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ANNUAL REPORT OF THE INTERNATIONAL PROGRAMS
of the
ASSOCIATION FOR VOLUNTARY SURGICAL CONTRACEPTION

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- Hugo Hoogenboom
Executive Director
- Terrence Jezowski
Director, International
Programs Division
- Lynn Bakamjian
Deputy Director,
International Programs
Division

PREFACE

This annual report of the Association for Voluntary Surgical Contraception (AVSC) is submitted to the Agency for International Development (AID) to fulfill reporting requirements of Cooperative Agreement DPE-0968-A-00-2001-00. This report describes AVSC's international activities conducted during the period January 1 to December 31, 1985, and reflects the total international effort by AVSC regardless of funding source (AID-central, AID-bilateral, or private).

On January 1, 1986, the Association for Voluntary Sterilization changed its name to the Association for Voluntary Surgical Contraception. The new name is used throughout this report.

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

Special thanks are due to those who helped with the production of the 1985 report: to AVSC staff who contributed information on their activities and programs; to Dana Evans, who tabulated the statistical data; to Millie Rondon and Thomasina Grace who cheerfully typed and retyped the many drafts; to Pam Harper for her support, guidance and, patience during the laborious editing process; to Dore Hollander for copy editing the manuscript; to Linda Levine for preparing the figures; and to Lynn Bakamjian for coordinating (and finally completing) the overall effort.

Terrence Jezowski
New York

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ASSOCIATION FOR VOLUNTARY SURGICAL CONTRACEPTION

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

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

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

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

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

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

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CHAPTER 1

INTRODUCTION

The purpose of AVSC's cooperative agreement with AID is "to carry out a program to increase the number of developing countries in which high quality voluntary sterilization services are institutionalized and routinely accessible to the majority of the population and to increase the number of developing countries in which voluntary sterilization has become acceptable as a family planning and health measure." 1985 marked the fourth year of AVSC's current five-year agreement with AID (April 1, 1982 to March 31, 1987).

During the year, AVSC made considerable progress toward achieving the goals of the cooperative agreement through an active program of technical and grant assistance to counterpart organizations and individuals overseas. In 1985 AVSC managed an international program that extended to all regions of the world. Grants assistance approximating \$8 million was obligated for subagreements, amendments, and small grants in support of services, information and education, training, and professional education activities. AVSC continued to shift grant resources from countries where sterilization programs are long-standing and have moved beyond the introductory stage (Asia and Latin America) to countries where sterilization services are not yet widely accessible (Africa). Table 1.1 summarizes some of the inputs and outputs of AVSC's grants assistance program.

AVSC emphasizes three main areas in our work: voluntarism, safety and effectiveness, and expansion of access. These areas are interdependent and mutually supportive. Services cannot be expanded unless they are voluntary, safe, and effective. Therefore, the principles of voluntarism and quality are underpinnings for all the activities described in this report and for all AVSC programs, whether they are in new, underserved regions or in places where voluntary sterilization is more readily available. The following section summarizes AVSC's efforts in the four major regions in which we work to expand access to voluntary sterilization services.

Regional efforts to expand services

The number of programs sponsored by AVSC in Sub-Saharan Africa has tripled since 1982, clearly demonstrating our growing interest and commitment to voluntary surgical contraception in this region. Four countries--Kenya, Nigeria, Senegal, and Zaire--have emerged as priorities for intensive program development efforts over the next several years. These four countries are important because of their size, their regional influence, and their potential for developing national programs.

Most of the programs in Africa are small, pilot service projects designed to test and demonstrate the feasibility of voluntary sterilization. A major objective at this time is to work closely with these programs and provide them with the necessary technical assistance so that they start off on the right track. Particular attention is being paid to training new service providers in minilaparotomy under local anesthesia, a simple and

TABLE 1.1: Highlights of AVSC's International Program, 1985

- Number of subagreements awarded	58
*Dollars awarded for subagreements (including amendments)	\$7,710,278
*Number of countries receiving subagreements	28
- Number of small grants awarded	66
*Dollars awarded for small grants	\$227,906
*Number of countries receiving small grants	30
- Regional allocation of grants funds	
* Africa	20%
* Latin America/Caribbean	34%
* Asia	29%
* North Africa/Middle East	9%
* Global (World Federation)	8%
- Number of voluntary sterilization procedures performed in AVSC projects	
* Female	168,318
* Male	44,120
- Number of physicians trained	257
- Number of nonphysicians trained	453

safe technique appropriate to the African health infrastructure, and to training nurse midwives in information, education, and counseling for family planning, including voluntary sterilization.

Also, AVSC is working closely with institutions that have the potential to serve as regional training facilities, e.g., the Family Planning Association of Kenya (minilap and counseling). Because of the intensive staff effort required to manage and provide technical assistance to a large number of small programs, the groundwork was laid in 1985 for the establishment of a regional office in Nairobi for Africa, and a country office in Lagos for Nigeria. Both offices will become operational in early 1986.

In North Africa and the Middle East, a major effort was begun to conduct a professional education program designed to gain acceptance of voluntary sterilization services as a part of routine health care and to assure the quality of services in the Arab World. This initiative will be conducted by AVSC and by the World Federation and its regional affiliate, the Regional Arab Federation, with special funding from AID's Near East Bureau. Activities will include the development of an annotated bibliography in Arabic about family planning, including voluntary sterilization, and a workshop for medical universities about how to incorporate family planning into routine training for physicians. Also in 1985, new service programs were developed in Jordan, South Yemen, and Sudan, while increased attention was paid to quality assurance and evaluation in older programs in Tunisia and Egypt. AVSC's major program accomplishment in the region in 1985 was the successful establishment of a five-year program with the Moroccan National Training Center for Reproductive Health to follow-up and provide technical support to trainees who will establish voluntary sterilization services in their home institutions. This program will serve as the future base for a national voluntary sterilization service program in Morocco.

In 1985 in Asia, AVSC continued to shift its focus from capital intensive projects to programs designed to improve quality and test new approaches for delivering voluntary sterilization services. Two areas which received considerable attention were voluntarism and medical safety. Asia continues to take center stage in voluntarism issues and programming. Sri Lanka hosted the World Federation's Leaders' Symposium on Voluntarism which brought together international representatives to discuss how to ensure voluntary choice in sterilization. National policies on counseling for voluntary sterilization were developed in Sri Lanka and Thailand, and AVSC provided technical assistance to develop counselor training curricula for programs in Indonesia and the Philippines. Major medical quality assurance efforts in 1985 included the development of a pilot medical supervision system in Indonesia and an infection control and asepsis monitoring program for mobile services in Nepal.

In Latin America and the Caribbean AVSC continued to work with many large, multisite nongovernmental service programs, many of which do not enjoy official support for their voluntary sterilization activities. Therefore, the issues of quality (both medical and voluntarism) and cost-effectiveness are very important for these programs, and they form the strategic foundation for many of our activities in this region. A major

activity in 1985 was the exchange of program successes and models among various programs in the region in order to introduce and promote the use of safe, simple technologies such as vasectomy and minilap under local anesthesia. Several training and observation opportunities were arranged for both new and more established service programs at the Nuestra Senora de la Altagracia Maternity Hospital in the Dominican Republic (minilaparotomy under local anesthesia); the Asociacion Pro-Bienestar de la Familia Colombiana (PROFAMILIA) (for outpatient services and program management); and Promocao de Paternidade Responsavel (PROPATER) in Brazil (for vasectomy and male reproductive health services). Another major area that received attention in 1985 was ensuring voluntarism; professional education workshops on this topic were held for policymakers and program managers. Such events were held in Brazil (for the South America region), Colombia, the Dominican Republic, and El Salvador.

Ensuring voluntarism

Voluntary surgical contraception merits special consideration as a family planning method because it is an elective surgical procedure which involves certain risks and is usually irreversible. AVSC considers voluntarism of primary importance and insists that all projects take the utmost care to protect the client's right to choose freely, without duress or coercion, a method of contraception. In addition to the regional or country-specific voluntarism efforts described above, AVSC undertook several other activities in 1985 to strengthen this aspect of our international program.

An audit of informed-consent documentation for AVSC grant recipients was conducted in 1985. The results indicated a need to provide more comprehensive guidelines to staff and grantees about the elements of informed consent and procedures for implementation and supervision. A major outcome of the audit will be the development in 1986 of a manual on informed consent for use by AVSC programs. AVSC also conducted a workshop to train several program and regional staff to serve as "voluntarism advisers" for the programs in their regions. This workshop was the direct result of an increasing number of requests for AVSC staff to serve as technical resources for the many counseling and voluntarism activities being undertaken by AVSC programs.

In 1984 AVSC supported a series of internationally comparable follow-up surveys of female sterilization clients in five countries: Bangladesh, Colombia, El Salvador, Indonesia, and Tunisia. The preliminary results were available at the end of 1985 for all countries but Colombia, and show that voluntary sterilization clients in each of the countries made an informed choice and that the overwhelming majority expressed satisfaction with the procedure. Although for the most part reassuring and positive, the results indicate that there is room for improvement, and they will be used to improve education and counseling efforts in AVSC programs. A sixth follow-up survey was initiated in Guatemala at the end of 1985, and the results should be available early in 1986.

Program safety and effectiveness

AVSC's top priority is assuring and maintaining the high quality and effectiveness of services. This is a difficult and demanding undertaking, given the varying conditions and characteristics of health care delivery systems in developing countries. Nevertheless, in 1985, AVSC attempted to expand our medical supervision program in several ways. AVSC has moved to decentralize medical oversight of programs to medical staff in AVSC field offices as well as to the programs themselves, in order to transfer both the skill and responsibility for assuring quality of services to those closest to the programs. AVSC supported several local workshops to introduce the safety guidelines developed by the World Federation in 1983. In addition, AVSC is assisting a number of programs to test safety monitoring protocols, either based on data collection systems or on medical supervision visits.

As part of our effort to improve the quality of services (and to increase access), AVSC continued to follow new developments in medical technologies and techniques. AVSC is studying the possibility of introducing Norplant in selected programs, and in 1985 staff from the Medical Division participated in a Norplant training program in Indonesia in order to ascertain the potential for AVSC involvement. Also, during an observation tour to China (supported by AVSC private funds), a new, refined vasectomy technique was observed that has potential for increasing the acceptability of male voluntary sterilization in other countries. This technique involves approaching the vas by means of a tiny perforation rather than an incision, and is called the Chinese no-scalpel technique. Finally, AVSC continued to focus on the advancement of existing, but underutilized techniques such as local anesthesia and minilaparotomy in order to improve the safety of services.

The World Federation

The World Federation is an important partner in support of AVSC's strategies and goals because of its special strength--its capacity for bringing developing country points of view and experience to bear on policy issues. The World Federation advances the needs of voluntary surgical contraception programs by developing standards and guidelines, disseminating technical and scientific information, and organizing leadership meetings and expert consultation groups. Its international character makes it particularly effective as a promulgator of policies and guidelines and as a definer of issues.

In 1985, the World Federation concentrated on professional education and quality assurance projects. It cosponsored with the Sri Lanka Ministry of Plan Implementation an international expert group that deliberated on client choice and voluntarism in surgical contraception programs. Thirty leaders from 21 countries participated in frank and informal discussions on how programs can ensure choice in service programs. Recommendations were made on how to monitor and evaluate voluntarism in programs. Other accomplishments of the World Federation are described in more detail in Chapter 5 and include conducting the Arab professional education initiative; testing the safety monitoring protocol in the Dominican Republic; and

disseminating publications such as Communique, the safety guidelines, and the Regional Arab Federation's medical textbook on family planning methods.

Conclusions

1985 was an appropriate time for reflection, for looking back and assessing the achievements of the past few years, and especially for looking forward to the future. In 1985, AVSC passed the midpoint of its five-year cooperative agreement, and AID conducted an independent evaluation of AVSC's international program. In addition, AVSC began work on a long-range plan to outline what we want to accomplish by the end of 1991 and how to achieve these goals. The results of both of these efforts will help set the stage for a new five-year cooperative agreement with AID for 1987 to 1991.

The AID evaluation reported on AVSC's accomplishments toward meeting the demand for voluntary sterilization, the quality of medical services and voluntarism in AVSC-supported programs, the impact of the World Federation's activities, and AVSC's management capability. The evaluators concluded that "AVS has won worldwide recognition as a leader in assisting both public and private institutions in developing countries to provide safe and affordable voluntary sterilization contraceptive services."

During the course of the current cooperative agreement, AVSC has begun to shift the focus from introduction of services to the maintenance of quality. As a consequence, the amount of time and resources devoted to technical assistance has increased. This trend was evident in 1985, as technical assistance was provided by staff, consultants, and the World Federation in such areas as medical safety, assurance of a free and informed choice, financial management, and self-reliance.

AVSC's long-range plan will be finalized in 1986. We expect no radical new directions or departures, and we will continue, through both grant and technical assistance, to emphasize protecting and enhancing voluntarism, assuring medical quality, and expanding access to voluntary surgical contraception services. We will continue to give priority to those projects that can exert influence into the future and beyond the particular activity that we are supporting. This is necessary because of the fact that the unmet need for voluntary surgical contraception, even by conservative estimates, is well beyond the resources available to AVSC.

CHAPTER 2

GRANTS ASSISTANCE PROGRAM

AVSC's grants assistance program is the major vehicle for conducting our international program in accordance with the cooperative agreement with AID. This chapter provides an overview of the number and types of grants awarded and reported accomplishments of projects in 1985. In the following chapter, a more in depth-review of programs from a regional perspective will be given.

PART I: OVERVIEW OF 1985 GRANTS ASSISTANCE

Number and types of grants

AVSC conducts its grants assistance program through the award of subagreements and small grants. Subagreements are grants for specific projects with budgets in excess of \$7,500. They require both AVSC board and AID approvals and involve a substantive relationship between AVSC and the counterpart organization during stages of proposal development and implementation. Small grants are for smaller, more limited activities with budgets of less than \$7,500. They do not require AID approval, are generally for one-time assistance, and are often considered seeding activities, which pave the way for a larger program in the future.

The number of subagreements and the total amount of funds awarded declined dramatically between 1984 and 1985 (see Table 2.1). In 1985, 58 subagreements totaling \$7,190,369 were awarded, as compared with 94 subagreements totaling \$9,113,964 in 1984. This decline was evident in all regions except Sub-Saharan Africa, where the number of projects awarded decreased but the amount of funds obligated increased by 58 percent.

This reduction in the number of awards is the result of AVSC's having completed several programs in 1985, many of which have been successfully institutionalized and do not require renewal. For example, in Indonesia, the number of projects awarded went from 12 in 1984 to two in 1985, as support for several training institutions was shifted from AVSC to the Indonesian government. Countries in which programs were completed and not continued include Egypt, Honduras, Italy, and the Republic of Korea. In several countries, currency gains enabled projects to manage for longer periods of time with funds obligated in 1984. For example, the Philippines accounted for 10 subagreements in 1984, whereas no funds were obligated in 1985. Similarly, five projects awarded in Sri Lanka in 1984 were ongoing in 1985 and did not require additional funding in 1985. Finally, several projects initiated in 1984 were awarded funds for 18-month periods or were extended beyond 12 months and will not come up for refunding until 1986 or beyond. Such projects are found in Kenya, Madagascar, Mali, Nigeria, Peru, South Yemen, and Uganda.

In 1985, 66 small grants (see Table 2.1) with budgets totaling \$227,906 were awarded in 30 countries. Of these, 31 were awarded in Sub-

TABLE 2.1 Number of Awards and Countries, Dollar and Percentage Distribution of Total Obligated, by Region and Type of Award, All Funding Sources, 1984 and 1985

Subregion and Type of Award	1984				1985			
	# Awards	# Ctrys	Amount	%	# Awards	# Ctrys	Amount	%
Asia								
Subagreements	34	7	\$3,753,906		10	5	\$2,284,014	
Amendments	25	5	\$ 406,285		5	3	\$ 36,091	
Small Grants	8	5	\$ 43,248		7	6	\$ 16,083	
Total	67	8	\$4,203,439	39.4%	22	8	\$2,336,188	29.4%
Sub-Saharan Africa								
Subagreements	19	10	\$ 957,022		15	3	\$1,508,311	
Amendments	11	6	\$ 81,620		3	3	\$ 14,926	
Small Grants	30	14	\$ 101,370		31	12	\$ 121,827	
Total	60	19	\$1,140,012	10.7%	49	13	\$1,645,064	20.7%
N, Africa/Middle East								
Subagreements	10	5	\$ 721,063		11	6	\$ 442,999	
Amendments	6	3	\$ 52,870		6	4	\$ 220,199	
Small Grants	11	4	\$ 28,978		7	3	\$ 30,915	
Total	27	6	\$ 802,911	7.5%	24	7	\$ 694,113	8.7%
Latin America/Caribbean								
Subagreements	29	14	\$2,843,028		20	11	\$ 2,368,238	
Amendments	12	6	\$ 772,279		11	5	\$ 248,693	
Small Grants	21	8	\$ 66,537		21	9	\$ 59,081	
Total	62	15	\$3,681,844	34.5%	52	13	\$ 2,676,012	33.7%
Europe								
Subagreements	1	1	\$ 6,025		1	1	\$ 6,707	
Amendments	0	0	\$0		0	0	\$0	
Small Grants	1	1	\$ 190		0	0	\$0	
Total	2	2	\$ 6,215	0.1%	1	1	\$ 6,707	0.1%

Subregion and Type of Award	1984				1985			
	# Awards	# Ctrys	Amount		# Awards	# Ctrys	Amount	
World Federation								
Subagreements	1	1	\$ 832,920		1	1	\$580,100	
Amendments	0	0	\$0		0	0	\$0	
Small Grants	0	0	\$0		0	0	\$0	
Total	1	1	\$ 832,920	7.8%	1	1	\$ 580,100	7.3*
TOTAL								
Subagreements	94	38	\$9,113,964		58	28	\$7,190,369	
Amendments	54	20	\$1,313,054		25	15	\$519,909	
Small Grants	71	32	\$ 240,323		66	30	\$227,906	
GRAND TOTAL	219	51	\$10,667,341	100.0%	149	44	\$7,938,184	100.0%

2.3

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Saharan Africa, 21 in Latin America and the Caribbean, and seven each in the Asia and North Africa/Middle East regions. A description of each small grant is found in Chapter 3.

Amount and source of funds

Approximately \$7.9 million were obligated for subagreements, small grants and amendments in 1985. (Amendments are funds added to existing subagreements to provide for unforeseen needs to extend the project to enable the completion of objectives.) AVSC provides support to subrecipients through three major funding sources: AID central funds, USAID bilateral funds (Bangladesh only), and AVSC private funds. Included in the AID central funds are monies provided as add-ons to AVSC's central cooperative agreement by USAID missions or AID regional bureaus that are restricted for use in a specific country or for a specific activity.

