in Tijuana, December 31, 1971.

(2) The MOH took over the Durango Program on October 1, 1973. Service statistics through Q_3 only.

(3) Almost all acceptors are Immediate Direct Acceptors in Mexico. This is true for all methods offered in all postpartum clinics.

Table V-15 Mexico: Number of Acceptors by Method, 1971-1973, for Country, and for Individual Hospitals

		Total Acceptors	IUD	Pill	Steril.	Inject.
Mexico	1971	4,053	744	2,151	53	1,092
	1972	5,232	1,179	2,979	90	984
	1973	6,135	1,433	3,647	178	873
Civil de Guadalajara	1971	1,802	437	953	0	412
	1972	3,819	1,099	2,294	0	426
	1973	4,870	1,390	2,873	48	559
Mujer (Toluca)	1971	453	52	195	15	189
	1972	559	32	229	53	245
	1973	550	33	217	103	196
Durango	1971	277	28	151	5	92
	1972	854	48	456	37	313
	1973	715	10	559	27	118

(See notes under Table V-14)

values.

Spread and Spin-off

Population Council support for the three hospitals ended in 1973. These programs are continuing under governmental or FEPAC's supervision, and the invaluable experience obtained from these pilot programs is now being put into practice in the development of new hospital programs throughout the country.

APPENDIX A: Table 1

FINANCIAL ANALYSIS:
SUB-GRANT STATUS BY COUNTRY
(Grant Nos. AID/la-550 & csd-2155)

Country & Sub-Grantee	Grant #	Period	Total Amount	Balance of Committed Funds not Paid to Grantees as of 12/31/73 (1)	Status of Sub-Grant Accounting (2)
Colombia					
ASCOFAME	I68.122 (la-550)	Oct'68-Sept'69	$118,207	Nil	I
	T69.129 (la-550)	Oct'69-Dec'70	253,475	Nil	I
	T70.159A (la-550)	Jan-Dec'71	355,984	Nil	I
	T72.10A (csd-2155)	Jan-Dec'72	321,955	65,700	II
	T73.6A (csd-2155)	Jan-Dec'73	194,338	54,540	III

(1) These amounts represent the difference between the granted amounts and the funds paid to the grantees. As audits are completed these amounts will be lapsed.

(2) Category I - Audited and Closed: Includes those sub-grants which have been audited, the audit accepted, and grant closed. Records complete. Available for AID audit.

Category II - Financial Report Received: Includes those sub-grants for which the year-end financial report has been received or which are in the process of being audited, or which have been audited but not yet closed. Amounts shown subject to final adjustment.

Category III- Financial Report Not Received: Includes those sub-grants for which year-end financial reports have not yet been received.

Category IV - Current Grant 1973: Includes those sub-grants which are currently active.

Country & Sub-Grantee	Grant #	Period	Total Amount	Balance of Committed Funds not Paid to Grantee as of 12/31/73 (1)	Status of Sub-Grant Accounting (2)
Ghana					
Ghana Natl. Fam. Plan. Program	T70.125A (csd-2155)	July'70-Dec'71	$ 17,489	Nil	II
	T72.20A (csd-2155)	Jan-Dec'72	25,591	$ 3,040	II
	T73.14A (csd-2155)	Jan-Dec'73	21,415	11,290	III
Korle Bu	I68.185 (csd-2155)	Aug'69-July'70	11,263	Nil	I
	T70.0105A (csd-2155)	Aug-Dec'70	3,040	Nil	I
	T70.166A (csd-2155)	Jan-Dec'71	18,390	7,870	II
	T72.21A (csd-2155)	Jan-Dec'72	13,260	Nil	II
	T73.15A (csd-2155)	Jan-Dec'73	12,580	Nil	III
Honduras					
Honduran Fam. Plan. Assoc.					
Materno Infantil	I69.95 (la-550)	Nov'69-Oct'70	18,029	Nil	I
	T70.121 (la-550)	Nov'70-Dec'70	24,944	Nil	I
	T71.149A (csd-2155)	Jan'72-Dec'73	27,545	17,500	II
Leonardo Martinez	I69.96 (la-550)	Dec'69-Nov'70	19,387	Nil	I
	T70.161A (la-550)	Dec'70-Dec'71	18,720	Nil	I
	T71.150A (csd-2155)	Jan-Dec'72	19,339	11,080	II