The breakdown by funding source of all grants awards in 1985 is as follows:

<u>Source of Funds</u>	<u>Amount</u>
Central Funds	\$4,856,256 (61.2%)
Central (restricted add-ons)	\$1,826,654 (23.0%)
USAID Bilateral (Bangladesh)	\$1,142,705 (14.4%)
<u>AVSC Private</u>	<u>\$112,569 (1.4%)</u>
TOTAL	\$7,938,184 (100.0%)

Subagreements funded by add-ons are becoming increasingly common as AVSC strives to coordinate activities with USAID bilateral projects and to thereby supplement funds provided by AID through the central cooperative agreement for additional voluntary sterilization activities. In 1985, add-on funds were obligated in Guatemala, Kenya, Morocco, Nigeria, and Tunisia. AVSC activities in Bangladesh are funded by a separate cooperative agreement with USAID Bangladesh (Cooperative Agreement No. 388-0050-A-00-1014-06). Details on this agreement are found in Appendix A.

Although privately funded subagreements make up a small percentage of the overall international program activities of AVSC, they are nevertheless very important. In some countries, AID funds cannot be used even though the need and demand for voluntary sterilization exist. Private funds are used for programs in countries that are ineligible for AID funding or where voluntary sterilization is politically sensitive. During 1985, five subagreements totaling \$112,569 were awarded with private funds for programs in Costa Rica, Ecuador, Nicaragua, South Yemen, and Spain. All of these projects are to introduce or provide voluntary sterilization services where none would be available otherwise.

Subagreements by primary emphasis

The overall goal of AVSC subagreements is to increase access to safe and effective voluntary surgical contraception services on a routine and

ongoing basis in the countries where we are working. While all subagreements serve this purpose, their short-term objectives may differ depending on the area of main emphasis. AVSC classifies subagreements according to their primary emphases: services (SV), training (TR), information and education (IE), professional education (PE), national leadership and policy development (NV), and evaluation or special studies (EV). (These codes are used in the subagreement classification number to indicate primary emphasis.) The classification is somewhat artificial, since many subagreements serve many purposes, particularly large, national programs with many separate components.

Figures 2.1 and 2.2 show the distribution of subagreement awards and the distribution of all funds (for subagreements, small grants, and amendments) in 1985. Service delivery is the major focus of AVSC activities, accounting for 72% of subagreements awarded and 84% of funds obligated. Twenty-six percent of subagreements awarded had service-related program emphases (i.e., training, professional education, and information and education), in that they were intended to have an impact on the quality of voluntary sterilization services in a given program or country. Finally, a small but significant amount of support (7%) went to national leadership and policy development activities, including the World Federation program. The World Federation, an international network of health organizations, brings together the views, experience, and expertise of developing countries' family planning programs in order to focus on issues important in the field of voluntary surgical contraception. Chapter 5 reviews the accomplishments of the World Federation and the impact of its activities on AVSC's international program.

Subagreements by region

Table 2.1 illustrates the distribution of programs and funds obligated in 1984 and 1985 for each of the major regions in which AVSC works: Asia, Sub-Saharan Africa, North Africa and the Middle East, and Latin America and the Caribbean. There has been a shift of grant resources from regions where voluntary sterilization programs are long-standing and have progressed beyond the introductory stage (Asia, and Latin America) to regions where quality voluntary sterilization services are not yet widely accessible (Sub-Saharan Africa). The share of funding (all fund sources) for programs in Sub-Saharan Africa increased from 11% in 1984 to 21% in 1985. In Asia, there was a corresponding decrease of 10 percentage points between 1984 and 1985. In Latin America and the Caribbean, although fewer subagreements were awarded in 1985 than in the previous years, the percentage of funds allocated to the region (about 34%) remained the same. The share of resources allocated to North Africa and the Middle East increased slightly between 1984 and 1985.

AVSC's allocation of resources is consistent with the general direction of AID's Resource Allocation Plan, the goal of which is to allocate 35% to Africa, 35% to Asia and the Near East, and 30% to Latin America by 1987. However, it must be recognized that development of voluntary sterilization programs proceeds at a different rate from, usually behind, development of temporary family planning services. The absorptive capacity of many health institutions in Africa is insufficient to handle a quick influx of funds for

FIGURE 2.1: Number and Percentage Distribution of Subagreement Awards by Primary Emphasis, 1985

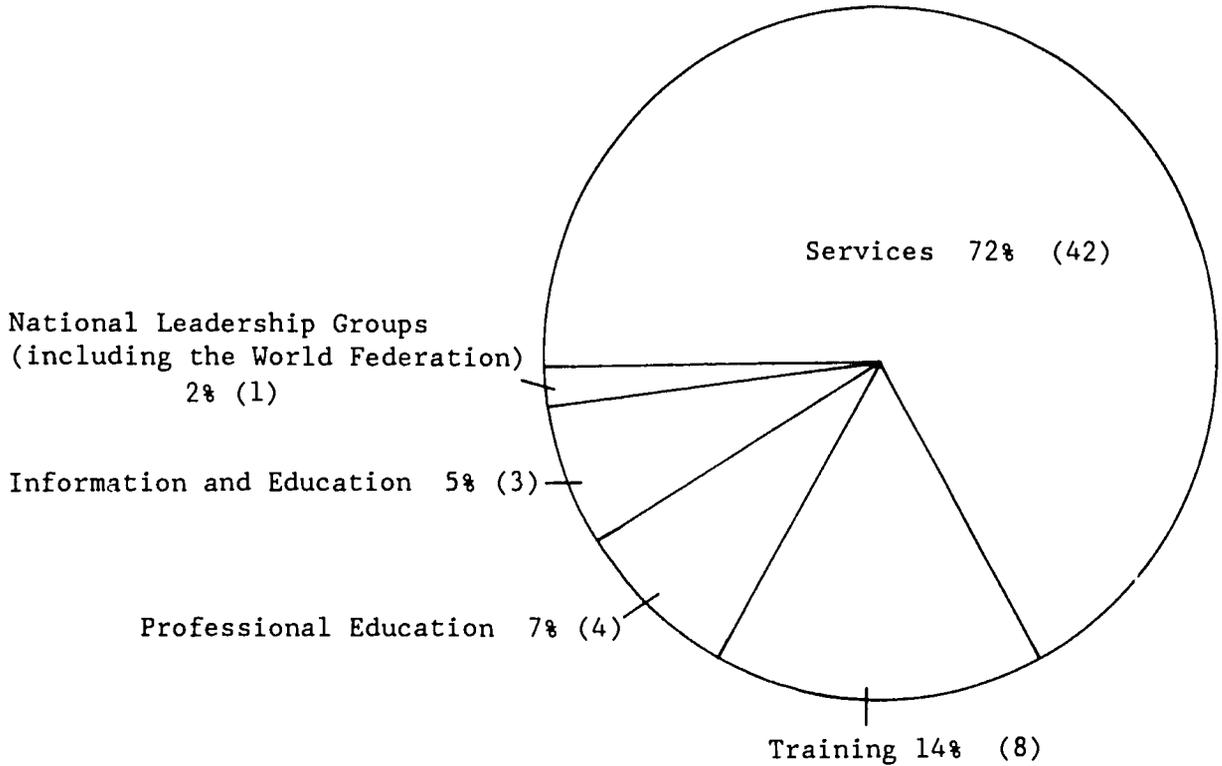
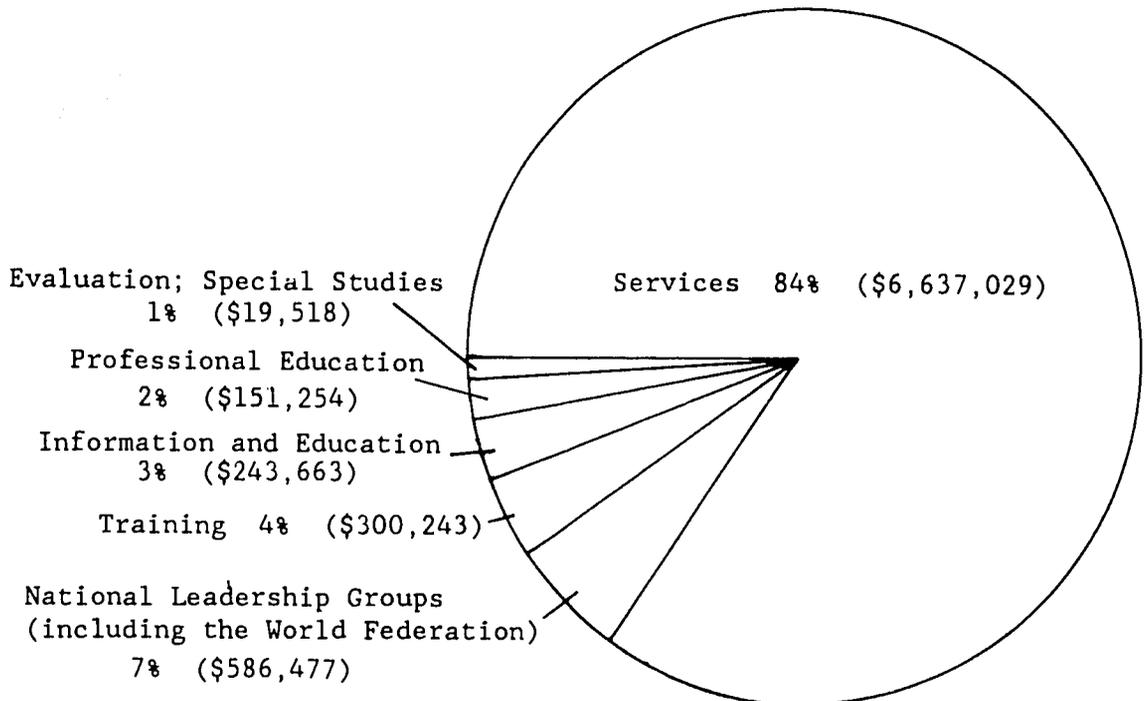


FIGURE 2.2: Dollar and Percentage Distribution of Total Funds Obligated (for Subagreements, Small Grants, and Amendments) by Primary Emphasis, 1985



voluntary sterilization programs. Also, although many countries in Asia and the Latin America/Caribbean region are receiving less priority because, in general, their family planning programs are more established, there may still be a need for a voluntary sterilization program that is not being met by existing programs. Therefore, while continued priority will be given to Africa, it probably will be some time before the majority of AVSC grant resources will be programmed there.

PART II: ACCOMPLISHMENTS OF AVSC PROJECTS

Each project funded by an AVSC subagreement is required to provide financial and progress reports. Service statistic and training reports are also required if these activities are funded under the subagreement. AVSC programs are also required to review all complications of procedures they provide and to maintain a mortality surveillance. This section is intended to give a summary of the reported accomplishments of AVSC projects that were active in 1985.

SERVICES

Number of procedures

In 1985, a total of 212,438 (168,318 female and 44,120 male) voluntary sterilization procedures were reported by AVSC projects, bringing the total number of procedures reported since 1976 to over 1.3 million (See Table 2.2). The 1985 total represents a 21 percent decrease in the number of procedures reported in 1984. This decrease would seem to mirror the decline in the number of subagreements awarded in 1985, as discussed in Part I of this chapter. While this is certainly part of the equation, particularly in South Asia and Central America, the decrease can be attributed mostly to the dramatic decline in sterilization performance by the Bangladesh program (see Appendix A). As shown in Figure 2.3, voluntary sterilizations reported by AVSC projects between 1984 and 1985 increased in Sub-Saharan Africa and South America and the Caribbean, and decreased only slightly in the North Africa/Middle East region and Central America. The major decline was seen in Asia.

It should be noted that these statistics reflect only the experience of AVSC-supported service projects that were active in 1985 and are not necessarily representative of what was happening in a region as a whole. It is only a few cases, that the AVSC program provides a significant proportion of the procedures in a given country. AVSC service projects are intended to demonstrate the feasibility or methods of delivering safe and effective voluntary sterilization services, rather than to subsidize service delivery per se. This is because AVSC, with its finite resources, cannot hope to support the worldwide demand for voluntary sterilization. Therefore, as AVSC branches out to do less-traditional programming (quality assurance workshops, operations research, follow-up surveys, etc.), it is likely that its projects will report fewer sterilization procedures in the future. However, such programming is intended to have an impact beyond the voluntary sterilization procedures performed in our own programs.

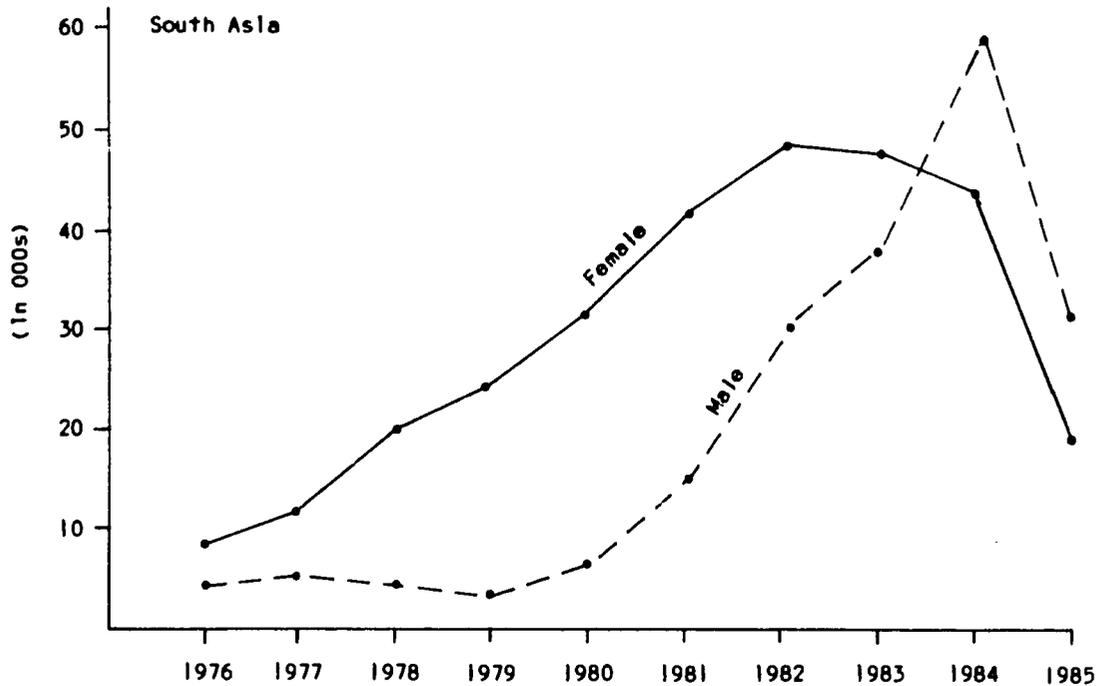
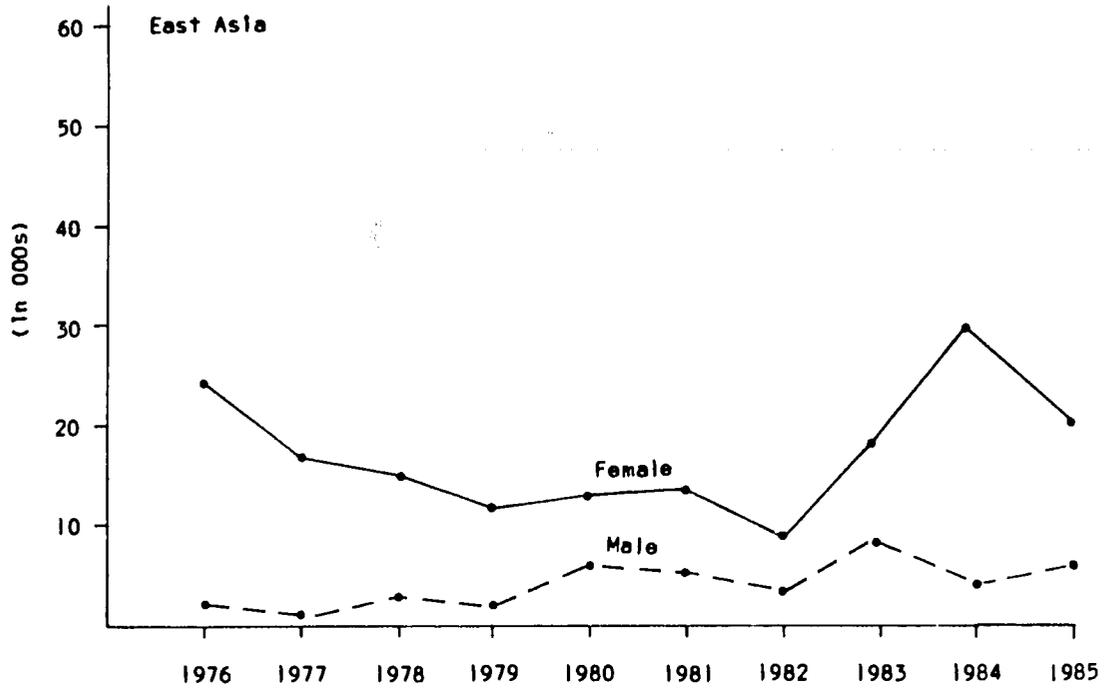
Choice of surgical procedure

Figure 2.4 illustrates that while the majority of the procedures performed by AVSC projects continue to be female sterilizations, the percentage that are male procedures is on the rise. This trend is expected to continue in the future, as AVSC works to find ways to make vasectomy a

TABLE 2.2 Number and Percentage Distribution of Female and Male Sterilization Procedures Reported by AVSC Recipients, All Funding Sources, 1976-1985

Year	Female Procedures		Male Procedures		Total Procedures	
	Number	%	Number	%	Number	%
1976	40,365	85.5	6,838	14.5	47,203	100.0
1977	41,453	83.1	8,424	16.9	49,877	100.0
1978	53,771	86.4	8,494	13.6	62,265	100.0
1979	65,878	90.1	7,277	9.9	73,155	100.0
1980	79,496	85.6	13,389	14.4	92,885	100.0
1981	101,935	81.1	23,697	18.9	125,632	100.0
1982	128,316	77.2	37,797	22.8	166,113	100.0
1983	174,507	76.3	54,324	23.7	228,831	100.0
1984	195,128	72.9	72,703	27.1	267,831	100.0
1985	168,318	79.2	44,120	20.8	212,438	100.0
<u>TOTAL</u>	1,049,167	79.1	277,063	20.9	1,326,230	100.0

Figure 2.3: Number of Female and Male Sterilization Procedures Reported by AVSC Recipients, All Funding Sources, 1976-1985, by Subregion and Year



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Figure 2.3 - continued

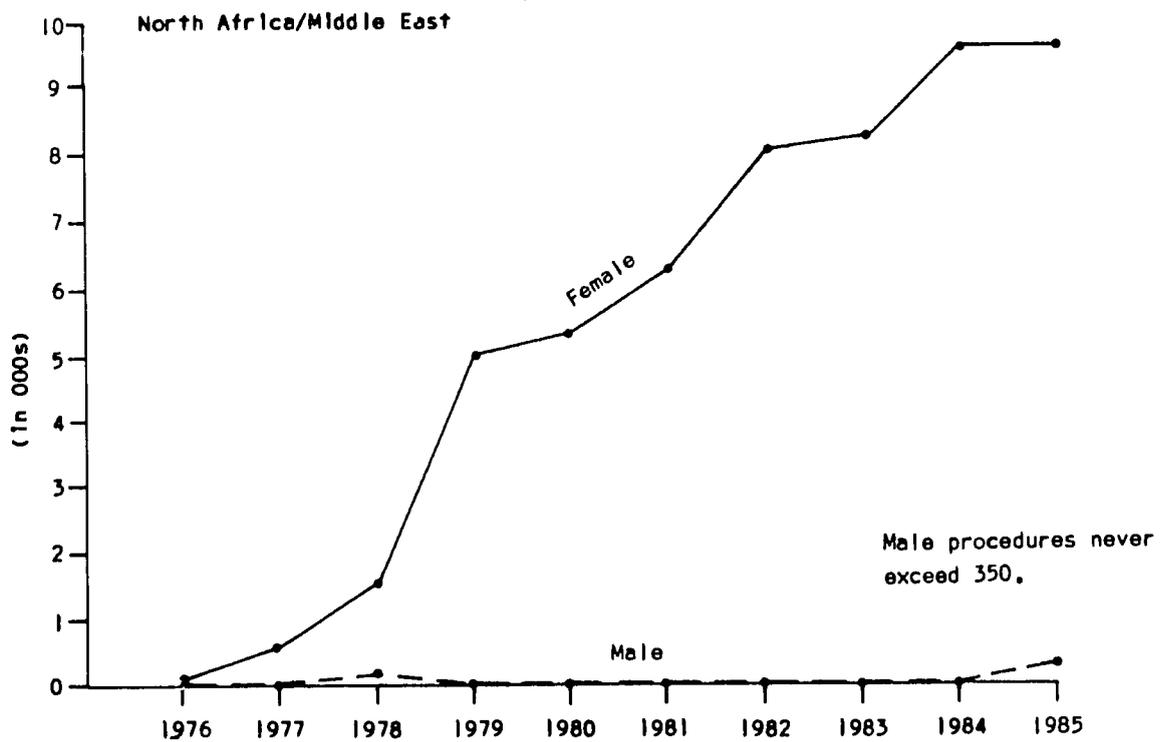
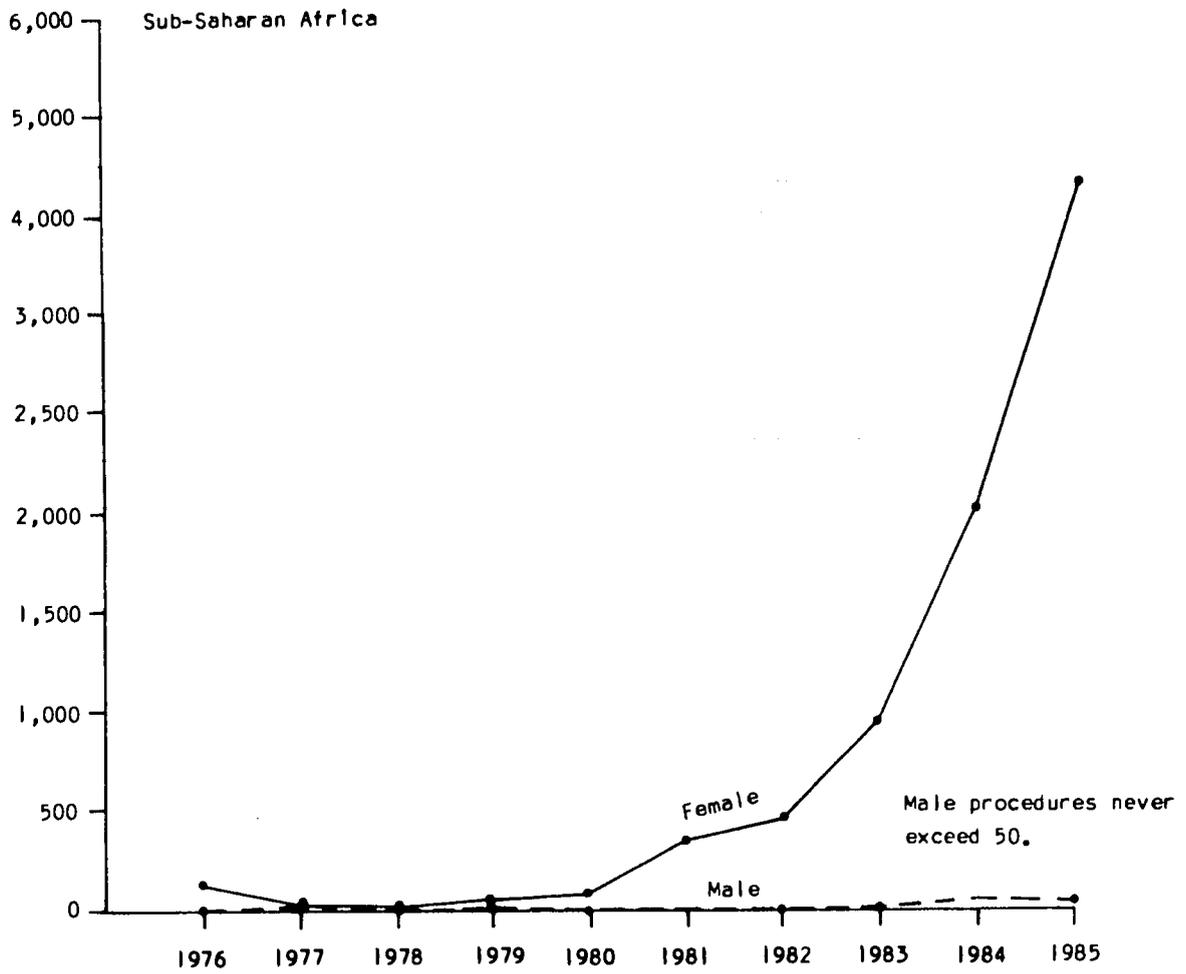


Figure 2.3 - continued

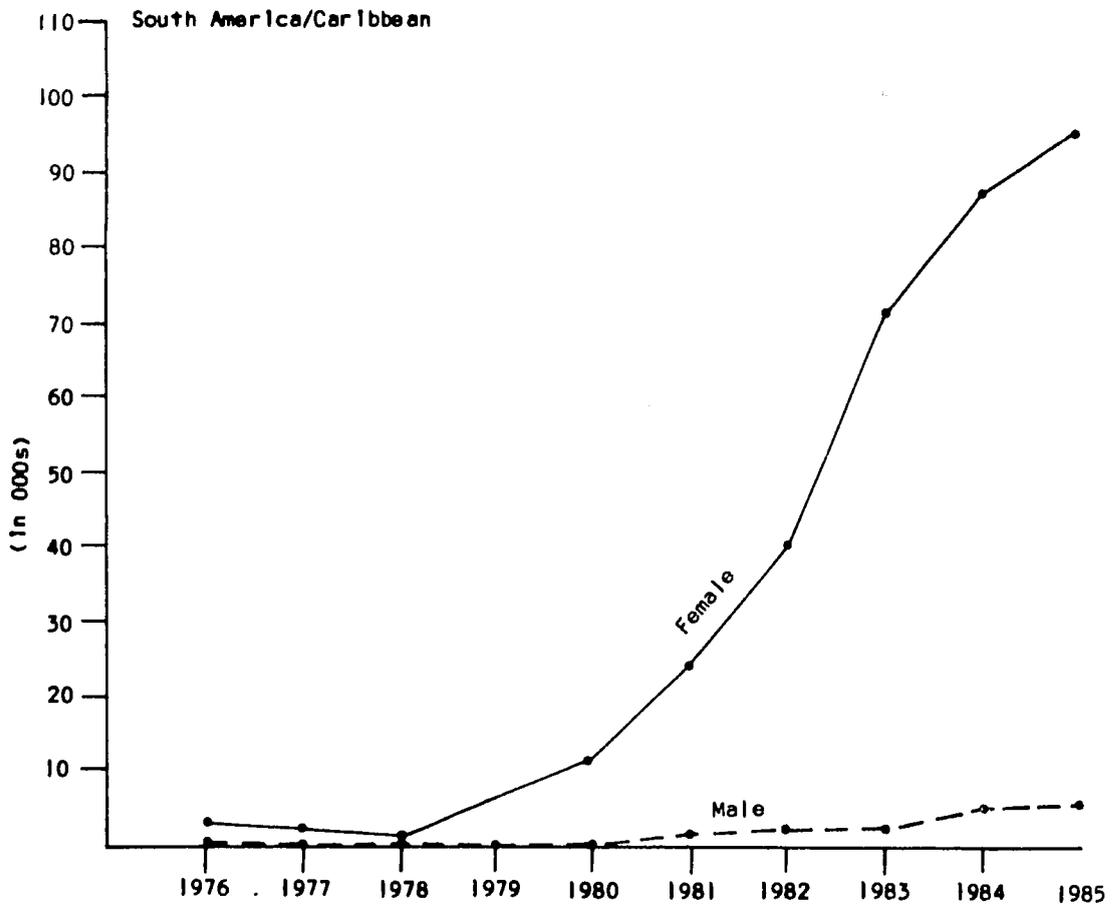
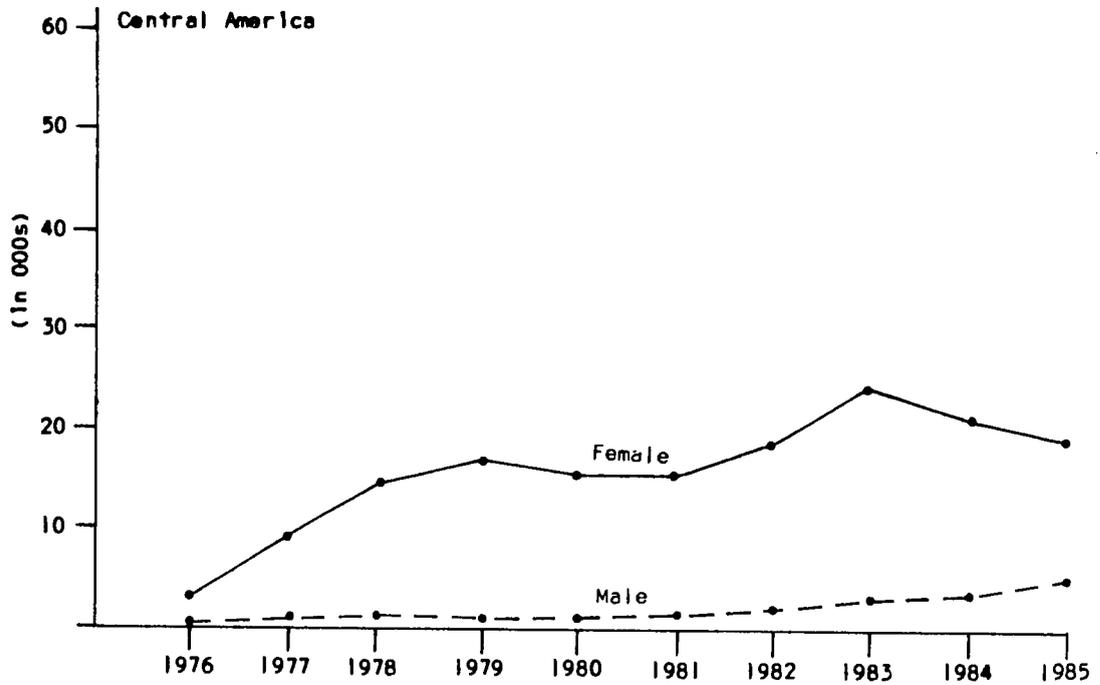
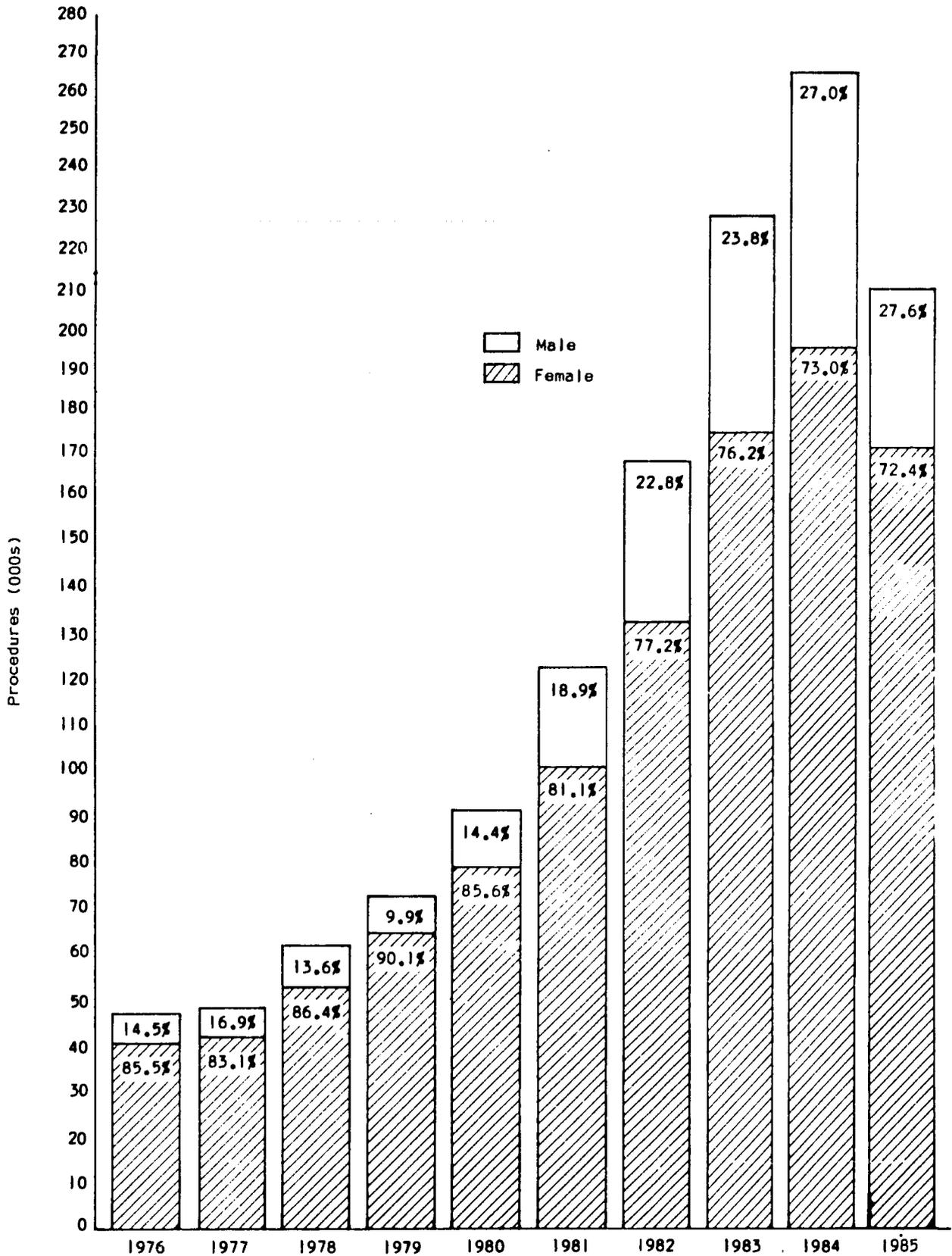


Figure 2.4: Number and Percent Distribution of Female and Male Sterilization Procedures Reported by AVSC Recipients, All Funding Sources, 1976-1985



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more acceptable contraceptive option for men and to design services that have men's reproductive health needs in mind.

Minilaparotomy accounted for slightly over one-half of all female procedures reportedly performed in 1985; this proportion has remained relatively stable over the past several years (see Figure 2.5). As AVSC involvement shifts toward Africa, however, it is expected that the proportion of procedures performed in AVSC projects representing minilaparotomies will also increase, because minilaparotomy is a technique better suited than others to the African health care infrastructure. Laparoscopy continues to play an important role in well-equipped facilities with high caseloads, particularly in the North Africa/Middle East, Latin America/Caribbean, and Asia regions.

Monitoring sterilization services

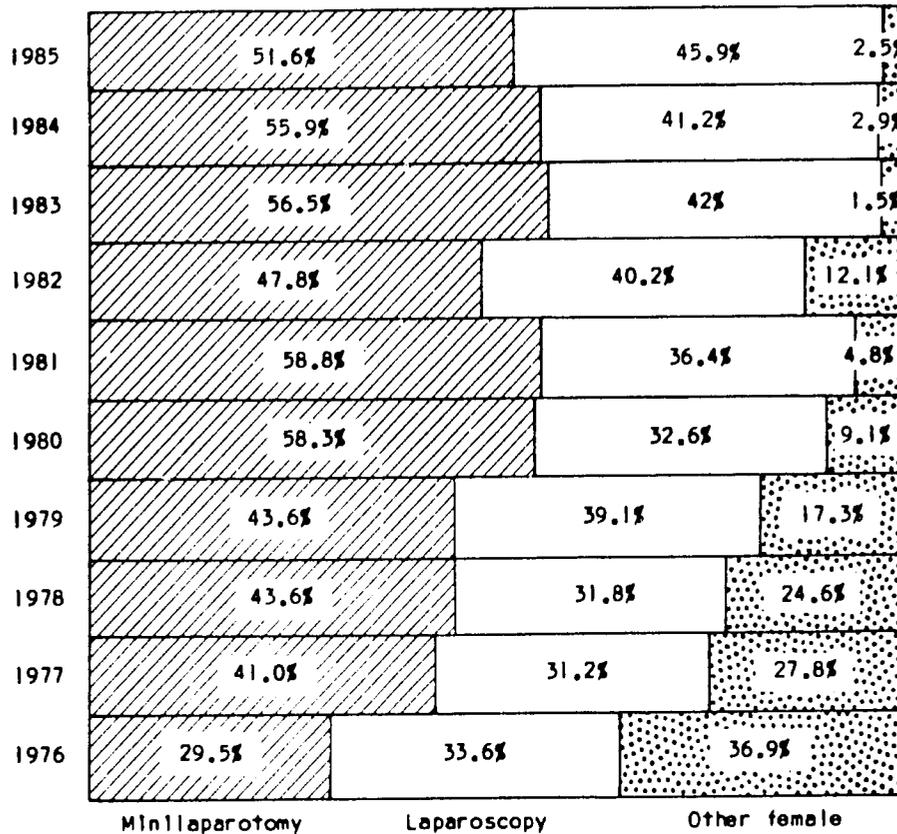
AVSC carefully monitors all major complications and deaths resulting from or related to voluntary sterilization procedures performed in service projects. This monitoring enables AVSC and the local programs to take swift, corrective action as necessary and to make improvements in program safety and effectiveness.