Country & Sub-Grantee	Grant #	Period	Total Amount	Balance of Committed Funds not Paid to Grantees as of 12/31/73 (1)	Status of Sub-Grant Accounting (2)
Hong Kong					
Hong Kong Fam. Plan. Association	I68.224A (csd-2155)	May'69-Apr'70	$ 56,668	Nil	I
	T69.180A (csd-2155)	May'70-Apr'71	31,800	Nil	I
	T71.65A	May'71-Apr'72	47,720	Nil	I
Indonesia					
Natl. Fam. Plan. Coord. Board	T71.18A (Jakarta) (csd-2155)	Jan-Dec'71	27,728	Nil	II
	T71.18A (Expanded) (csd-2155)	Mar-Dec'71	107,752	$ 15,170	II
	T72.29A (csd-2155)	Jan'72-June'73	202,332	11,980	II
	T72.54A (csd-2155)	Jan-Dec'72	1,313	Nil	I
Indonesian Plan.Parent-hood Assoc.	I68.181 (csd-2155	Jan-Dec'69	35,151	Nil	I
	T69.178 (csd-2155)	Jan-Dec'70	26,340	Nil	II
Univ. of Pajajaran	I68.182 (csd-2155)	Jan-Dec'69	28,300	Nil	I
	T69.179 (csd-2155)	Jan-Dec'70	22,545	Nil	I
	T70.171A (csd-2155)	Jan-Dec'71	20,710	Nil	II

Country & Sub-Grantee	Grant #	Period	Total Amount	Balance of Committed Funds not Paid to Grantees as of 12/31/73 (1)	Status of Sub-Grant Accounting (2
Iran					
Farah Matern.Hosp.	I69.99 (csd-2155)	Sept'69-Aug'70	$ 35,300	$ Nil	I
	T70.124 (csd-2155)	Sept'70-Dec'71	47,749	Nil	I
	T72.16A (csd-2155)	Jan-Dec'72	49,398	2,470	II
Nigeria					
Lagos Island Hosp.	I68.184 (csd-2155)	May'69-June'70	15,598	Nil	II
	T70.0106A (csd-2155)	July-Dec'70	8,542	Nil	II
	T70.164A (csd-2155)	Jan-Dec'71	23,951	Nil	II
	T71.172A (csd-2155)	Jan-Dec'72	49,492	1,390	III
	T73.16A (csd-2155)	Jan'73-March'74	75,192	21,560	IV
Univ. of Ibadan	I69.98 (csd-2155)	Jan-Dec'70	25,614	Nil	II
	T70.165A (csd-2155)	Jan-Dec'71	26,773	Nil	II
	T72.22A (csd-2155)	Jan-Dec'72	33,673	Nil	II
	T73.17A (csd-2155)	Jan-Dec'73	36,533	5,150	III
Philippines					
Philippines Gen.Hosp.	T69.134 (csd-2155)	Oct'69-Sept'70	13,453	Nil	I
	T70.134 (csd-2155)	Oct'70-Dec'71	22,898	2,880	II
	T72.53A (csd-2155)	Jan-Dec'72	7,887	4,870	II

Country & Sub-Grantee	Grant #	Period	Total Amount	Balance of Committed Funds not Paid to Grantees as of 12/31/73 (1)	Status of Sub-Grant Accounting(
Philippines					
Fabella Hospital	T69.133 (csd-2155)	Feb'70-Jan'71	$ 40,502	Nil	II
	T70.172A (csd-2155)	Feb'71-Dec'72	71,010	$ 8,210	II
Thailand					
Chulalongkorn Hospital	T69.175 (csd-2155)	Sept'70-Sept'71	18,989	Nil	I
	T71.155A (csd-2155)	Oct'71-Dec'72	15,392	Nil	II
	T73.19A (csd-2155)	Jan-Dec'73	12,227	Nil	II
Siriraj Hospital	I69.40 (csd-2155)	Mar'69-Feb'70	8,641	Nil	I
	T69.176 (csd-2155)	Mar'70-Feb'71	10,840	Nil	I
	T70.168A (csd-2155)	Mar'71-Dec'72	21,445	Nil	II
Vajira Hospital	T69.177 (csd-2155)	Dec'69-Dec'70	7,249	Nil	II
	T70.169A (csd-2155)	Jan-Dec'71	9,133	Nil	II
Women's Hospital	T70.040A (csd-2155)	Dec'69-Dec'70	9,227	Nil	I
	T70.170A (csd-2155)	Jan-Dec'71	10,450	Nil	II
	T72.022A (csd-2155)	Jan-Dec'72	9,341	Nil	II
	T72.0147A (csd-2155)	Jan-June'73	9,044	4,520	II