*Mortality surveillance: AVSC-supported programs are obligated to report immediately (within 24 hours) any death of a male or female client occurring within 42 days of surgery or resulting from a complication developed within the 42-day postoperative period. All reported fatalities in AVSC programs are thoroughly investigated by the AVSC Medical Division to determine whether the death was attributable to sterilization and whether it could have been prevented. A new policy was developed in 1985 that after a sterilization-related death, the operating surgeon and the facility where the surgery was performed have to be recertified. Recertification is granted after the surgeon performs several procedures under the supervision of the medical director or senior surgeon in the program (or AVSC medical staff, whenever possible), and is implemented as a rapid response to ensure the quality of services while the death is being investigated. Thus, AVSC and the program are able to take swift, corrective action on any problems and to make recommendations for improving the safety and effectiveness of services.

In 1985, AVSC-funded programs reported 11 sterilization-attributed fatalities: four in the Dominican Republic, two in Colombia, two in Bangladesh, two in Nepal, and one in Sierra Leone. The causes of death were bowel injury (two cases in the Dominican Republic and two cases in Colombia); anesthesia-related complications (one case each associated with local anesthesia medication in Nepal and Sierra Leone, and a case of meningitis associated with spinal anesthesia in the Dominican Republic); hemorrhagic shock due to intraabdominal bleeding (one case each in Nepal and the Dominican Republic); and infection (two cases in Bangladesh: a reactivated case of underlying pelvic peritonitis and a case of septicemia resulting from massive incisional infection).

All the deaths in 1985 followed female sterilization, yielding a mortality rate of six per 100,000 procedures. This rate is comparable with

Figure 2.5: Proportion of Female Sterilization Techniques Performed by AVSC Recipients, 1976-1985



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

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or lower than the internationally accepted rate, and reflects efforts made, particularly by large, national programs, to improve safety and provide high-quality services. It also may reflect underreporting, which is inherent in any surveillance system, regardless of the attention and vigilance pay to reporting such occurrences.

*Review of complications: All 501 complications reported in 1984 were reviewed in 1985, and suggestions for improved care were made where appropriate. Based on the performance of 267,831 procedures during the year, the complication rate was 0.19%, lower than many reported in the medical literature. Underreporting of complications continued to be a concern, and efforts to encourage better reporting seem to be making a difference, particularly in large, national programs where medical surveillance systems are in effect or being developed.

The 1984 complications were analyzed according to the type of complication. Infection accounted for 37% of the total reported. Following close behind was failure, at 27%. Bleeding and trauma to organs other than the uterus were about equal in frequency, 13% each. Uterine perforation represented only 3%, and complications related to anesthesia or sedation accounted for only 2% of the total 501. Analysis of 1985 complications will be included in the 1986 annual report.

VSC TRAINING AND PROFESSIONAL EDUCATION

The two major thrusts of AVSC's international program are to increase access to and assure high quality of voluntary sterilization services. Training of physicians and nonphysicians is one of the most important ways to carry out both goals. In addition, professional education activities, such as workshops and seminars, are effective means for developing or disseminating guidelines concerning medical safety and voluntarism and for helping to standardize safe and effective service delivery practices in many programs. They can also help to ensure access by removing obstacles to service delivery that occur when medical professionals have inadequate or incorrect information about the role of voluntary sterilization in health and family planning programs.

Physician training

In 1985, AVSC-supported projects reported training 257 physicians from 15 countries: 173 in minilaparotomy, 51 in laparoscopy, and 86 in vasectomy (physicians could receive training in more than one technique). In regions where services are not widely accessible (such as Sub-Saharan Africa, and North Africa and the Middle East), training is generally provided as an initial step in establishing services. Training was conducted in Brazil (vasectomy), Egypt, Kenya, Nigeria, and Peru for new service providers. In countries with large, established programs, training is also provided to support the personnel needs of ongoing service facilities. Such refresher training occurred in Bangladesh, Indonesia, the Philippines, and Sri Lanka. Training was also provided to orient current service providers to new approaches and techniques. This was particularly true in Latin America, where physicians from Brazil, Colombia, and Guatemala were trained in the

Dominican Republic to perform minilaparotomy under local anesthesia. Individual training programs are listed in the subagreement and small grant tables found in Chapter 3.

Health-support personnel training

AVSC is focusing increased attention on the training needs of health-support personnel (such as nurses, midwives, educators, and counselors), because these personnel have the most contact with clients and play an important role in assuring the quality of services and client satisfaction. In 1985, 453 such personnel received training in one or more of the following areas: counseling (280), information and education (238), assistance in the operating theater (48), clinic management (29), and anesthesia administration (18). Formal training programs for development of counseling skills require intensive technical assistance and oversight by AVSC staff, as this is a relatively new field for international programs. Pilot counselor training efforts were undertaken in 1985 in Indonesia, Kenya, and Nigeria, and will help AVSC to define components of a good counselor training program, including trainee selection criteria, appropriate curricula and methodologies, and training evaluation.

Professional education workshops

In 1985, AVSC supported several professional education events in order to orient program managers to issues concerning medical safety and voluntarism. These included seminars in Colombia and the Dominican Republic to develop safety standards for voluntary sterilization services for their large, national programs; a regional workshop on counseling and voluntarism for AVSC programs in South America; and national-level workshops on counseling in Malaysia, the Philippines, and Thailand. These are described in more detail in the following chapter.

CHAPTER 3

REGIONAL PERSPECTIVES

NORTH AFRICA AND THE MIDDLE EAST

Summary of regional strategies and issues

The countries of North Africa and the Middle East display great economic, political, and demographic contrasts; however, they are bound by the Muslim religion and, except in Tunisia, Islam is a significant obstacle to the development of voluntary sterilization programs in the region.

In North Africa and the Middle East, AVSC must respond to two very different situations: the development of new initiatives in countries where family planning programs are not well developed and the improvement and refinement of established programs in countries where AVSC has worked for many years. Thus, AVSC's strategy is to demonstrate the need and demand for voluntary sterilization, to introduce appropriate and high-quality services, and to increase awareness of the benefits of sterilization among health professionals and policymakers.

In 1985 new programs were established in Jordan, South Yemen, and Sudan, while increased attention was paid to quality control and evaluation in older programs in Tunisia, Morocco, and Egypt. The political turbulence in the region, particularly in Sudan, Egypt, and South Yemen, hindered AVSC's ability to develop and monitor programs, although activities were by no means halted. Because of political developments in Sudan and South Yemen, AVSC expects that the new programs in these countries will take longer to get started than originally anticipated.

Summary of funds obligated

In 1985 a total of \$694,113 was awarded for activities in North Africa and the Middle East: \$442,999 for 11 subagreements, \$220,199 for 6 amendments, and \$30,915 for 7 small grants.

Regional initiatives

For both old and new programs, professional education activities are important, both to assure quality and to gain acceptance of voluntary sterilization services as part of routine health care delivery. In 1985 AVSC received special funding from the Near East Bureau of the Agency for International Development for a two-year family-planning professional-education initiative for the Arabic region. This initiative includes two components: (1) the development and distribution of an annotated bibliography in Arabic about family planning, including voluntary sterilization, and (2) a workshop for medical universities about how to incorporate family planning into routine physician-training activities.

AVSC is working closely with the World Federation and its Arabic leadership network in this effort.

Major programs

AVSC's project in Morocco with the National Training Center for Reproductive Health (NTRH) was this region's most remarkable program success in 1985. The five-year project provides technical and financial support to NTRH trainees, to help them establish voluntary sterilization services in their home institutions. Because of the interest and commitment of trainees, the program was expanded to cover 20 provincial hospitals, instead of the 5 originally planned. Program and financial-management systems were developed, including a supplies-distribution system, and the foundation was laid for a national program.

In Tunisia the Office National de la Famille et de la Population (ONFP) concluded a five-year project which provided voluntary sterilization services in clinics throughout the country. Because of the worsening economic situation in Tunisia, ONFP is unable to assume full financial responsibility for the program, as had been originally planned. Without AVSC financial assistance, the service program would continue, but both access and quality would suffer. In 1985 negotiations were begun to develop a framework for another three years of AVSC support. Service delivery will continue, with the focus on quality-assurance activities, including stronger medical supervision systems and continuing education for staff in anesthesia and counseling.

AVSC has been extensively involved in Egypt for the past ten years. In 1985 support in this country was phased down because of the increasing sensitivity to voluntary sterilization in the worsening political climate. Training was discontinued at all but three institutions, and support to the Egyptian Fertility Care Society was reduced, with a view towards terminating funds by the end of 1986. At the end of the year, AVSC contracted with consultants to review past training activities, to determine the impact of the training program on voluntary sterilization in Egypt, and to propose future program directions for AVSC. The assessment included a survey of all past trainees, visits to a select number of trainee institutions, and a meeting of past trainees at which focus groups were conducted. The results will be available in 1986.

In 1985 extensive program development was conducted in Jordan, a new country for AVSC. After supporting a small demonstration service program in the private sector, AVSC developed two new programs in Ministry of Health hospitals, El Bashir Hospital in Amman and Princess Basma Hospital in Irbid (slated for obligation in 1986). Contacts were also established with the Jordanian Women's Union and Jordan University Hospital. In a meeting with AVSC staff, the Minister of Health gave his verbal approval for these programs and for an AVSC presence in Jordan. These developments exceeded expectations regarding the pace of program development in this country.

Planned initiatives for 1986

*Professional education: A major event in this region in 1986 will be the workshop on how to incorporate family planning, including voluntary sterilization, into the curricula of medical schools. AVSC will collaborate closely with the World Federation and the Regional Arabic Federation on this conference and will follow up on the recommendations that are produced. The National Training Center for Reproductive Health in Morocco will host the meeting, while at the same time serving as an excellent model for VSC training.

Participants at the workshop will also review the Arabic annotated bibliography on family planning, to ensure its usefulness for training programs.

*Medical quality assurance: In 1986 AVSC will place special emphasis on the quality of voluntary sterilization services provided in programs in this region. Early in the year a medical program adviser will be recruited for the Tunis regional office. With this staff member on board, AVSC will be able to conduct more frequent site visits and to provide more direction on medical supervision, particularly for multisite programs in Tunisia and Morocco.

*New countries: In 1984 Turkey liberalized its laws on voluntary sterilization. AVSC continues to be ready to develop programs in Turkey, pending a favorable attitude among local USAID personnel about the prospects for voluntary sterilization programs in that country. The two new programs in Jordan will get under way in 1986, and AVSC will follow up the results of the facilities survey in North Yemen.

*Information, education, and counseling: When both clients and health workers fully understand voluntary sterilization, then voluntarism is protected. In this region in 1986, AVSC will emphasize the training of paramedical personnel in client-education techniques. ONFP in Tunisia will receive financial and technical assistance to train its outreach workers. AVSC will also work with other donor agencies that train health personnel, to encourage them to incorporate voluntary sterilization into the courses they finance. A coordination meeting with the Ronco Consulting Organization will be held to explore possible collaboration in this area.

TABLE 3.1

Subagreements Awarded in 1985: North Africa and the Middle East

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
<u>EGYPT</u>		
Ain Shams University EGY-12-TR-4-A	\$ 32,050	To provide continued support for a physician-training and service-delivery program in female VSC.
Alexandria University EGY-17-TR-5-A	\$ 24,455	To provide continued support for a physician-training and service-delivery program, with the initiation of a postpartum component.
Misr Spinning and Weaving Hospital EGY-20-TR-3-A	\$ 8,388	To provide continued support for a physician-training and service-delivery program, with the initiation of a postpartum component.
<u>JORDAN</u>		
Ibrahim Clinic JOR-02-SV-1-A	\$ 17,638	To provide support for the delivery of tubal occlusion services in the private sector as a demonstration of demand.
<u>PEOPLE'S DEMOCRATIC REPUBLIC OF YEMEN (SOUTH YEMEN)</u>		
Yemeni Council for Family Care PDY-03-IE-1-P	\$ 11,046	To integrate an information and education program dedicated to voluntary sterilization into the community program for paramedical personnel.
<u>SUDAN</u>		
Omdurman Maternity Child Care/ Family Planning Training Center SUD-05-SV-1-A	\$ 21,090	To increase the availability and accessibility of tubal occlusion services in strategic locations in Sudan and to institutionalize these services at the training center.

TABLE 3.1 - continued

Subagreements Awarded in 1985: North Africa and the Middle East

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
Sudan - cont'd		
Sudan Fertility Control Association SUD-06-SV-1-A	\$ 75,903	To provide voluntary sterilization services in the Khartoum metropolitan area, including information and education activities.
<u>TUNISIA</u>		
Office National de la Famille et de la Population TUN-07-SV-6-A	\$164,050	To continue voluntary sterilization activities at the El Ariana, Bardo, and Hammam-Lif Clinics in greater Tunis and at 14 regional family planning centers.
Office National de la Famille et de la Population TUN-10-PE-1-A	\$ 57,314	To support seminars on counseling and anesthesia in order to improve the quality of services.
<u>YEMEN ARAB REPUBLIC (NORTH YEMEN)</u>		
Yemen Family Planning Association (Al-Thourah Hospital) YEM-01-SV-2-A	\$ 22,013	To continue support for the delivery of female voluntary sterilization services.
Ibrahim's Clinic YEM-02-SV-1-A	\$ 9,052	To support the initiation of male voluntary sterilization services in a model clinic.

TABLE 3.2

Small Grants Awarded in 1985: North Africa and the Middle East

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
<u>JORDAN</u>		
Al Bashir Hospital S-770-SV	\$ 110	To provide a supply of Falope-Rings.
Jordan University Hospital S-774-SV	\$ 6,650	To provide a laparoscope.
Ibrahim Clinic S-785-TR	\$ 2,500	To train one physician in minilaparotomy in Morocco.
Ibrahim Clinic S-805-SV	\$ 4,620	To provide a laprocator.
Al Bashir Hospital S-809-SV	\$ 7,500	To provide a laparoscope.
<u>SUDAN</u>		
KNH Hag Youssef Maternal/Child Health and Family Planning Center S-773-IE	\$ 2,035	To provide three films and a film projector to educate health personnel and clients.
<u>TUNISIA</u>		
Office National de la Famille et de la Population S-803-TR	\$ 7,500	For attendance of the clinic administrator at a workshop on family planning held at the University of California.

7

SUB-SAHARAN AFRICA

Summary of regional strategies and issues

The number of projects sponsored by AVSC in Sub-Saharan Africa has tripled since 1982--a clear demonstration of the growing interest in voluntary surgical contraception in that region. Numbering 33 subagreements in 10 countries at the end of calendar year 1985, these projects also reflect AVSC's increased allocation of staff and financial resources to African programs.

Despite the vast territorial and cultural differences among the approximately 40 nations of Sub-Saharan Africa, the general health status of people in these countries is quite similar. Birth and death rates are more than twice those of industrialized nations. The health infrastructures are inadequate and trained health personnel insufficient to keep pace with the population growth.

In terms of programs, AVSC considers each country as unique and adapts its assistance to meet the needs of each nation and to respect the priorities of health authorities. At the same time, AVSC works to introduce or reinforce VSC services within the context of maternal-child health care and to increase awareness of the health benefits of voluntary sterilization among health professionals, policymakers, and the general public.

In 1985 AVSC identified Kenya, Nigeria, Senegal, and Zaire as priority countries for intensive development efforts over the next several years. These four countries were selected because of their growing populations, their regional influence, and their potential for developing successful national programs. Less intensive but sustained attention is being given to selected other countries, including Burkina Faso, Burundi, Ghana, Ivory Coast, Mali, Mauritius, and Sierra Leone.

Where facilities are inadequate for high-quality VSC services, AVSC provides support for dedicated operating-room space, whether in university teaching hospitals (as in Senegal and Nigeria), in public-sector facilities (Burkina Faso, Kenya, Madagascar, Nigeria, Uganda), through family planning associations (Kenya, Mali, Mauritius), or in private institutions (Cameroon, Kenya, Nigeria, Senegal). Information and education activities are important program components, especially in areas of latent potential demand (i.e., Madagascar, Nigeria, Senegal). The importance of voluntarism is stressed in counseling seminars for nursing personnel conducted in an increasing number of countries.

A major objective at this time is to strengthen existing programs, many of which are in key medical facilities, so that they can serve as model service and training sites in the future. Training sites in Africa currently exist in Kenya, Morocco, Senegal, and Tunisia. AVSC is working to develop, within five years, centers of service excellence in both East and West Africa. These centers will be able to train health personnel

(including trainers) to replicate the following aspects of their model programs:

1. Performing high-quality, low-cost voluntary sterilization procedures (minilaparotomy using local anesthesia; vasectomy, where appropriate)
2. Providing long-lasting contraceptive methods (IUDs, Norplant)
3. Identifying clients who are likely to have high-risk pregnancies
4. Providing appropriate client education and counseling, including use of client educational materials
5. Administering voluntary sterilization programs, including record-keeping procedures

To enhance its ability to develop and monitor projects, AVSC will increase the number of staff responsible for programs in the region and decentralize responsibility. In late 1985 AVSC named the director of the Africa Regional Office, to be located in Kenya, and the in-country representative for Nigeria; both offices became operational in January 1986.

Summary of funds obligated

In 1985 a total of \$1,645,064 was awarded for activities in Sub-Saharan Africa: \$1,508,311 for 15 subagreements, \$14,926 for 3 amendments, and \$121,827 for 31 small grants.

Regional initiatives

In 1985 while AVSC continued to increase funds awarded to Africa, it also emphasized technical assistance to new programs in the region so that they would start off on the right track. Two areas received special attention: (1) training and (2) information, education, and counseling.

Realizing that it does not have the resources to meet all the training needs in this vast region, AVSC works with other donor agencies who are involved in training in Africa. In August 1985 AVSC hosted a meeting which included the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO), the Pathfinder Fund, Family Planning International Assistance (FPIA), and International Training in Health (INTRAH); the purpose was to explore ways in which these organizations could incorporate voluntary sterilization training into their activities. The emphasis was on training for paramedical staff because these individuals can pose obstacles to the delivery of voluntary sterilization when they do not understand the procedure.

During 1985 AVSC enhanced its training activities in Sub-Saharan Africa by using the facilities of three regional centers:

- o Le Dantec Hospital in Dakar, Senegal--physician training in diagnosis and tubal occlusion
- o National Training Center for Reproductive Health in Rabat, Morocco--physician training in minilaparotomy and laparoscopy
- o Family Planning Association of Kenya in Nairobi--physician training in minilaparotomy; nurse training in counseling, information, and education

Providing training at regional centers not only maximizes the utilization of these facilities but also gives health care providers from different countries an opportunity to exchange information and ideas.

In Nigeria and Kenya, where AVSC has a number of service programs, in-country training programs in information, education, and counseling were developed and implemented in 1985. The purpose was to ensure voluntarism and to produce personnel trained to provide these services to clients. University College Hospital in Nigeria and the Family Planning Association of Kenya held one-week workshops for nurse-midwives from other AVSC-supported projects in their countries.

To supplement the training programs for nurse-midwives and because appropriate educational materials are scarce in Africa, AVSC funded the production of an inexpensive educational package to be used by nurse-midwives and family planning counselors in AVSC service programs. This package contains a large flip chart, a small flip chart, a set of slides, a booklet, and a poster. The materials were developed by the Department of Obstetrics and Gynecology of the University of Benin Teaching Hospital in Benin City, Nigeria, with technical assistance provided by AVSC staff. These materials were pretested in Nigeria and distributed on a limited basis to AVSC programs in Kenya, Sierra Leone, Uganda, and several other countries. Before distributing the package more widely, AVSC plans to test it outside of Nigeria.

Major programs

In Nigeria the first statewide VSC demonstration program was awarded to the Ministry of Health in Oyo State. This project will establish services at three state hospitals and will conduct a statewide seminar on voluntary sterilization for health care professionals and policymakers. AVSC believes the Oyo State program will serve as a model for other Nigerian states as they begin to expand services. In 1985 AVSC awarded \$600,000 to AFRICARE to conduct a survey of hospitals and clinics in 7 of Nigeria's 19 states. AFRICARE will identify appropriate sites for primary health care, family planning, and voluntary sterilization services and will procure and distribute equipment to selected sites.

In 1985 AVSC awarded \$264,956 to the Family Planning Association of Kenya (FPAK) to continue its high-quality service and training programs. During its fourth year of assistance, FPAK will establish voluntary sterilization services at two additional clinics, bringing the total number of FPAK clinics routinely providing services to seven. FPAK will conduct courses in minilaparotomy with local anesthesia for physicians and operating nurses, and courses in information, education, and counseling for nurse-midwives, counselors, and health educators. Trainees will include regional participants as well as Kenyans.

Also in Kenya in 1985, AVSC awarded a subagreement to the Protestant Churches Medical Association (PCMA). This grant supports VSC services at nine of PCMA's rural hospitals and includes a model quality assurance, monitoring, feedback, and data collection system based on the work of the World Federation and AVSC's Medical Division.

AVSC's successful work with nongovernmental institutions in Kenya has led government authorities to express interest in voluntary sterilization. In 1985 subagreements were awarded to three Ministry of Health facilities (Machakos Provincial Hospital, Rift Valley Provincial Hospital, and the Division of Family Health in Nairobi).

In Senegal AVSC supported two major programs in 1985. The more important of these programs is at Le Dantec Hospital of the University of Dakar, which, because of cooperation between the grantee, AVSC, and JHPIEGO, has become a regional training center for reproductive health in Francophone West Africa. AVSC has provided funds to renovate and equip dedicated space for voluntary sterilization and has subsidized services in conjunction with JHPIEGO's training effort. Capital improvements have been made, and the first training course is scheduled for 1986.

At Abass N'Dao Hospital, a municipal facility in Dakar, AVSC has provided funds for dedicated space and services to enable that facility to meet the unsatisfied demand for voluntary sterilization services.

During 1985 AVSC's project with the IPPF affiliate in Mali, the Association Malienne pour la Promotion et la Protection de la Famille (AMPPF), continued to deliver female sterilization services in two hospitals in Bamako. In Burkina Faso operating rooms were renovated and equipped in two national hospitals, one in Ouagadougou and the other in Bobo Dioulasso; service delivery is scheduled to begin in 1986.

AVSC's work with the Mauritius Family Planning Association (MFPA) expanded in 1985, the second year of a five-year program. With the assistance of AVSC, MFPA continues to be a pioneer in family planning by providing outpatient female sterilization and vasectomy services, which are largely unavailable in the public sector but for which there is substantial demand.

In Madagascar AVSC supported three programs in the private sector during 1985: service-delivery programs at Lutheran Hospital in Antsirabe and at Organisation Sanitaire Tananarivienne Inter-Enterprises in Antananarivo, and a nationwide information and education effort with Fianakaviana Sambatra, the IPPF affiliate. AVSC also provided support to

renovate and equip dedicated space at El Maarouf Hospital, the major Ministry of Health facility located in Moroni, Comoros.

Planned initiatives for 1986

*New countries: AVSC programs will be initiated for the first time in Burundi, Ethiopia, Ghana, Ivory Coast, Liberia, and Zimbabwe.

*Service delivery: Ongoing service delivery will be carefully monitored to ensure the provision of high-quality services. AVSC expects to develop or expand services in Burundi, Ghana, Ivory Coast, Liberia, Zaire, and Zimbabwe during 1986. Private funds will be sought to support service programs in Ethiopia and Tanzania; these programs would follow up the training of two Tanzanian and two Ethiopian physicians at the Family Planning Association of Kenya in September 1985.

*Training: The Family Planning Association of Kenya will expand its training programs during 1986. FPAK will train teams of physicians and nurses from the Sub-Saharan region in minilaparotomy with local anesthesia and will conduct a seminar on VSC training standards in Kenya.

*Information, education, and counseling: In Nigeria and Kenya AVSC will continue to support workshops about information, education, and counseling for nurse-midwives, health educators, and counselors. FPAK will expand its training efforts in this area to include regional participants as well as Kenyans. AVSC expects that workshops in Nigeria will be decentralized during 1986, with a pilot workshop to be held at the University of Enugu Teaching Hospital in the eastern part of the country. This is in addition to the University College Hospital's second workshop tentatively scheduled for August 1986.

*New technologies: Privately funded programs using the Filshie clip will begin at Provincial General Hospital in Nyeri, Kenya, and at Kenyatta National Hospital in Nairobi. These projects will include service delivery, training, and research.

*Cooperation with Ministries of Health: AVSC expects to begin providing support to Ministries of Health in Mauritius and in Burundi in 1986. Three-year programs are being planned in both countries, with funds for capital improvements and the expansion of VSC services in several MOH facilities. In Senegal AVSC is planning to work with the Projet de Sante Familiale, under the aegis of the Ministry of Health and the Ministry of Social Development. Information about VSC will be incorporated into the educational activities of this nationwide family health program, with the anticipated result being the establishment of a referral network for VSC service delivery.

*Private sector: In 1986 AVSC plans to extend its activities in Senegal to the private sector by initiating a service program with the Association Senegalaise pour le Bien-Etre de la Famille, the IPPF affiliate located in Dakar.

*Bilateral funds: In Mali AVSC will participate in a USAID bilateral project by developing, implementing, and monitoring the voluntary sterilization component of a model clinic. The clinic will be established under the auspices of the Association Malienne pour la Promotion et la Protection de la Famille, the IPPF affiliate in Bamako.

*Technical assistance: During 1986 AVSC program staff will work closely with the Regional Development Office/West and Central Africa to prepare for a meeting of experts on medical standards for contraception in Francophone Africa. AVSC staff will help develop the portion of the conference program dedicated to voluntary sterilization.

*Program management: To improve project development and monitoring, AVSC will decentralize program staff responsible for Sub-Saharan Africa. Both the Africa Regional Office in Nairobi and the Nigeria Country Office in Lagos became operational early in 1986. In addition, AVSC will continue to explore possible sites for a West Africa Regional Office.

TABLE 3.3

Subagreements Awarded in 1985: Sub-Saharan Africa

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
<u>KENYA</u>		
Family Planning Association of Kenya KEN-02-SV-4-A	\$264,956	To continue providing voluntary sterilization services at five sites; to establish services at FPAK clinics in Eldoret and Kisii; to train medical and paramedical personnel in sterilization techniques and counseling.
Provincial General Hospital, Nyeri KEN-05-SV-2-A	\$ 18,945	To continue to expand female service provision in central Kenya; to conduct workshops for medical personnel, paramedical personnel, and the general public
Protestant Churches Medical Association KEN-08-SV-1-A	\$233,391	To expand services at nine rural hospitals; to integrate information, education, and counseling about voluntary sterilization into ongoing family planning efforts; to implement a model quality assurance, monitoring, feedback, and data collection system.
Machakos Provincial General Hospital KEN-09-SV-1-A	\$ 34,030	To establish dedicated space; to provide counseling and services; to train nine physicians in minilaparotomy; to conduct workshops for medical personnel and counselors.
Kisii District Hospital KEN-10-SV-1-A	\$ 38,378	To create dedicated operating space; to expand service provision; to orient medical, paramedical, and family planing staff from the district.
Division of Family Health, Ministry of Health, Nairobi KEN-11-SV-1-A	\$ 12,250	To establish dedicated space for the provision of outpatient services; to serve as a training site.
Rift Valley Provincial Hospital KEN-12-SV-1-A	\$ 26,798	To establish dedicated space for service provision; to conduct workshops for health care professionals and counselors.
<u>NIGERIA</u>		
University College Hospital, Ibadan NIR-12-TR-1-A	\$ 19,830	To train 20 nurse-midwives from AVSC-supported projects in Nigeria in information, education, and counseling.

TABLE 3.3 - continued

Subagreements Awarded in 1985: Sub-Saharan Africa

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
<u>Nigeria - cont'd</u>		
Akure State Specialist Hospital NIR-13-SV-1-A	\$ 35,478	To develop a pilot service, information, education, and counseling program to serve as a model for future expansion of voluntary sterilization services to other hospitals in Ondo State.
Minna General Hospital NIR-14-SV-1-A	\$ 32,234	To develop a pilot service, information, education, and counseling program to serve as a model for future expansion of voluntary sterilization services to other hospitals in Niger State.
Nigeria Army Reference Hospital, Kaduna NIR-15-SV-1-A	\$ 34,598	To develop a pilot service, information, education, and counseling program to serve as a model for future expansion of voluntary sterilization services to other Army hospitals and other hospitals in Kaduna State.
AFRICARE NIR-16-SV-1-A	\$600,000	To survey hospitals and clinics in seven Nigerian states to identify appropriate sites for model clinics; to provide equipment and supplies for selected sites in the seven states; to evaluate distribution and use of equipment and supplies provided; to identify sites with adequate facilities for the provision of services.
Oyo State Ministry of Health NIR-17-SV-1-A	\$ 99,070	To establish voluntary sterilization services at three Ministry of Health facilities in Oyo State; to develop a demonstration statewide program including counseling, information, education, training, services, and media publicity that will serve as a model for other states in Nigeria.
<u>SENEGAL</u>		
Le Dantec Maternity Hospital, University of Dakar SEN-03-SV-2-A	\$ 34,529	To expand services and training programs in fertility management as a component of maternal-child health services.

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TABLE 3.3 - continued

Subagreements Awarded in 1985: Sub-Saharan Africa

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
<u>Senegal</u> - cont'd		
Clinique de la Crois-Bleue SEN-05-SV-1-A	\$ 23,554	To expand the availability and accessibility of voluntary sterilization services in the context of maternal and child health.

TABLE 3.4

Small Grants Awarded in 1985: Sub-Saharan Africa

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
<u>BURKINA FASO</u>		
Ministry of Family Welfare S-784-TR	\$ 4,459	For attendance of a staff member at the Sixth Annual Workshop on Family Planning in Africa held at Columbia University.
<u>BURUNDI</u>		
University of Burundi S-778-PE	\$ 1,840	For attendance of a physician from the university at an AVSC-sponsored STD conference in Gabon.
Prince Louis Rwagasore Clinic S-807-SV	\$ 5,676	To provide minilap kits and emergency equipment.
<u>CAMEROON</u>		
Polyclinique Sende S-757-SV	\$ 1,040	To provide medical equipment for the provision of voluntary sterilization services.
Djoungolo Hospital S-793-SV	\$ 2,240	To provide an operating table, ceiling lamp, and additional operating equipment.
<u>GHANA</u>		
University Hospital S-817-SV	\$ 6,700	To provide medical equipment for voluntary sterilization services.
<u>KENYA</u>		
Protestant Churches Medical Association S-780-TV	\$ 4,625	For attendance of the information, education, and counseling coordinator at the Sixth Annual Workshop on Family Planning in Africa held at Columbia University.

TABLE 3.4 - continued

Small Grants Awarded in 1985: Sub-Saharan Africa

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
<u>Kenya - cont'd</u>		
Kenyatta National Hospital S-789-TV	\$ 7,500	For attendance of an administrator at the CEDPA course on women in management.
University of Nairobi S-813-SV	\$ 7,370	To provide medical equipment and instruments.
<u>MADAGASCAR</u>		
Fianakaviana Sambatra S-783-TR	\$ 5,823	For attendance of the executive director at the Sixth Annual Workshop on Family Planning in Africa held at Columbia University.
<u>MALI</u>		
Hamdallaye Maternity Hospital S-804-PE	\$ 2,500	For attendance of an operating surgeon at the meeting of the Society for Advancement of Contraception (SAC) in Bordeaux, France.
Hamdallaye Maternity Hospital S-819-SV	\$ 5,500	To provide an anesthesia machine.
<u>MAURITIUS</u>		
Ministry of Health S-794-IE	\$ 3,930	To provide two movie projectors and films.
<u>NIGERIA</u>		
Ahmadu Bello University S-786-TV	\$ 7,500	For attendance of the assistant chief nursing officer at the CEDPA course on women in management.

TABLE 3.4 - continued

Small Grants Awarded in 1985: Sub-Saharan Africa

RECIPIENT	AMOUNT	PURPOSE
<u>Nigeria</u> - cont'd		
University College Hospital, Ibadan S-787-TR	\$ 1,500	To train one physician in minilaparotomy with local anesthesia at a course given by the Family Planning Association of Kenya; to allow him to observe all aspects of the FPAK program, including client education and counseling.
University College Hospital, Ibadan S-792-EV	\$ 7,497	To support a comparative study of sterilization rates at University College Hospital, Ibadan, before and after the employment of a full-time information, education, and counseling coordinator for sterilization services.
Minna General Hospital S-798-TR	\$ 1,473	To train a physician in mini-laparotomy; to allow him to observe client counseling and information and education activities.
Apex Medical Center S-800-IE	\$ 3,200	To provide support for information and education during a health and family-planning week.
Akure State Specialist Hospital S-803-TR	\$ 1,473	To train a surgeon in mini-laparotomy in Sierra Leone.
University of Benin Teaching Hospital S-811-EV	\$ 2,310	To develop a package of information materials, including a large flip chart, small flip charts, a set of slides, a booklet, and posters for use in Africa.
Alheir Specialist Hospital S-812-SV	\$ 1,400	To provide medical equipment.
Katsina-Ala General Hospital S-815-SV	\$ 200	To provide a minilaparotomy kit.

TABLE 3.4 - continued

Subagreements Awarded in 1985: Sub-Saharan Africa

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
<u>Nigeria - cont'd</u>		
Otukpo General Hospital S-816-SV	\$ 200	To provide a minilaparotomy kit.
Onitsha Specialist Hospital S-833-SV	\$ 5,115	To provide instruments and emergency equipment for voluntary sterilization procedures.
 <u>SENEGAL</u>		
Abass N'Dao Hospital S-810-PE	\$ 2,300	For attendance of the medical director at the meeting of the Society for Advancement of Contraception (SAC) in Bordeaux, France.
 <u>TOGO</u>		
University Teaching Hospital S-822-SV	\$ 7,500	To provide medical instruments, supplies, and teaching materials to train residents.
Ministry of Health S-823-SV	\$ 1,350	To provide anatomical models to train medical and paramedical personnel.
Association Togolaise pour le Bien-Etre Familial S-824-SV	\$ 7,500	To provide medical examination instruments, audiovisual equipment, and films.
Association Togolaise pour le Bien-Etre Familial 825-SV	\$ 3,450	To provide equipment for a private physician who will receive sterilization referrals from ATBEF.
Clinique La Fraternite S-826-TR	\$ 2,104	For refresher minilaparotomy training for a physician.

TABLE 3.4 - continued

Small Grants Awarded in 1985: Sub-Saharan Africa

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
<u>UGANDA</u>		
Makerere University S-753-EV	\$ 6,552	To conduct a family planning voluntary sterilization knowledge, attitude, and practice survey in the towns of Jinja, Kampala, and M'bele in order to determine demand for services and to provide information for designing an information and education campaign.

ASIA

Summary of regional strategies and issues

AVSC continues to consider the Asia region the testing ground for new ideas and innovative approaches for voluntary sterilization program developments. Asia is characterized by mature, experienced programs which have successfully introduced voluntary sterilization services and have had substantive, favorable impact on policy development as well. In recent years, AVSC has shifted its focus from capital intensive projects to programs designed to improve quality and to test new approaches for delivering services.

Two program areas that received considerable attention in 1985 were counseling and medical safety. Significant achievements were made in both policy development and the establishment of model programs which, once evaluated, will serve as demonstrations both within and outside the region. In every Asian country where AVSC had programs, counseling played a prominent role in program development. In countries where AVSC's assistance was largely service-oriented, such as Bangladesh, Indonesia, and Nepal, special attention was given to medical safety and quality assurance.

In 1985 program management began to emerge as a priority and as a concern that will require more attention in the near future. Many AVSC programs in Asia are implemented by national leadership groups that were formed several years ago to focus on voluntary sterilization issues and services. While these groups have been largely responsible for the program successes in the region, many of them are presently defining their future roles or need to do so. This is especially true in the Philippines, Thailand, and Sri Lanka where the governments have assumed major responsibility for the implementation and coordination of voluntary sterilization programs. For these national leadership groups, self-reliance is becoming a higher priority as AVSC continues to shift resources away from older programs to underserved and new areas.

During the year the Bangladesh Association for Voluntary Sterilization (BAVS) made strides towards self-reliance. BAVS has established a special fund for local donations, and eight clinics have applied for and received free land for clinic sites. The BAVS experience illustrates an important lesson: Even programs that rely heavily upon outside support can lessen their dependency.

Summary of funds obligated

In 1985 AVSC obligated a total of \$2,336,188, or 29% of the total amount of grant funds, in Asia: \$2,284,014 for 10 subagreements, \$36,091 for 5 amendments, and \$16,083 for 7 small grants. This represents a decrease of 44 percent from the amount of funds obligated in 1984. This is because several service programs in Indonesia were successfully completed. Also, programs in Sri Lanka and the Philippines were able to continue during

1985 with funds obligated in 1984 due to favorable currency exchange gains.