Country & Sub-Grantee	Grant #	Period	Total Amount	Balance of Committed Funds not Paid to Grantees as of 12/31/73 (1)	Status of Sub-Grant Accounting (2)
Thailand					
Ministry of Public Health Medical Servs.	I68.180 (csd-2155)	Mar'69-Feb'70	$ 31,300	Nil	II
	T70.56A (csd-2155)	Mar'70-Feb'71	33,048	Nil	II
	T71.16A (csd-2155)	Mar-Dec'71	43,536	Nil	II
Ministry of Public Health MCH	I68.223 (csd-2155)	Mar'69-Feb'70	8,650	Nil	I
	T70.57A (csd-2155)	Mar'69-Dec'71	14,065	Nil	I
	T70.167 (csd-2155)	Mar-Dec'71	13,565	Nil	II
MOPH	T71.173A (csd-2155)	Jan-Dec'72	108,355	$ 5,250	II
	T73.18A (csd-2155)	Jan-June'73	60,211	30,106	III
Venezuela					
Maternidad Concepcion Palacios	T70.55A (la-550)	Mar'70-Dec'71	50,611	Nil	I
	T71.171A (csd-2155)	Jan-Dec'72	62,207	1,540	II
	T72.056A (csd-2155)	Apr-Dec'72	6,393	Nil	II
	T73.1A (csd-2155)	Jan-Dec'73	68,357	Nil	III
Venezuelan Family Plan. Association	I68.123 (la-550)	Oct'68-Sept'69	129,236	Nil	I
	I68.186 (la-550)	Oct'68-Sept'69	7,620	Nil	I
	T69.130 (la-550)	Oct'69-Dec'70	231,134	Nil	I

Country & Sub-Grantee	Grant #	Period	Total Amount	Balance of Committed Funds not Paid to Grantees as of 12/31/73 (1)	Status of Sub-Grant Accounting (2)
Venezuela Venezuelan Family Plan. Association	T70.160 (la-550)	Jan-Dec'71	$303,940	$101,059	II
	T72.12A (csd-2155)	Jan-Dec'72	534,142	53,750	II
	T73.13A (csd-2155)	Jan-Dec'73	423,298	77,810	II

APPENDIX A: Table 2

International Postpartum Program (IPP) - Expenditures[a] by Source of Funds
1966 - 1973

	AID/csd 2155	AID/csd 1565	AID/ 1a-550	Council	AID/ Nesa 391	Total
1966	$			301,256		301,256
1967		866		344,247		345,113
1968		73,988	61,861	161,231	14,241	311,321
1969	170,092	81,157	294,745	35,708	28,483	610,180
1970	305,770	49,774	448,491	59,830		863,865
1971	489,315	34,823	726,190	53,614	101,891	1,405,833
1972	1,133,209			36,926		1,170,135
1973	898,415			54,582		952,997
	$2,996,801	240,608	1,531,287	1,047,389	144,615	5,971,700

(a) New York costs are excluded.

APPENDIX A: Table 3

SUB-GRANTS ACTIVE IN 1973:
BUDGET CATEGORIES AS PERCENTAGES
OF TOTAL BUDGETS, BY SUB-GRANT

Country & Sub-grantee	Grant #	Total Grant	Percentage of Total				
			Personnel	Perm. Equip.	Cons. Supp.	Travel	Admin. Expenses
Africa							
Ghana							
Korle Bu	T73.15	$ 12,580	83.9	4.6	2.4	5.1	4.0
GNFPP	T73.14	21,415	77.0	---	8.1	3.7	11.2
Nigeria							
Ibadan	T73.17	36,533	77.1	0.8	13.7	5.9	2.5
Lagos Island	T73.16	75,192	68.2	0.5	14.0	7.8	9.5
Far East							
Indonesia							
BKKBN	T72.29*	21,042	14.3	17.2	10.3	58.2	---
Thailand							
Chulalongkorn	T73.19	12,227	80.0	---	18.1	---	1.9
MOPH	T73.18	60,211	99.6	---	---	---	0.4
Women's	T72.0147	4,522	97.3	---	---	---	2.7

* Portion of grant extended to June 30, 1973 for Mobile Training Project.

Country & Sub-grantee	Grant #	Total Grant	Percentage of Total: Personnel	Perm. Equip.	Cons. Supp.	Travel	Admin. Expenses
Latin America							
Colombia							
ASCOFAME	T73.6	$194,338	61.9	0.8	25.5	2.1	9.7
Honduras							
Hond. Fam. Plan. Assn.	T71.149A	1,950	100.0	---	---	---	---
Venezuela							
Mat. Concepcion Palacios	T73.1	68,357	89.3	0.6	2.8	0.9	6.4
Venz. Fam. Plan. Assn.	T73.13	423,298	76.9	0.5	18.5	0.9	3.2