Regional initiatives

By 1985, as a result of the regional workshop on counseling held in the Philippines in 1983, each of AVSC's major programs in the region had a counseling component. The 1983 workshop was the first of its kind in the world and, as such, has had an international impact on AVSC programming. The importance of this meeting becomes more and more apparent as Asia continues to take center stage on voluntarism issues.

During 1985 the British and U.S. press voiced considerable opposition to the government voluntary sterilization program in Bangladesh. Officials in that country spent a good deal of time documenting and defending voluntariness in the program.

In May Sri Lanka hosted the World Federation's Leaders' Symposium on Voluntarism, which brought together international representatives to discuss how to ensure voluntary choice in sterilization programs.

During the year AVSC completed client follow-up surveys in both Bangladesh and Indonesia. While results showed a high degree of client understanding and satisfaction, they also pointed the way for program improvements.

In several countries the focus was on developing national counseling policies. The Thai Association for Voluntary Sterilization conducted a workshop at which representatives from the Ministries of Health and the Interior developed a client-counseling policy for VSC programs. National coordinating committees for counseling policy and program development were formed by the Sri Lanka Association for Voluntary Surgical Contraception (SLAVSC) and the Family Planning Association of Nepal (FPAN).

The other major thrust in counseling was the development of curricula and the implementation of training programs. In 1985 AVSC provided a technical consultant to the Indonesian Association for Secure Contraception (PKMI) and the Philippines Association for the Study of Sterilization. The consultant observed counselor training sessions, reviewed the curricula being used, and recommended ways to improve training. During the year both BAVS and SLAVSC developed counseling training manuals.

Related to the counseling efforts was an AVSC-sponsored workshop held in July by the Family Planning Association for Sri Lanka. The purpose was to train mid- and upper-level managers from the Asian region how to effectively use and manage volunteer outreach workers in providing quality information and education to prospective VSC clients.

The year was marked by several initiatives to improve medical safety through enhanced surveillance and supervision. In Nepal AVSC provided a technical consultant to assist FPAN with its quality assurance program, which selects, trains and deploys infection-control monitors to assess and improve asepsis in mobile VSC services. In Indonesia PKMI developed a pilot medical-supervision system to be tested in 46 facilities in the province of

Surabaya, in cooperation with government health and family planning officials. This project, if successful, will be expanded to provide medical supervision to all provinces in Indonesia.

Major programs

AVSC's program in Bangladesh is our largest and one of the most important programs in the world. It is supported through a separate cooperative agreement with USAID/Dhaka. A detailed report on program accomplishments during 1985 is found in Appendix A.

In 1985 significant progress was made towards the eventual institutionalization of voluntary sterilization in Indonesia. The Indonesian Association for Secure Contraception (PKMI), on behalf of USAID/Jakarta and the government of Indonesia, surveyed hospitals and health centers in 13 provinces to assess equipment and training needs for an expanded VSC effort. This development signifies both the government's increased commitment to assuming major responsibility for VSC service delivery and PKMI's evolving role as technical adviser to the national family planning program.

As a result of the survey, USID has provided AVSC with additional funds of approximately \$1.5 million for Indonesia. The funds will be used to upgrade the hospitals and health centers in 13 provinces and to provide a technical adviser who will assist the government's national family planning coordination unit as the program expands.

AVSC also worked with PKMI to improve its fiscal and management capabilities. All funds for AVSC-supported activities were consolidated under one umbrella grant, and AVSC helped PKMI review the financial management of its network.

Pakistan is the one country in Asia where AVSC is establishing new service programs, primarily in the private, nongovernmental sector. In 1979 U.S. support for programs in Pakistan was suspended. But in 1985 AVSC once again began providing funds to that country by awarding subagreements to the Pakistan Society for Planned Parenthood and Pakistan Medico International. These organizations are initiating services in Lahore and Karachi. Several other new projects with nongovernmental organizations will be awarded in 1986. AVSC assistance to NGOs will complement the government family planning program which provides some voluntary sterilization services; these efforts are limited because of political and religious sensitivities in Pakistan. AVSC plans to support several demonstration projects, both for services and information and education, in different geographic areas of the country; these programs will be designed to show the acceptability and feasibility of VSC services in Pakistan.

Although no grant awards were made in the Philippines in 1985, there were several programs active during the year which had been awarded previously. A significant development in 1985 was the decision by the Philippine government to adopt a "high scenario" program plan. The purpose of this effort is to increase the use of effective contraceptive methods in the national family planning program, particularly in regions that are

underserved or have low rates of contraceptive use.

During 1985 AVSC began planning a needs assessment that will examine how to improve and strengthen VSC services through well-established private-sector organizations. The assessment will determine how to use a \$500,000 add-on to the cooperative agreement that AVSC expects to receive from USAID/Manila. It will also define the role of several long-time AVSC supported groups such as the Philippine Association for the Study of Sterilization, the Family Planning Organization of the Philippines, and the Philippines General Hospital/National Sterilization Training Center. AVSC will use the results of the assessment to determine the level and type of support required in the future.

Planned initiatives for 1986

*Program assessments: By far the most important effort for 1986 will be planning and executing several country-wide program assessments. These activities will measure past accomplishments and will identify program needs to guide AVSC in future program development. This work is especially important for countries in which AVSC has been involved for a long time, such as the Philippines and Thailand. These assessments will also help identify opportunities for voluntary surgical contraception programs that involve new technologies and approaches, so that Asia will remain in the vanguard of voluntary sterilization and family planning.

*New countries: In early 1985, an AVSC team visited India to explore ways AVSC can help the government of India strengthen its training programs, particularly in laparoscopic sterilization and reversal. AVSC expects that a proposal will be developed in 1986 seeking support to create model centers for high quality sterilization and reversal training in four existing training facilities--one in each of the major regions in the country. AVSC's assistance will be primarily technical in nature: providing consultants to develop in-country training programs and supporting specialized training and equipment for microsurgery. Another important aspect of the program will be to establish appropriate quality assurance mechanisms for both sterilization and reversal.

TABLE 3.5

Subagreements Awarded in 1985: Asia

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
<u>BANGLADESH</u>		
Bangladesh Association for Voluntary Sterilization BGD-03-CO-10-B	\$1,103,401	To support BAVS's national service-delivery program. delivery program.
National Institute of Population Research and Training BGD-31-TR-2-B	\$ 39,304	To provide refresher training courses for 600 government physicians at 12 BAVS clinics.
Directorate of Health Services, Ministry of Health and Population Control BGD-32-TR-1-A	\$ 39,195	To train government physicians and to improve the quality of services in Bangladesh.
<u>INDONESIA</u>		
Indonesian Association for Secure Contraception INS-03-SV-2-A	\$ 300,171	To support the national leadership, professional education and training, quality assurance, and policy development activities.
Indonesian Association for Secure Contraception INS-13-SV-2-A	\$ 13,696	To provide continued support for the voluntary sterilization program in Padang, West Sumatra.
<u>NEPAL</u>		
Family Planning Association of Nepal NEP-01-CO-9-A	\$ 323,459	To provide voluntary sterilization services, training, counseling, and education.
<u>PAKISTAN</u>		
Pakistan Society for Planned Parenthood PAK-12-IE-1-A	\$ 45,957	To conduct information and education activities for vasectomy and to provide male sterilization through private medical practitioners.

TABLE 3.5 - continued

Subagreements Awarded in 1985: Asia

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
Pakistan - cont'd		
Pakistan Medico International PAK-14-SV-1-A	\$ 41,836	To provide voluntary sterilization services for both males and females in two hospitals and 10 dispensaries.
 <u>THAILAND</u>		
Thai Association for Voluntary Sterilization THA-08-CO-9-A	\$ 273,103	To provide client education and counseling; to assure the quality and safety and vasectomy services.
Population and Community Development Association THA-18-IE-2-A	\$ 103,892	To increase the accessibility and acceptability of male contraception by establishing two family planning information centers in Bangkok.

TABLE 3.6

Small Grants Awarded in 1985: Asia

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
<u>INDONESIA</u>		
Indonesian Association for Secure Contraception S-802-TV	\$ 2,400	For attendance of a physician at a conference on obstetrics and gynecology in Sri Lanka.
Indonesian Association for Secure Contraception S-814-PE	\$ 2,200	For attendance of a physician at the Third Congress of the Indonesian Society of Andrology, held in Jakarta.
Indonesian Association for Secure Contraception S-827-TV	\$ 783	For a visit by a physician to AVSC's Asia regional office to learn about AVSC's systems, goals, and procedures and to observe governmental and private voluntary sterilization programs in Bangladesh.
<u>NEPAL</u>		
Family Planning Association of Nepal S-821-TV	\$ 2,600	For attendance of FPAN executives at a meeting with executive and program staff at AVSC/New York.
<u>PAKISTAN</u>		
Family Planning Association of Pakistan Model Clinic S-762-EQ	\$ 4,400	To provide a Laproclator.
<u>PHILIPPINES</u>		
Jose Fabella Memorial Hospital S-795-TR	\$ 3,100	To train four Nigerian physicians in minilaparotomy at the Jose Fabella Memorial Hospital in Manila.
<u>SRI LANKA</u>		
Family Planning Association of Sri Lanka S-832-EQ	\$ 600	To provide spare parts for autoclaves.

LATIN AMERICA AND THE CARIBBEAN

Summary of regional strategies and issues

AVSC's program of grant and technical assistance to the large region of Latin America and the Caribbean is shaped by several factors. In many of the countries, governments provide limited or no support for organized family planning activities, particularly for voluntary sterilization. Consequently, AVSC collaborates primarily with nongovernmental groups, many of them affiliates of the International Planned Parenthood Federation who have been working in the field of family planning for over 20 years. Many of the countries in this region have large Catholic majorities, and grantees face political opposition from both the right and left sides of the political spectrum.

Despite these conditions, in most countries of the region, there have been significant achievements not thought possible when family planning programs first began 20 years ago. Knowledge of contraceptive methods is almost universal, and in some countries over 50% of married women of reproductive age use contraception. In 11 of the 15 countries in which AVSC works, the prevalence rate for sterilization is 5% or higher.

Many of AVSC's programs in this region are large, multisite projects, national in scope, which must grapple with the many issues inherent in the delivery of safe and cost-effective voluntary sterilization services to large numbers of men and women. Several of these programs are the major providers of sterilization services in their countries (Colombia, Dominican Republic, El Salvador, Guatemala, Honduras). While this fact has sometimes made these programs vulnerable to political attack because the groups are strongly identified with sterilization, it also enables AVSC's assistance to have far-reaching impact on the quality of services. Because most of the programs in the region involve the direct delivery of services, AVSC continued to emphasize both safety and voluntarism during 1985.

There are several countries in the region that lag far behind their neighbors in contraceptive prevalence and program development. In these countries (Bolivia, Haiti, Peru, Paraguay), AVSC's strategy is to introduce voluntary sterilization services through small-scale pilot projects designed to determine demand.

Summary of funds obligated

In 1985 funds totalling \$2,676,012 were obligated in Latin America and the Caribbean: \$2,368,238 for 20 subagreements, \$248,693 for 11 amendments, and \$59,081 for 21 small grants.

Regional initiatives

One of the major regional initiatives, which began in 1984 and was intensified in 1985, was the exchange of program successes and models among various countries. These activities have two major purposes:

1. To introduce and promote the use of safe, simple technologies such as vasectomy, minilaparotomy, and local anesthesia in existing programs.
2. To establish a network of voluntary sterilization experts who can provide technical assistance to programs in the region.

While professional-education efforts are one-time, low-cost activities (most have been funded through the small-grant mechanism), they have a large potential impact. In 1985, AVSC sent physicians from programs in Brazil and Colombia to observe interval and postpartum minilaparotomy under local anesthesia at the Nuestra Senora de la Altagracia Maternity Hospital in the Dominican Republic. AVSC also supported an observation tour for the director of the Clinica Integral de la Mujer of the Centro Paruagayo de Estudios de Poblacion. The director visited the Enrique Sotomayor Hospital in Guayaquil, Ecuador, and three clinics operated by the Asociacion Pro-Bienestar de la Familia Colombiana (PROFAMILIA). As a result of this experience, the organization of services at the Clinica Integral was improved, and more clients were subsequently served.

The all-male program developed in Brazil by Promocao de Paternidade Responsavel (PROPATER) has demonstrated, for the previously unconvinced, that vasectomy services are feasible in Latin America. After officials from PROFAMILIA in Colombia toured the PROPATER program in 1984, they opened two new, male-only clinics in 1985 in Bogota and Medellin, both of which have had good initial success. Program managers from the Dominican Republic also visited PROPATER in 1985 and subsequently announced plans to introduce vasectomy services at their clinics.

A subject that has received regionwide attention is the importance of ensuring voluntarism through client counseling. In 1985 a regional workshop for South America was held at PROPATER in Sao Paulo, Brazil; the purpose was to review and adapt guidelines on client counseling drafted by the World Federation. Participating institutions are planning follow-up workshops to implement the Sao Paulo recommendations in their own programs. In late 1985 a national voluntarism workshop was held in the Dominican Republic for the two major family planning service providers, the Consejo Nacional de Poblacion y Familia and the Asociacion Dominicana Pro-Bienestar de la Familia.

A national voluntarism workshop was also held in El Salvador to discuss findings of the follow-up survey of female clients, conducted by Tulane University with support from AVSC, and completed in early 1985. The results indicated both that clients receive high-quality care and that requestors freely choose sterilization. However, the survey also pointed to two needs: improved client counseling regarding risks, alternative contraceptive methods, and permanence, and improved informed-consent record-keeping.

Participants included policymakers from all sectors delivering voluntary sterilization services, and measures were recommended to rectify program weaknesses. A similar follow-up survey was begun in late 1985 in Guatemala to follow up female clients, including indigenous women, served by the Asociacion Pro-Bienestar de la Familia (APROFAM).

Major programs

AVSC conducted an assessment of its programs in Brazil in September 1985. The purpose was to evaluate program effectiveness and to identify strategies for AVSC support in the next three to five years. The focus was on three private-sector institutions through which AVSC funds are channeled to a large number of local service providers. These three lead organizations are the Associacao Brasileira de Entidades de Planejamento Familiar (ABEPF), Sociedade Civil Bem-Estar Familiar no Brasil (BEMFAM), and Promocao de Paternidade Responsavel (PROPATER). These programs account for approximately 10% of the estimated number of sterilizations performed in Colombia annually. In Brazil most tubal occlusions are performed in public or private facilities, generally in conjunction with cesarean sections (which are reimbursable according to the Social Security regulations while voluntary sterilizations are not). The assessment concluded that ABEPF, BEMFAM, and PROPATER have done much to establish sound voluntary sterilization programs which demonstrate alternatives to the widespread practice of performing tubal occlusion with cesarean section. The study also recommended that AVSC continue to work with these programs to identify ways of influencing medical professionals to perform safe and appropriate procedures.

In 1985 PROFAMILIA in Colombia, one of the major recipients of AVSC support in the region and the world, embarked on the final year of a three-year subagreement designed to support voluntary sterilization services nationwide through its network of clinics and mobile teams. A principal objective of the program during the three years of the subagreement was to enhance the institution's capacity for self-reliance. As part of this effort, PROFAMILIA completed a study in 1985 to identify all cost components associated with sterilization service delivery and to see how these costs varied according to type of procedure and service setting. Also in 1985, PROFAMILIA opened vasectomy clinics in Bogota and Medellin and conducted a safety seminar for its clinic personnel which resulted in the development of service-delivery norms for laparoscopy, minilaparotomy, and anesthesia practices.

In late 1984 the USAID mission in Guatemala commissioned Tulane University to conduct an evaluation of APROFAM's voluntary sterilization program, which is funded almost totally by AVSC. The evaluation looked at such issues as client satisfaction, cost-effectiveness, and demand for sterilization in different service-delivery settings (mobile teams, private physicians, clinics). The results were positive, indicating a high degree of client satisfaction and no evidence of coercion. The evaluation also recommended ways to improve access to cost-effective services and laid the groundwork for a new three-year program of AVSC support to APROFAM. This program is funded in large part by USAID/Guatemala through a \$1.3 million buy-in to AVSC's cooperative agreement with AID.

In Mexico AVSC funds, through many public and private groups, discrete projects spread out over a large territory. Consequently, program coordination and management are key concerns. An assessment of these programs was scheduled to take place in October 1985 in order to address these concerns and to define future program strategies for AVSC's involvement in Mexico. The evaluation was postponed to 1986 because of the devastating earthquake that occurred in Mexico City in September. The results of the assessment will also be used to program a \$500,000 buy-in from the Latin America Bureau of AID intended specifically for Mexico. A workshop on counseling for programs in Central America, to be hosted by the Instituto Nacional de la Nutricion, and three seminars on male contraception (cofunded by AVSC and the Pathfinder Fund) were also postponed to 1986 due to the earthquake.

Planned initiatives for 1986

*Medical safety: One of the major findings of the assessment of AVSC programs in Brazil was the fact that local service sites differed significantly in surgical techniques and anesthesia practices. This phenomenon is not confined to Brazil. AVSC has noted a similar lack of standardization during medical site visits to multisite programs both in Latin America and around the world. A regional workshop for Latin American programs is planned for mid-1986 to develop guidelines for medical supervision for voluntary sterilization programs.

*Program management: In 1986 AVSC plans to consolidate responsibility for the management of all programs in Latin America and the Caribbean under the regional office in Bogota, Colombia. (In the past, programs in Central America and Mexico were handled by staff in New York.) This move will facilitate the exchange of experiences and resources from programs within the region. As part of this management change, AVSC plans to take a fresh look at programs in Central America, particularly those which have been supported by AVSC for several years (El Salvador, Guatemala, Honduras, and Mexico). Program assessments are planned for each of these countries in 1986.

TABLE 3.7

Subagreements Awarded in 1985: Latin America and Caribbean

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
<u>BRAZIL</u>		
Sociedade de Assistencia a Maternidade Escola Assis Chateaubriand BRA-26-TR-1-A	\$ 38,868	To train physicians and to increase the availability of voluntary sterilization services.
Promocao da Paternidade Responsavel BRA-27-SV-1-A	\$231,974	To provide vasectomy services.
Promocao da Paternidade Responsavel SAM-01-PE-1-A	\$ 33,622	To conduct and administer a counseling workshop for program managers in the South America Region.
<u>COLOMBIA</u>		
Asociacion Pro-Bienestar de la Familia Colombiana COL-11-SV-3-A	\$457,077	To provide sterilization services and to strengthen PROFAMILIA's capacity for self-sufficiency.
<u>COSTA RICA</u>		
Federacion Sindical Agraria Nacional COS-08-SV-1-P-V	\$ 25,431	To increase awareness about and access to vasectomy, particularly the campesino population.
<u>DOMINICAN REPUBLIC</u>		
Consejo Nacional de Poblacion Familia DOM-08-SV-1-A	\$182,927	To increase the availability of voluntary sterilization services at Ministry of Health Hospitals.
<u>ECUADOR</u>		
Asociacion Pro-Bienestar de la Familia Ecuatoriana ECU-04-SV-1-P	\$ 28,670	To provide tubal occlusion services in Quito and Guayaquil.

TABLE 3.7

Subagreements Awarded in 1985: Latin America and Caribbean

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
<u>EL SALVADOR</u>		
Asociacion Demografica Salvadorena ELS-13-SV-4-A	\$337,221	To increase access to voluntary sterilization services.
<u>GUATEMALA</u>		
Asociacion Pro-Bienestar de la Familia GUA-08-SV-1-A	\$713,073	To support voluntary sterilization programs in four regional clinics.
<u>MEXICO</u>		
Instituto Nacional de la Nutricion Salvador Zubiran CAM-02-PE-1-A	\$ 17,182	To improve the counseling abilities of service providers in Mexico and Central America by raising their awareness about the function and importance of counseling, by strengthening counseling skills, and by providing an update on contraceptive methodology.
Asociación de la Planificación Familia en la Provenza El Oro MEX-22-SV-2-A	\$ 14,150	To strengthen the voluntary sterilization program and provide complementary educational activities.
Instituto Nacional de la Nutricion Salvador Zubiran MEX-23-SV-3-A	\$ 15,615	To provide female and male sterilization services; to train Ministry of Health physicians in minilaparotomy and local anesthesia techniques.
Asociación para la Bienestar de la Familia MEX-25-SV-2-A	\$ 25,596	To increase the availability and accessibility of voluntary sterilization in a marginal zone of Mexico City.
EL Hospital Huejotzingo MEX-27-SV-2-A	\$ 19,650	To provide voluntary sterilization services in a rural area.

for

TABLE 3.7 - continued

Subagreements Awarded in 1985: Latin America and Caribbean

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
<u>Mexico</u> - cont'd		
Private physicians training MEX-37-TR-1-A	\$ 10,080	To provide private physicians with minilaparotomy kits in conjunction with a training program by Family Health International.
Desarrollo e Investigacion de la Planificacion Familiar MEX-38-PE-1-A	\$ 97,370	To repair and maintain all publicly-donated laparoscopic equipment in Mexico.
Academia Mexicana de Investigacion en Demografica Medica MEX-39-PE-1-A	\$ 20,316	To stimulate interest in vasectomy and to identify candidates for training by conducting a workshop on male contraceptive methods, research findings, and service program developments.
<u>NICARAGUA</u>		
Asociacion Demografica Nicaraguense NIC-05-SV-3-P	\$ 40,715	To provide female and male services; to provide equipment and expendable supplies.
<u>PARAGUAY</u>		
Centro Paraguayo de Estudios de Poblacion PAR-02-SV-2-A	\$ 40,211	To prevent pregnancy complications among high-risk women providing integrated services, including a voluntary sterilization service program, supported by an information and education campaign.
<u>PERU</u>		
Instituto Peruano de Paternidad Responsable PER-13-SV-1-A	\$ 18,490	To provide minilaparotomy services in rented operating and recovery space at a clinic in Lima.

TABLE 3.8

Small Grants Awarded in 1985: Latin America and Caribbean

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
<u>BOLIVIA</u>		
Clinica San Pablo S-799-SV	\$ 7,050	To promote the establishment of a network of private family planning clinics where female voluntary sterilization services can be provided.
<u>BRAZIL</u>		
Associacao Brasileira de Entidades de Planejamento Familiar S-765-TR	\$ 6,310	For minilaparotomy training at the Nuestra Senora de la Altagracia Maternity Hospital in the Dominican Republic and at PROFAMILIA in Colombia.
Sociedade Civil Bem-Estar Familiar no Brasil S-766-TR	\$ 2,030	To enable staff members to observe PROFAMILIA clinics in Bogota, Medellin, and Cali where self-sufficiency is being promoted.
Promocao da Paternidade Responsavel S-767-TR	\$ 4,067	For microsurgery training at the University of Louisville.
Associacao Brasileira de Entidades de Planejamento Familiar S-768-EQ	\$ 4,283	To purchase of 2 laryngoscopes, 20 medical kits, 60 nasopharyngeal airways, and 100 oral airways.
Hospital Cesar Cals S-790-TR	\$ 3,150	For minilaparotomy training at the Nuestra Senora de la Altagracia Maternity Hospital in the Dominican Republic and at PROFAMILIA in Colombia.

TABLE 3.8 - continued

Small Grants Awarded in 1985: Latin America and Caribbean

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
<u>COLOMBIA</u>		
Asociacion Pro-Bienestar de la Familia Colombiana S-764-TV	\$ 6,130	To provide the PROFAMILIA clinic director and experienced surgeons and anesthetists the opportunity to examine current sterilization practices and anesthesia regimens in order to improve safety within PROFAMILIA and to produce medical norms.
Asociacion Pro-Bienestar de la Familia Colombiana S-788-TR	\$ 1,700	To train two PROFAMILIA clinic directors in minilaparotomy at the Nuestra Senora de la Altagracia Maternity Hospital in the Dominican Republic.
Asociacion Pro-Bienestar de la Familia Colombiana S-829-TR	\$ 5,218	To train the Medellin men's clinic director and surgeon in the technical and organizational aspects of a men's clinic by visiting PROPATER in Brazil.
Asociacion Pro-Bienestar de la Familia Colombiana S-831-TR	\$ 2,809	To enable a clinic physician to visit PROPATER in Brazil to become acquainted with its operation and to apply that knowledge to the men's clinic in Bogota.
<u>DOMINICAN REPUBLIC</u>		
Consejo Nacional de Poblacion y Familia, S-781-PE	\$ 2,019	To conduct a training seminar for regional supervisory teams to increase standards of medical care and safety in public and private institutions.
Consejo Nacional de Poblacion y Familia S-796-SV	\$ 1,100	To provide 25 boxes of naloxone.

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TABLE 3.8 - continued

Small Grants Awarded in 1985: Latin America and Caribbean

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
<u>Dominican Republic - cont'd</u>		
Asociacion Dominicana Pro-Bienestar de la Familia S-806-PE	\$ 798	To allow the medical adviser to make a study tour of some of the principal Brazilian programs and to observe the female program carried out by PROFAMILIA in Colombia.
<u>EL SALVADOR</u>		
Tulane University 772-PE	\$ 669	To allow the principal investigator to visit the Asociacion Demografica Salvadorena to discuss the findings of the follow-up study of female sterilization clients conducted by Tulane University.
<u>GUATEMALA</u>		
Asociacion Pro-Bienestar de la Familia de Guatemala S-769-TV	\$ 1,714	To provide funds for travel to AVSC, New York to develop a continuation program for voluntary sterilization service delivery.
Asociacion Pro-Bienestar de la Familia de Guatemala S-801-TV	\$ 648	To provide funds for travel to Mexico to review and edit the Central American safety seminar report.
<u>HONDURAS</u>		
Asociacion Hondurena Planificacion de la Familia S-771-SV	\$ 3,065	To provide five Falope-Ring applicators.
<u>MEXICO</u>		
Instituto Mexicano de Seguro Social S-759-SV	\$ 450	To assess the use of the Technicator coagulation unit for vasectomy.

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TABLE 3.8

Small Grants Awarded in 1985: Latin America and Caribbean

<u>RECIPIENT</u>	<u>AMOUNT</u>	<u>PURPOSE</u>
<u>Mexico</u> - cont'd		
Universidad de Yucatan S-779-SV	\$ 1,200	To provide a movie projector for the voluntary sterilization information program and gaskets for a sterilizer.
Asociacion Demografica Salvadorena and Asociacion Pro-Bienestar de la Familia de Guatemala S-782-TV	\$ 1,512	To provide funds for travel to Mexico to serve as consultants at a seminar on voluntary sterilization for Mexican physicians sponsored by the Federacion Mexicana de Asociaciones de Planificacion Familiar.
<u>REGION</u>		
Tulane University S-830-PE	\$ 3,159	To provide funds for three researchers from El Salvador, Guatemala, and Honduras to travel to Tulane University to finalize the design and methodology for an operations-research project on barriers to vasectomy.

CHAPTER 4

TECHNICAL ASSISTANCE AND PROGRAM SUPPORT

More and more, AVSC's work overseas involves the provision of technical as well as grants assistance. This chapter reviews the various ways AVSC supports international programs in four major technical areas: improving medical quality, assuring voluntarism, program evaluation, and equipment.

IMPROVING MEDICAL QUALITY

AVSC's top priority is assuring and maintaining the high quality of voluntary sterilization services. Programs offering high-quality services have the greatest opportunity for success, because satisfied clients speak favorably about their experiences to others, and in countries where services are not well established, authorities see that services are in demand, acceptable, and performed well by qualified providers.

A major vehicle for assuring quality is periodic site visits by AVSC medical staff or, when staff are unavailable or an outside perspective would be beneficial, consultants. This process also provides AVSC with the opportunity to learn from projects what technical assistance is required. During 1985, medical site visits were conducted in Bangladesh, the Dominican Republic, India, Indonesia, Jordan, Kenya, Mali, Mauritius, Nepal, Sierra Leone, Sri Lanka, and the Sudan.

AVSC has moved toward decentralizing medical oversight of programs to medical staff in its field offices and to the programs themselves. This not only is economical and provides better coverage, but also transfers both the skills and the responsibility for assuring quality of services to the field and those closest to the programs. To further the process of decentralization, the AVSC Medical Division held an orientation in 1985 for medical personnel from the Asia and Latin America/Caribbean regional offices, which covered such topics as how to conduct a medical review of voluntary sterilization programs and specific technical information on anesthesia and microsurgery. In addition, written guidelines were developed to assist staff and consultants in conducting medical site visits.

As part of our effort to improve the quality of services, AVSC's Medical Division closely follows new developments in medical technologies and techniques. Norplant, the long-acting hormonal contraceptive implant, is a particularly promising alternative for women who want no more children, but, for one reason or another, do not choose voluntary sterilization. In 1985, two AVSC staff members attended a Norplant training session at the Klinik Raden Saleh in Jakarta, Indonesia, under the auspices of the Population Council. They interviewed clients, medical personnel, and program staff in order to ascertain the potential for AVSC to introduce Norplant on a pilot basis into its projects. Although Norplant is not yet approved by the U.S. Food and Drug Administration, AID has indicated that AVSC could use public funds for a pilot Norplant project if the project

included an operations research component. (Private AVSC funds would be necessary for the purchase of the Norplant itself.) AVSC anticipates that several pilot projects will be developed in the coming years to test the introduction of Norplant in ongoing family planning and voluntary sterilization programs.

Also in 1985, AVSC supported (with private funds) visits by an international team of voluntary sterilization experts to various sites in China, where they studied chemical sterilization techniques in both men and women. The team concluded that the chemical technique for female sterilization would require more investigation, but that the male technique might be ready for export to other countries earlier. An unexpected opportunity was provided to the team to observe a new, refined vasectomy technique developed in Sichuan Province. This technique, referred to as "clamping method under direct vision," involves a small puncture rather than an incision with a scalpel. The team was enthusiastic about the potential of this refined technique to enhance the acceptability of vasectomy, as the method presumably will lower the incidence of infections and hematomas. AVSC anticipated arranging for training in this technique in 1986 for senior vasectomists from selected international programs, in order to test the potential for use throughout the world.

ASSURING VOLUNTARISM

Conscious of the profound effects that voluntary sterilization can have on the psychological, physical, and economic well-being of clients, AVSC considers voluntarism to be of primary importance. Thus, in all of our programs, AVSC insists that utmost care be taken to ensure that each client receives all the information necessary to make a reasoned, informed decision, and that this decision is made in an atmosphere free from deceit, constraint, coercion, or personal bias on the part of the provider of services. In 1985, there were several major efforts to gain a better understanding of the principles of voluntarism in AVSC programs.

*Monitoring informed consent: All subagreements for service programs contain explicit requirements about voluntarism and informed consent. All programs must use an informed-consent form that complies with AVSC and AID requirements and must submit a sample to AVSC prior to the start-up of services. AVSC staff monitor compliance with informed-consent requirements during field visits.

Documentation of informed consent is one indicator of a program's voluntarism effort. In 1985, AVSC hired a student intern to review informed-consent policies and procedures in order to determine subrecipient compliance with AVSC requirements, to assess the adequacy of AVSC monitoring and follow-up, and to make recommendations to AVSC for improvement. The study highlighted several weaknesses in current informed-consent procedures, including the need for a better review of informed-consent forms submitted by projects and better guidance to program personnel about the elements of informed consent. New informed consent-procedures have been implemented, and a manual on informed consent is under development that is intended to provide information on the elements of informed consent and guidelines regarding its implementation and supervision. It will be a practical guide

designed primarily for use by project directors responsible for service delivery, but it may also be useful to counselors and other family planning donor agencies.

*Regional voluntarism advisers: As AVSC continues to emphasize the importance of ensuring informed choice in its programs, the number of counseling and education programs initiated by AVSC grantees toward this end continues to increase as well. (Chapter 3 cites several examples of voluntarism and counseling efforts in Africa, Asia, and Latin America.) As a result, AVSC program staff have felt increasing pressure to identify or to serve as technical resources in the areas of client education and counseling. Therefore, in 1985, AVSC held a one-week staff workshop to train one or two staff members from each region to serve as resource persons in the development and monitoring of voluntarism-related programs and issues. In addition to helping these staff members better cope with the technical needs of their programs, this initiative helped AVSC as an agency to clarify counseling concepts and to better define the role of information, education, and counseling programs in assuring informed choice.

*Client follow-up surveys: As reported in the 1984 annual report, AVSC is supporting a series of follow-up surveys of voluntary sterilization clients in selected programs it assists around the world. This series constitutes the first internationally comparable survey of female sterilization clients. The main purpose of these surveys has been to learn, from a client's point of view, how effectively information, counseling, and services were delivered and to ensure that clients made fully informed, voluntary decisions about sterilization.

Five countries were selected for the initial round of surveys: Bangladesh, Colombia, El Salvador, Indonesia, and Tunisia. Surveys have been completed in all five countries, and at the end of 1985, preliminary results from all but Colombia were available. A sixth follow-up survey, of female voluntary sterilization clients served by APROFAM in Guatemala, was initiated in late 1985, and the results were expected to be available in 1986.

The survey instrument was made up of a core questionnaire to which were added country-specific questions. For example, questions on client reimbursement were included in the Bangladesh survey. Women of reproductive age were interviewed a week after sterilization, then at the time of the first return to the clinic for a normal follow-up check. This approach was selected because of its high potential for response rates, minimal cost, and ease of implementation, and because investigators had full access to recent clinical records. In Tunisia, for practical reasons, home interviews were conducted.

The preliminary results show that voluntary sterilization clients in each of the countries made informed choices and for good reasons. The average age of the clients ranged from 28 in Bangladesh and El Salvador to 33 in Indonesia and 36 in Tunisia. Nearly all clients had three or more children and wished to terminate fertility. Knowledge of other contraceptive methods was high in all four countries--ranging from 98% to 99.7%. The voluntary sterilization decision-making process typically took several months, and in most cases, it included discussion with the husband.

The primary reason for choosing voluntary sterilization in all four countries was to "stop having children," closely followed by "economic" considerations of bringing up additional children. More than 95% of women in each of the countries expressed satisfaction with the procedure, and a clear majority of clients had already recommended voluntary sterilization to other women. The percentages of women who stated that the procedure was permanent ranged from 95% to 99.5%.

The results, although overwhelmingly positive with regard to voluntarism and informed choice, indicate that there is still room for improvement in the quality of information and counseling provided to clients in some clinics, particularly with regard to other methods of contraception and on the question of the permanent nature of voluntary sterilization.

A more detailed and comprehensive analysis of the results by the principal investigators, followed by a comparative international analysis by AVSC, was planned for 1986.

PROGRAM EVALUATION

Program evaluation is an indispensable tool in developing cost-effective, efficient, and appropriate voluntary sterilization programs. Over the past fifteen years, AVSC has amassed a wealth of knowledge and wisdom about how to set up and implement high-quality voluntary sterilization services in developing countries. There remains, however, much to be learned about making services more available, accessible, and used; more efficient and cost-effective; safer; and more sensitive and responsive to the needs of clients. In general, as voluntary sterilization programs expand and mature, the issues and problems they pose become increasingly complex. Therefore, AVSC has recognized the need to pay more systematic attention to evaluating its programs and documenting the lessons learned in order to improve future programs.

Several levels of evaluation are conducted by AVSC. At the specific project level, AVSC program staff informally evaluate the progress and impact of programs by reviewing quarterly reports and making site visits. In 1985, AVSC's evaluation staff developed working guidelines to assist program staff to develop built-in evaluation components for each subagreement funded by AVSC. Evaluation sections are now routine features of AVSC subagreement documents.

As part of an effort to improve a program's ability to monitor and evaluate its own performance, AVSC is working with multisite programs in Kenya to develop a new model client record form. This form will serve as the base for a management information system to monitor complications and the quality of services. This system is designed to guide clinic staff toward a complete medical assessment, as well as to ensure adequate counseling and informed consent. Data from each client form will be transferred to simple, precoded forms at the clinic level and sent to the project headquarters, where complications will be tabulated and rates calculated. This information will be fed back to the clinics and utilized by medical supervisors to monitor the quality of care. It will also be used to define the needs for further medical supervision and refresher training.

A similar exercise is being conducted in the Dominican Republic in conjunction with the World Federation and with partial support from the World Health Organization. A medical record form has been developed and will be introduced in two sets of clinics involved in the national family planning program. In one set, the more routine data collected will be used by medical supervisors without any central data processing and feedback. In the other set of clinics, complications and other parameters to judge medical quality will be tabulated as in the Kenya program and used for feedback and medical supervision.

In both countries, the medical staff and project directors have been enthusiastic about the potential for these systems to provide a more definitive way to monitor quality and provide a basis for comparison between clinics, as well as to identify medical problems early in their development.

Also in 1985, AVSC conducted and planned several national-level assessments to evaluate past accomplishments and identify future program strategies in countries where AVSC has provided sustained high levels of support for voluntary sterilization programs. These assessments are special exercises conducted by AVSC staff and consultants, and are meant to be independent of the press of routine grants management business in order to give priority to reflection and strategy development. They are important because they allow a more objective look at the programs we support, and time to examine and refine the strategies we are pursuing. In 1985, AVSC conducted team assessments in Brazil and Egypt, and participated in a USAID-sponsored evaluation of voluntary sterilization programs in Jamaica.