APPENDIX A: Table 4.1

ANALYSIS OF TRANSACTIONS
AS OF DECEMBER 31, 1973

POSTPARTUM - GENERIC GRANT - AID/csd-2155

Summary of Obligations and Charges

Six Year Grant for $4,798,407.00
From June 28, 1968 to June 30, 1974

		Principal	Deferred Overhead
ORIGINAL OBLIGATION		$ 500,000.00	
AMENDMENTS:			
No. 1 - 6/28/69	$750,000,00		
No. 4 - 6/30/71	956,450.00		
No. 5 - 12/30/71	905,000.00		
No. 6 - 5/ 3/72	607,170.00		
No. 7 - 1/ 1/73	770,000.00		
No. 9 - 5/15/73	309,787.00		
Total		4,298,407.00	
TOTAL OBLIGATION TO DATE		4,798,407.00	
Overhead Recoverable		432,250.00	$432,250.00
NET AVAILABLE FOR APPROPRIATIONS		4,366,157.00	
SUB-GRANTS & CHARGES - PRIOR YEARS		2,905,198.52	
BALANCE AVAILABLE - 1973		$1,460,958.48	

APPENDIX A: Table 4.2

POSTPARTUM - GENERIC CONTRACT - AID/csd-2155

1973 Sub-Grants and Charges

BALANCE AVAILABLE - 1973			$1,460,958.48
1973 - Sub-Grants & Charges:			
T73.1A	- Maternidad Concepcion Palacios, Caracas, Venezuela	$ 68,357.00	
T73.6A	- Colombian Association of Medical Schools, Bogota	194,338.00	
T73.13A	- Venezuelan Family Planning Association, Caracas	423,298.00	
T73.14A	- Ghana National Family Planning Program, Accra	21,415.00	
T73.15A	- University of Ghana, Medical School, Accra	12,580.00	
T73.16A	- Lagos State Ministry of Health and Social Welfare, Lagos Island Maternity Hospital, Nigeria	75,192.00	
T73.17A	- University of Ibadan, Nigeria	36,533.00	
T73.18A	- Ministry of Public Health, Bangkok, Thailand	60,211.00	
T73.19A	- Chulalongkorn Hospital, Bangkok, Thailand	12,227.00	
T73.905A	- International Postpartum Family Planning Program	87,104.00(1)	
	Total		991,255.00
BALANCE AVAILABLE - December 31, 1973			$ 469,703.48
Overhead earned			$318,199.64
Deferred overhead - December 31, 1973			$114,050.36

(1) See APPENDIX A: Table 4.4

APPENDIX A: Table 4.3

POSTPARTUM - GENERIC CONTRACT - AID/csd-2155

List of Sub-Grants and Charges Prior to 1973

1968 - Sub-Grants & Charges:

I68.180	- Ministry of Health, Bangkok, Thailand (Lapsed $4,400.00)	$ 31,300.00	
I68.181	- Indonesian Planned Parenthood Association, Jakarta (Lapsed $64.26)	35,150.74	
I68.182	- University of Pajajaran, Indonesia (Lapsed $800.00)	27,500.00	
I68.184	- Ministry of Health, State of Lagos, Nigeria (Lapsed $3,323.13)	15,257.87	
I68.185	- Korle Bu Hospital, Accra, Ghana (Refund $5,550.56) (Lapsed $343.42)	10,920.02	
I68.223	- Ministry of Public Health, Bangkok, Thailand (Lapsed $149.65)	8,650.35	
T68.224	- Family Planning Association of Hong Kong (Lapsed $5,332.41)	56,667.59	
	Total		$185,446.57

1969 - Sub-Grants & Charges:

I69.40	- Siriraj Hospital, Dhonburi, Thailand (Lapsed $934.03)	$ 8,640.97
I69.98	- University of Ibadan, Nigeria (Lapsed $8,851.45)	24,648.55
I69.99	- Farah Maternity Hospital, Iran (Lapsed $5,596.42)	29,703.58
T69.133	- University of The Philippines, Manila (Lapsed $11,106.83)	40,502.17
T69.134	- University of The Philippines, Manila (Lapsed $44.24)	13,452.76
T69.135	- Ministry of Health, Teheran, Iran (Lapsed $104,640.00 Aid never responded to approval request)	-
T69.175	- Chulalongkorn Hospital, Bangkok, Thailand (Lapsed $8,210.81)	18,989.19
T69.176	- Siriraj Hospital, Dhonburi, Thailand (Lapsed $1,159.66)	10,840.34
T69.177	- Vajira Hospital, Bangkok, Thailand (Lapsed $2,751.37)	7,248.63

APPENDIX A: Table 4.3 (Continued)

1969 - Sub-Grants & Charges (Continued)			
T69.178	- Indonesian Planned Parenthood Association, Jakarta (Lapsed $11,660.00)	26,340.00	
T69.179	- University of Pajajaran, Bandung, Indonesia (Lapsed $8,455.00)	22,545.00	
T69.180	- Family Planning Association of Hong Kong (Lapsed $400.00)	31,800.00	
	Total		$234,711.19
1970 - Sub-Grants & Charges:			
T70.040A	- Women's Hospital, Bangkok, Thailand (Lapsed $330.98)	$ 9,227.02	
T70.0105A	- Korle Bu Maternity Hospital, Accra, Ghana (Lapsed $4,859.84)	3,040.16	
T70.0106A	- Ministry of Health, State of Lagos, Nigeria (Lapsed $153.33)	8,541.67	
T70.56A	- Ministry of Public Health, Bangkok, Thailand (Lapsed $2,402.14)	33,047.86	
T70.57A	- Ministry of Public Health, Bangkok Thailand (Lapsed $535.40)	14,064.60	
T70.124A	- Farah Maternity Hospital, Teheran, Iran (Lapsed $12,050.71)	47,749.29	
T70.125A	- Ministry of Finance & Economic Planning, Ghana (Lapsed $29,960.82)	17,489.18	
T70.134A	- University of The Philippines, Manila	22,898.00	
T70.164A	- Ministry of Health, State of Lagos, Nigeria (Lapsed $4,058.69)	23,951.31	
T70.165A	- University of Ibadan, Nigeria (Lapsed $1,569.28)	26,820.72	
T70.166A	- University of Ghana Medical Schools, Korle Bu Hospital, Accra, Ghana (Refund $1,178.59)	17,211.41	
T70.167A	- Ministry of Public Health, Bangkok, Thailand (Lapsed $1,350.28)	13,564.72	
T70.168A	- Mahidol University, Bangkok, Thailand (Lapsed $215.00)	21,445.00	
T70.169A	- Vajira Hospital, Bangkok, Thailand (Lapsed $946.98)	9,133.02	
T70.170A	- Ministry of Public Health, Thailand (Lapsed $88.31)	10,361.69	
T70.171A	- University of Pajajaran, Bandung, Indonesia (Lapsed $2,615.00)	20,710.00	
T70.172A	- University of The Philippines, Manila (Lapsed $8,870.00)	71,010.00	
	Total		$370,265.65

APPENDIX A: Table 4.3 (Continued)

1971 - Sub-Grants & Charges:

T71.16A	- Ministry of Public Health, Bangkok, Thailand (Lapsed $4,364.03)	$ 43,535.97	
T71.18A	- National Family Planning Coordinating Board, Jakarta, Indonesia (Lapsed $34,520.00)	135,480.00	
T71.65A	- Family Planning Association of Hong Kong (Lapsed $480.00)	47,720.00	
T71.149A	- Honduran Family Planning Association, Tegucigalpa	27,545.00	
T71.150A	- Honduran Family Planning Association, San Pedro Sula (Lapsed $1,244.10)	19,339.00	
T71.155A	- Chulalongkorn Hospital, Thailand (Lapsed $55.38)	15,336.62	
T71.160A	- International Postpartum Family Planning Program	434,500.00(1)	
T71.171A	- Maternidad Concepcion Palacios, Caracas, Venezuela	62,207.00	
T71.172A	- Lagos Island Maternity Hospital, Nigeria	49,492.00	
T71.173A	- Ministry of Public Health, Bangkok, Thailand	108,355.00	
	Total		$943,510.59

1972 - Sub-Grants & Charges:

T72.10A	- Colombian Association of Medical Schools, Bogota	$321,955.00
T72.12A	- Venezuelan Family Planning Association, Caracas	334,142.00
T72.16A	- Farah Maternity Hospital, Teheran, Iran (Lapsed $16,806.00)	51,227.00
T72.20A	- Ghana National Family Planning Program, Accra (Lapsed $6,495.00)	25,591.00
T72.21A	- University of Ghana, Medical School, Accra (Lapsed $9,329.48) (Refund $2,352.50)	4,178.02
T72.22A	- University of Ibadan, Nigeria	33,673.00
T72.29A	- National Family Planning Coordinating Board, Jakarta, Indonesia (Lapsed $2,611.00)	202,332.00
T72.53A	- University of The Philippines, Philippine General Hospital, Manila (Lapsed $27,800.00)	7,887.00

(1) See APPENDIX A: Table 4.4

APPENDIX A: Table 4.3 (Continued)

1972 - Sub-Grants & Charges (Continued)			
T72.54A	- National Family Planning Coordinating Board, Jakarta, Indonesia (Lapsed $23,687.50)	1,312.50	
T72.142A	- International Postpartum Family Planning Program	164,189.00(1)	
T72.022A	- Women's Hospital, Bangkok, Thailand	9,341.00	
T72.056A	- Maternidad Concepcion Palacios, Caracas, Venezuela	6,393.00	
T72.0147A	- Ministry of Public Health, The Department of Medical Service, Bangkok, Thailand	9,044.00	
	Total		$1,171,264.52
GRAND TOTAL			$2,905,198.52

(1) See APPENDIX A: Table 4.4

APPENDIX A: Table 4.4

POSTPARTUM - GENERIC CONTRACT - AID/csd-2155

Summary of Core Budget and Expenditures

International Postpartum Family Planning Program

Council Authorization - T71.160A	$434,500.00
Council Authorization - T72.142A	164,189.00
Council Authorization - T73.905A	87,104.00
Total	$685,793.00

	Budget (Revised)(a)	Expended to 12/31/73(b)	Balance 12/31/73
Personnel	$413,372.00	$298,058.18	$115,313.82
Travel and Per Diem	63,188.00	41,114,71	22,073.29
Conferences	36,364.00	6,070.02	30,293.98
Evaluation	23,729.00	22,276.92	1,452.08
Audit	84,345.00	4,178.53	80,166.47
Miscellaneous direct cost (including data processing)	64,795.00	58,292.05	6,502.95
Totals	$685,793.00	$429,990.41	$255,802.59

(a) As approved by AID (Amendment #9 dated 5/31/73).

(b) Council Projects 44.404 and 44.406.

APPENDIX B

COMMODITIES REPORT 1968 - 1973

Equipment and Supplies Requested and Approved

Grant Codes:
1. PC/AID/csd-1565
2. PC/AID/la-550
3. PC/AID/csd-2155
4. PC/AID/nesa-391
5. PC-non-AID monies

* PC funds for these specific items

Code	Grant No.	Grantee	Contraceptives	Other Items
LATIN AMERICA				
COLOMBIA				
2	I68.122	Colombian Association of Medical Schools	50M OCs 200 Diaphragms 200 Vaginal Jelly 1700 Vaginal Foam	18 Filmstrip Projectors 10 Motion Picture Projectors 18 Projection Screens 8 Tape Recorders 8 220v. Transformers 7 Dozen Tapes
2	T69.29	Same	45M OCs	15 Disney Films 1 Calculator
2	T70.159	Same	115M OCs * 35M IUDs * 5M Inserters 1250 Diaphragms 6M Vaginal Foam 6M Vaginal Jelly 3M Applicators 65M Condoms	2 Air Conditioners 5 Slide Projectors 5 Motion Picture Projectors 5 Projection Screens 10 Medical Kits 19M Disposable Gloves
3	T72.10	Same	159M OCs * 8M Inserters (Reg.) 2M Inserters (PP.) 350 Gross Condoms	4 Slide Projectors 4 Movie Projectors 20M Disposable Gloves 8 Projection Screens
3	T73.6	Same	251M OCs	49M Disposable Gloves

Code	Grant No.	Grantee	Contraceptives	Other Items
VENEZUELA				
1	I68.45	Maternidad Concepcion Palacios		74 Packages X-Ray Film 1300 Lipidol
1	I68.225	Same	40M OCs	
2	I70.55	Same		1 Film Projector 1 Photocopy Machine
3	T71.171	Same		1 IUD Removal Hook
2 2	I68.123 I68.86	Venezuelan Family Planning Association (VFPA)	* 15M IUDs * 1M Inserters	6 Medical Kits 4 Motion Picture Projectors 4 Projection Screens 2 Slide Projectors
2	I68.186	Same	40M OCs	
2	T69.130	Same	60M OCs	1 Electric Calculator 1 Electric Typewriter 8 Medical Kits 1 Gynecological Table 4 Motion Picture Projectors 20 Films
5	T70.086C	Same	* 50M IUDs * 2M Inserters	
2	T70.160	Same	170M OCs 150 Gross Condoms	1 Electric Typewriter 1 Motion Picture Camera 20 Medical Kits 30M Disposable Gloves
5	T72.0114C	Same	* 60M IUDs * 6M Inserters	
3	T72.12	Same	125.5M OCs 300 Gross Condoms 3M Kits Foam 3M Tubes Jelly	100M Disposable Gloves 1 16" Electric Typewriter 26 No.1 Medical Kits
5	T73.011C	Same	40M IUDs 4M Inserters	

Code	Grant No.	Grantee	Contraceptives	Other Items
VENEZUELA				
3	T73.13A	VFPA	376.4M OCs 300 Gross Condoms 3M Kits Foam 3M Tubes Jelly	1 Electric Typewriter
HONDURAS				
2	I68.95	Materno Infantil Hospital	20M OCs 300 Foam Tablets *600 IUDs * 6M Vaginal Foam	4 Medical Kits 1 Sterilizer 1 Projection Screen 1 Motion Picture Projector
2	T70.121	Same	39M OCs 8M Foam Tablets 144 Aerosol Foam	
3	T71.149	Same	65M OCs	
2	I69.96	Hospital Leonardo Martinez	30M OCs * 1M IUDs * 6M Vaginal Foam	1 Electric Typewriter 1 Sterilizer 4 Medical Kits 1 Slide Projector 1 Motion Picture Projector 1 Projection Screen
2	T70.161	Same	13M OCs * 3M IUDs * 300 Inserters	
2	T71.150	Same	15M OCs 1M Inserters	
MEXICO				
5	T69.131C	Fundacion para Estudios de la Poblacion (FEPAC)	* 2M IUDs * 200 Inserters	
5	T71.0100C	Same	* 2M IUDs * 200 Inserters	

Code	Grant No.	Grantee	Contraceptives	Other Items
MEXICO				
5	T72.11C	FEPAC	* 2M IUDs * 100 Inserters	
5	T73.11C	Same	* 1M IUDs * 200 Inserters	
CHILE				
5	T70.196C	University of Chile	* 40M IUDs * 2M IUD Inserters	
AFRICA GHANA				
3	T70.125	Ghana National Family Planning Program (GNFPP) Effia Nkwanta	* 9M OCs *6.5M IUDs	1 Motion Picture Projector 2 File Cabinets 2 Sterilizers 2 Sphygomanometers 2 Hemoglobinometers 10M Hemoglobinometer Applicators 1 Portable Voice Projector 4 Medical Kits 2 Hospital Carts 1 Slide Projector, with Film Strips & Slides
3	T72.20	Same		5M Disposable Gloves 1 Aspirator Swivel Handle 1 Lenticular Projection Screen 1 Hubbard Pelvic Mode
3	T73.14A	Same		6M Disposable Gloves

Code	Grant No.	Grantee	Contraceptives	Other Items
GHANA				
3	T70.125	GNFPP Komfo Anokye	15M OCs * 9M IUDs	4 Medical Kits 3 Portable Voice Projectors 3 File Cabinets 3 Sphygomanometers 3 Hemoglobinometers 10M Hemoglobinometer Applicators 3 Hospital Carts 3 Portable Sterilizers
3	T72.20	Same		1 Movie Projector 12M Disposable Gloves 1 Aspirator Swivel Handle 1 Lenticular Projection Screen 1 Hubbard Pelvic Model
3	T73.14A	Same		15M Disposable Gloves
3	I68.185	Korle Bu Hospital	22.5M OCs * 6M IUDs * 1M IUD Inserters	3 Surgical Instrument Kits *3 Hospital Carts *3 Sterilizers
3	T70.0105	Same	2M OCs * 1M IUDs	1 Portable Voice Projector 1 Slide Projector, with Film Strips & Slides 2 Portable Sterilizers
3	T70.166	Same	2M OCs * 3M IUDs * 400 IUD Inserters	
5	T73.011C	Same	* 2M IUDs * 1M IUD Inserters	
3	T73.15A	Same	10M OCs	2 Ortho Pelvic Models
NIGERIA				
3	I69.98	University of Ibadan	15M OCs * 8M IUDs * 1M IUD Inserters	2 Medical Kits

Code	Grant No.	Grantee	Contraceptives	Other Items
NIGERIA				
3	T70.165	University of Ibadan	15M OCs * 6M IUDs	2 Audio-visual Kits
3	T72.22	Same	10M OCs * 1M IUD Inserters	2 Medical Kits
5	T73.011C	Same	* 4M IUDs * 2M IUD Inserters	
3	T73.17A	Same	20M OCs	
3	I68.184	Lagos Maternity Hospital	10M OCs * 6M IUDs * 1M IUD Inserters	4 Medical Kits
3	T70.0106	Same		1 Audio-visual Kit
3	T70.164	Same	10M OCs * 6M IUDs * 1M IUD Inserters	
3	T71.172	Same	10M OCs 1M IUD Inserters	10M Disposable Gloves 1 Movie Projector
5	T72.0113C	Same	* 6M IUDs	
5	T73.011C	Same	* 8M IUDs * 2M IUD Inserters	
3	T73.16	Same	41.6M OCs	24M Disposable Gloves 1 Ortho Pelvic Model
IRAN				
3	I69.99	Farah Maternity Hospital		6 Medical Kits 20 Specula 1 Station Wagon 1 Projection Screen 1 Projector 1 Slide/Film Strip Projector
3	T70.124	Same		30M Disposable Gloves 5 Graves Specula, Small 23 Graves Specula, Medium 19 Graves Specula, Large

Code	Grant No.	Grantee	Contraceptives	Other Items
IRAN				
3	T72.16	Farah Maternity Hospital		60M Disposable Gloves 30 Specula, Vaginal 1 Hubbard Pelvic Model
SOUTHEAST ASIA THAILAND				
3	I68.180	Ministry Public Health		8 Manual Typewriters
3	T71.16	Same		5 Audio-visual Kits
3	I69.40	Mahidol		* 1 Binocular Microscope * 1 Trinocular Microscope
1	I69.43	Chulalongkorn		26 Filing Cabinets 1 Tissuematon 2 Typewriters 1 Movie Screen 6 Microscopes 2 Tissue Flotation Baths 1 Incubator 1 Microtome 12 Microtome Knives 1 Micro Slide Cabinet
3	T69.177	Vajira Hospital		1 Manual Typewriter 1 Tape Recorder 1 Adding Machine 20 Graves Specula 9 Uterine Dressing Forceps 6 Kelly Forceps
3	T70.169	Same		1 Binocular Microscope
3	T70.040	Women's Hospital		1 Calculator 30 Specula
3	T70.170	Same		1 Medical Kit 1 Autoclave 1 Illuminator 3 Filters

Code	Grant No.	Grantee	Contraceptives	Other Items
INDONESIA				
3	I68.181	Indonesian Planned Parenthood Association (IPPA)	* 105M IUDs * 5600 IUD Inserters	3 Cassette Tape Recorders 15 Blank Cartridges 4 Medical Kits
3	I68.182	University of Pajajaran		2 Medical Kits
3	T71.18 (Jakarta)	Badan Koordinasi Keluarga Berentjana Nasional (BKKBN)		3 Central Sound Systems 3 Medical Kits
3	T71.18 (Expanded)	Same		6 Manual Typewriters 1 Cassette Tape Recorder 5 Sterilizers 20 Slide Projectors 4 Loud Speakers 1 Motion Picture Projector 17 Medical Kits 21 Tape Recorders 120 Batteries
3	T72.29	Same		1 Film Strip/Slide Projector 14 Electric Sterilizers 1 Manual Mimeo M/C 11 IUD Medical Kits 2 Manual Typewriters 1 Lenticular Projection Screen 1 Calculator 1 Station Wagon 23 Sound Systems
PHILIPPINES				
3	T69.133	Fabella Hospital	100M OCs	1 Air Conditioner 3 Medical Kits

Code	Grant No.	Grantee	Contraceptives	Other Items
PHILIPPINES				
3	T70.172	Fabella Hospital	42M OCs 1100 Containers Foam 73 Gross Condoms * 25M IUDs * 2M IUD Inserters	1 Calculator 3 Medical Kits 4M Disposable Gloves
3	T69.134	Philippines General Hospital		1 Medical Kit
3	T70.134	Same	35M OCs	2 Medical Kits
3	T72.53	Same		1 Medical Kit 20 IUD Removal Hooks 100 Demalon Monofiliment
HONG KONG				
3	I68.224	Hong Kong Family Planning Association	150M OCs * 10M IUDs * 1M IUD Inserters	
5	T70.074C	Same	* 12M IUDs * 600 IUD Inserters	
5	T71.080C	Same	* 5M IUDs * 1M IUD Inserters	
INDIA				
4	I68.183	All-India Postpartum Program		50 Movie Projectors 50 Projection Screens 10 Microscopes 20 Opthalamascope/ Otoscopes Projector Parts 6 Manual Typewriters 50 Tape Recorders and 500 Tapes
4	T71.159	Same		50 Microscopes and cases 250 Bulbs 125 Uterine Aspirators 125 Sets Spare Parts 1M Tapes 125 Filmstrip Projectors 75 Projection Screens 25M IUD Inserters

APPENDIX C

BIBLIOGRAPHY OF INTERNATIONAL POSTPARTUM PROGRAM
(from information reported by authors to cover period through 1973)

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APPENDIX D

CIRCULARS ISSUED 1973

Number	Title	Date
61	First Ovulation After Childbirth	January 1973
62	Family Planning Training for the Nurse-Midwife	January 1973
63	Use of Paramedical Personnel for Prescription of Oral Contraceptives	February 1973
64	Performance Data: 1972	August 1973
65	Follow-up of Family Planning Acceptors	August 1973
66	Laparoscope and Other Sterilization Equipment	August 1973
67	Effect of Depo-Provera on Lactation	October 1973
68	Early Postpartum and Immediate Post-abortum IUD Insertion	October 1973
69	Survey of Hospitals No Longer Receiving Population Council Support as of January 1, 1973	November 1973
70	Metallic Copper As An Intrauterine Contraceptive Agent	December 1973
71	Contraceptive Practices of Wives of Obstetricians	December 1973