On a more global level, AVSC's assessment of international trends in voluntary sterilization was published in 1985 with support from the Rockefeller Foundation. Voluntary Sterilization: An International Fact Book documents that voluntary sterilization protects more women against pregnancy than does any other method of contraception in the world, and that people of every region in the world, and varying widely in economic, political, religious, and social background, find voluntary sterilization to be the method of preference. It documents in considerable detail the incidence and prevalence of sterilization in countries where data are available. It also reviews extensively the laws and regulations, both de jure and de facto, covering sterilization. Other sections address service-delivery programs, social science findings, surgical procedures, morbidity and mortality associated with sterilization, effectiveness, reversibility, and demographic effectiveness of sterilization. This publication has been widely distributed and has been extremely well received by program administrators and policymakers in developing countries as well as in the United States.

As part of AVSC's continuing efforts to promote self-reliance among its programs, AVSC contracted with a consultant to conduct a qualitative evaluation of self-reliance and income-generating activities and potential in voluntary sterilization projects. A survey of current grantees was conducted, and case studies and models for income generation were developed. An outcome of this review, the development of guidelines for financial plans for subagreement documents, will be very useful to guide staff and grantees in future self-reliance efforts.

EQUIPMENT

In addition to properly trained personnel, facilities, funds, and good management and supervision, voluntary sterilization programs require an extensive range of material resources, including expendable and nonexpendable supplies and equipment. From the start of its international program in 1972, AVSC has recognized the essential role of equipment in voluntary sterilization services. AVSC's equipment program began with the basic aim of providing equipment to start voluntary sterilization programs. With a growing appreciation of the critical importance of equipment, particularly as a factor contributing to the quality of services, our equipment program is expanding to encompass more than the simple procurement of equipment.

Therefore, in 1985, AVSC began to reorganize its equipment program to shift the emphasis from procurement to technical and programmatic areas of concern. As a first step in this reorganization, AVSC contracted with International Development Procurement Services (INDEPS), a commodities procurement group specializing in service to international family planning organizations, to perform equipment purchasing and shipping functions formerly carried out by AVSC staff with INDEPS. With INDEPS conducting the administrative aspects of procurement, AVSC staff can now focus more attention on technical issues, such as investigating new and alternative equipment for use in voluntary sterilization programs. A formal review of the AVSC/INDEPS contract was scheduled to take place in mid-1986; thus far, the arrangement has proved to be a positive one for AVSC and has resulted in a more efficient procurement process.

During 1985, via subagreements and small grants, AVSC distributed medical, surgical, and audiovisual equipment, and medical commodities worth \$706,350. Major equipment items accounted for \$537,133 (see Appendix B). Major equipment is defined as items that cost over \$100 or that are considered essential to a voluntary sterilization service program.

In addition, AVSC is acting as a procurement agent for a bilateral program between USAID/Jakarta and the Indonesian National Family Planning Coordinating Board (BKKBN). AVSC will procure \$1.3 million worth of medical and emergency equipment to upgrade 240 hospitals and 290 health centers in 13 provinces and enable them to provide voluntary sterilization services. During 1985, the preliminary work of conducting the needs assessment (by questionnaire), determining equipment specifications, and developing an importation plan was completed. The equipment is expected to be purchased and imported in seven shipments over a period of 18 months beginning in 1986. AVSC received funds from USAID/Jakarta via an add-on to our cooperative agreement to cover the cost of this activity and for an in-country staff adviser to oversee the equipment project.

During 1985, the Equipment Service Department, in cooperation with the Medical Division, reviewed a number of equipment items that are commonly provided to our international programs. The purpose of the review is to assess the appropriateness of the equipment for the settings in which it is used, and investigate possible improvements where necessary. One such

review, involving two different models of operating room tables, entailed an inspection of the tables and a questionnaire to recipients about the performance of the table in their programs. Each table was found to have limitations, and investigations into alternative models are under way. Other items reviewed include operating room lamps and sterilizers. In addition, laproscator systems were upgraded by including Veress needles, a carbon dioxide system, and a light source.

A large part of the technical assistance described above is provided by AVSC's program and technical staff from both the field and the headquarters office during the course of their program development and monitoring work. However, more and more, AVSC has found the need to turn to outside consultants to provide technical support and backup to staff's own efforts. In 1985, AVSC contracted with 20 consultants for assistance in various aspects of our international work. Many assignments involved conducting medical and program assessments, and every effort was made to locate appropriate local or regional consultants to participate in such efforts. A list of all international program and medical consultancies is found in Table 4.1.

TABLE 4.1

International Consultants: 1985

<u>Name and Country of Consultant</u>	<u>Scope of Assignment</u>	<u>Length of Assignment</u>
Ridha Ben Salem, M.D. (Tunisia)	Conduct a medical site visit and provide technical assistance to new service programs in Mali	6 days February 11-16
Sallie Craig Huber (USA)	Identify, analyze, and report on various local financing arrangements used by international VSC programs	60 days July 1 to November 15
Steven Smith (USA)	Participate in a needs assessment of equipment and facilities for family planning services in Nigeria in conjunction with AFRICARE	10 days July 18-28
Carlos Huevo, M.D.	Develop a voluntary sterilization safety monitoring protocol in the Dominican Republic	14 days July 28 to August 10
Ellen Hardy, Ph.D. (Brazil)	Participate in an assessment of AVSC programs in Brazil	26 days September 5-30
Linda Tietjen (USA)	Conduct an infection control workshop in Nepal and a needs assessment in Nepal and Bangladesh	60 days October 1 to November 30
John Snow, Inc. (USA)	Provide technical assistance in medical quality assurance to AVSC programs in Asia in general and Bangladesh in particular	October 1, 1985 to June 1986
M.M. Kapur, M.D. (India)	Review, comment, and revise sections of the WHO vasectomy guidelines	30 days October 1-31
Gustavo Argueta, M.D. (El Salvador)	Participate in an assessment of AVSC programs in Mexico	19 days October 6-25
Philip Darney, M.D. (USA)	Assess AVSC training programs in Egypt	15 days December 26 to January 12, 1986

TABLE 4.1 - continued

INTERNATIONAL CONSULTANTS: 1985

<u>Name and Country of Consultant</u>	<u>Scope of Assignment</u>	<u>Length of Assignment</u>
Leila Kafafi, Ph.D. (Egypt)	Assess AVSC training programs in Egypt	12 days December 29 to January 11, 1986
Gabriel Ojeda, Ph.D. (Colombia)	Conduct an assessment of AVSC's vascetomy program in El Salvador	7 days October 14-25
Evelyn Landry (USA)	Provide technical assistance in conducting a follow-up survey of female VSC clients in Guatemala	6 days December 14-20
Jane Bertrand, Ph.D. (USA)	Provide techical assistance in conducting a follow-up survey of female clients in Guatemala	6 days December 14-20
Diogo Mastrorocco, M.D. (Brazil)	Serve as a resource person for a training course for counseling personnel in Dominican Republic	11 days November 26 to December 6
Victor Jaramillo, Ph.D. (Colombia)	Assist PROPATER in developing systems and the capacity to super- vise and provide support to affil- iated service sites throughout Brazil	12 days November 24 to December 6
Tessa Wardlaw (USA)	Generate tabulations from sterilization cohort analysis	5 days December 16-20

CHAPTER 5

ACCOMPLISHMENTS OF THE WORLD FEDERATION

The World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception is an international public health organization consisting of national and regional leadership organizations and individual experts dedicated to including voluntary surgical contraception as a choice within basic health services. AVSC provides financial and programmatic support to the World Federation.

During 1985 the World Federation emphasized four major areas: (1) guaranteeing voluntary choice for the client, (2) assuring quality in service programs, (3) expanding leadership contacts around the world, especially in the Middle East and Sub-Saharan Africa, and (4) communicating with a growing base of organizations and individuals who are working in the field of voluntary surgical contraception. The Federation addressed these areas through a variety of programs and activities.

Leaders' Symposium on Voluntarism

Free and informed choice in voluntary sterilization programs was discussed in depth by an international expert group in May 1985 in Kalutara, Sri Lanka. The meeting was cosponsored by the World Federation and the Sri Lanka Ministry of Plan Implementation. Thirty leaders from 21 countries discussed how program administrators can insure voluntary choice in service programs. The group expressed its commitment to free choice and listed several ways to evaluate voluntarism in programs.

The group recommended that appropriate agencies help to develop and strengthen mechanisms that assure free and informed choice. Such mechanisms should include the three elements of supervision, monitoring, and periodic surveys.

The leaders noted that, by monitoring certain program parameters, managers should be able to assure that voluntarism is observed. Such parameters include:

- o The method mix. If the mix changes or is out of balance, then managers should examine three questions. Is one method being promoted at the expense of other methods? Do individuals and couples have a free choice among methods? Are some methods more available than others?
- o Client characteristics. For various reasons, the profile of voluntary sterilization clients rarely reflects the socioeconomic, sex, racial, and ethnic distribution of the general population. Program managers should analyze the profile carefully to identify any signs of coercion or denial of services to specific population groups.

- o Rejection rates. Programs should maintain records of clients who are denied voluntary sterilization. Decreases in rejection rates may indicate that services are being offered to inappropriate candidates; increases may be a sign that services are being denied unnecessarily. In either case staff members may not be counseling or screening clients properly.
- o Requests for reversal. Programs should maintain records about requests for reversal. While clients have various reasons for requesting reversal of voluntary sterilization, adhering to sound counseling practices and ensuring free and informed choice should keep the demand low. If requests increase, something may be wrong with the counseling process.
- o Reports or rumors about instances of involuntary sterilization. Programs should seriously examine such cases. If they prove valid, a more extensive investigation should be conducted and adequate measures taken to prevent other such incidents.
- o Informed consent. Compliance with informed-consent requirements can be monitored by periodic audits of consent forms.

The leaders noted that periodic surveys can help programs assess client satisfaction and the observance of voluntarism and can highlight areas that need remediation. In various countries a number of instruments have been used on a small scale. Programs should draw upon the experience gained in these surveys; the instruments that have been used should be refined and made easily adaptable and as widely applicable as possible.

In regard to the experts' recommendation about surveys, the World Federation, the Association for Voluntary Surgical Contraception, and the International Planned Parenthood Federation are working together to develop materials and sample instruments.

The Federation received a grant of \$10,000 from the United Nations Fund for Population Activities to publish a report on the voluntarism symposium; it will be produced in 1987.

Counseling

During the year the Federation's Information and Education Committee continued work on its counseling manual, which is now under review for publication. In addition, the Secretariat provided technical assistance in counseling to many agencies and projects. During 1986 the Secretariat's assistant director helped the Association for Voluntary Surgical Contraception with its workshop on

counseling held in Ibadan, Nigeria; codirected AVSC's staff workshop on voluntarism; lectured to international nurse practitioners at the Margaret Sanger Center in New York; and helped to develop AVSC's counseling seminar held in Brazil.

Monitoring safety

A number of agencies and programs have shown an interest in the model protocol for monitoring safety developed by the World Federation's Voluntary Surgical Contraception Statistics Committee in 1984. The Centers for Disease Control has distributed the model protocol, and it has been used in several countries around the world. The Association for Voluntary Surgical Contraception adapted the protocol for use in Kenya by the Protestant Churches Medical Association in nine mission hospitals. The Pathfinder Fund is planning a similar project in Indonesia, to be conducted by the Indonesian Association for Secure Contraception (PKMI).

The World Health Organization indicated their interest in the protocol in 1984. In July 1985 World Federation representatives traveled to the Dominican Republic to work with officials of the Consejo Nacional de Poblacion y Familia (CONAPOFA) and with AVSC staff members, to adapt the protocol for use in the government VSC program. A proposal was then developed and submitted for funding to the World Health Organization; \$29,352 has been approved for the project.

Training guidelines finalized

Guidelines for voluntary sterilization training programs, developed by an expert committee that met in Brazil in 1984, were prepared and reviewed in 1985. The experts recommended that local-anesthesia training be an integral part of instruction and that surgical trainees in laparoscopy also be trained in minilaparotomy. The guidelines produced by this group are being used by training programs funded by the Association for Voluntary Surgical Contraception. The May 1985 issue of Communique, the World Federation's newsletter, described how training programs are being implemented in Kenya and the Philippines, and included a report about training in nonsurgical male sterilization in the People's Republic of China.

The Nairobi Women's Conference

As an international nongovernmental organization recognized by the United Nations Economic and Social Council, the World Federation was invited to participate in the United Nations Decade for Women Conference in Nairobi in July. Members of the Federation's delegation spoke on maternal mortality at the NGO Forum and carried a resolution to the official government conference through the Sierra Leone delegation. The maternal mortality resolution, which appeared as an addendum in the conference's final document, resembled the official

World Federation policy statement on maternal mortality. This official statement covers the following issues:

- o Reducing high maternal mortality rates.
- o Providing voluntary surgical contraception to high-risk mothers
- o Increasing men's participation in family planning, either as supporters of partners or as users of contraceptive methods themselves
- o Improving women's status in general.
- o Repealing laws, policies, or procedures that discriminate against women.
- o Increasing the involvement of women and women's groups in the development of family planning policies and in the management of programs
- o Responding to the special needs of women as clients

The December issue of Communique summarized the proceedings of the Nairobi conference and asked readers to help the World Federation develop strategies in these areas. The Federation is developing a women's leadership network and expects to sponsor future activities to promote women's involvement in voluntary surgical contraception policymaking and service delivery.

Presentations at international meetings

To promote greater understanding about voluntary surgical contraception in other agencies and in related fields, the World Federation sponsored several presentations by VSC specialists at international meetings in 1985:

- o Dr. Virgilio Oblepias, president of the Philippines Association for the Study of Sterilization, spoke on "The Role of Leadership Groups in the Management of Family Planning Programs" at the National Council for International Health in June in Washington, D.C.
- o Hon. Anne-Marie Dourlen Rollier of France, president of the Association Nationale pour l'Etude de la Sterilisation Volontaire, spoke on "Wrongful Birth Resulting from Failed Procedures" at the Congress on Medical Law in Ghent in August.
- o Dr. John C. Cutler, president, World Federation, and Dr. Zein Khairullah, Executive Board member, represented the World Federation at the Federation Internationale de Gynecologie et d'Obstetrique in



September in West Berlin. During this conference the World Federation sponsored a meeting of 25 leaders from 15 nations who reviewed the progress of voluntary surgical contraception in their countries.

- o In November Beth S. Atkins, executive secretary of the Federation, presented the findings of the Leaders' Symposium on Voluntarism at the annual conference of the American Public Health Association in Washington, D.C.

Publications for policymakers and providers of clinical services

During 1985 the World Federation disseminated to health-care leaders the recommendations made by the 200 participants who attended the 1984 Conference on Reproductive Health Management in Sub-Saharan Africa. In a special issue of the Federation's newsletter Communique devoted to the conference, several authors discussed how to increase family planning services, including voluntary surgical contraception, in maternal health programs in the region. A lengthy article in International Family Planning Perspectives reported on the conference, its significance, and the work that came out of it. The World Federation will publish a report summarizing the 53 papers presented at the conference and other conference activities.

During the first half of 1985, the World Federation produced the final report of the Fifth International Conference on Voluntary Surgical Contraception, entitled Meeting the Needs of the Eighties.

Other documents currently being distributed to professionals are the following:

- o Report on the First International Conference on Vasectomy, October 4-7, 1982
- o Standard Terms for Voluntary Surgical Contraception
- o Safety of Voluntary Surgical Contraception: Report of an Expert Committee, Manila, the Phillipines, May 9-12, 1983
- o Family Planning Methods (Arabic)
- o Expansion of Voluntary Surgical Contraception into Rural, Remote, and Peripheral Areas: Report of an Expert Study Committee, October 1982
- o Report on the First Scientific Conference, Regional Arab Federation of Associations for Voluntary Fertility Care, Khartoum, Sudan, December 13-15, 1982

- o Ensuring Informed Choice for Voluntary Surgical Contraception: Guidelines for Counseling and for Informed Consent
- o Suggested Guiding Principles for Legislation and Administrative Regulation of Voluntary Surgical Contraception
- o Abstracts: First International Conference on Vasectomy, Colombo, Sri Lanka, October 4-7, 1982
- o Abstracts: Fifth International Conference on Voluntary Surgical Contraception, Santo Domingo, Dominican Republic, December 5-7, 1983
- o Abstracts: Conference on Reproductive Health Management in Sub-Saharan Africa, Freetown, Sierra Leone, November 5-8, 1984
- o World Federation: Goals, Philosophy, Activities, History, Structure (English, French, Spanish)
- o Communique (newsletter), published twice a year

Materials development for the Arab Region

During 1985 the World Federation coordinated the distribution of the Regional Arab Federation's medical textbook in Arabic on family planning methods. Over 2,500 copies have been distributed to date--to medical schools and government agencies in the Arab World and the United States. Favorable reports about the text continue to come in.

In 1985 the Near East Bureau of the Agency for International Development awarded the Association for Voluntary Surgical Contraception almost \$100,000 to develop professional-education materials about family planning in Arabic. The World Federation is coordinating this project for AVSC. In addition to producing materials, this project will also conduct a workshop for medical school leaders and other trainers in the Arab World.

Information clearinghouse activities

In addition to distributing a variety of professional-education publications, the Federation carries out several other informational activities. The Secretariat receives and answers about 100 requests for information every month, many of which require considerable research. The informal newsletter Update reports about activities of member organizations.

Organizational growth and program management

Organizations that applied for membership in 1985 included groups from Brazil, Mauritius, Mexico, Morocco, and Nicaragua.

During the year members and staff began preparing for the Federation's Ninth General Assembly, scheduled for October 25, 1986, in Singapore, before the XII World Congress on Fertility and Sterility. The Federation will sponsor a scientific session at the World Congress, to update participants on technical and medical issues concerning voluntary surgical contraception.

The Executive Board of the Federation met in Dhaka, Bangladesh, in December to develop a new five-year plan for Federation activities. Board members decided that professional education and policy development will remain the focus of the Federation's work.

CHAPTER 6

FISCAL AND PROGRAM MANAGEMENT

Contract status and fiscal management

*Central AID funds: 1985 was the fourth year of AVSC's current five-year cooperative agreement with AID. In general, AID funds enable AVSC to carry out its program of grant and technical assistance, thereby contributing to the increased availability of high-quality voluntary sterilization services in developing countries. In 1985, this agreement was increased by \$13,978,222 to an overall total of \$44,376,233. (The maximum amount of funds which can be received under the five-year agreement is \$78,500,000.) The additional funds obligated by AID to AVSC in 1985 are shown below:

<u>Funding Action</u>	<u>AID Obligation Date</u>	<u>Purpose</u>	<u>Amount</u>
Amendment 8	February 22, 1985	To support and implement the overall purposes of the cooperative agreement.	\$9,700,000
Amendment 9	April 15, 1985	To support the provision of voluntary sterilization services for a three-year period in Guatemala under the auspices of APROFAM.	\$1,350,000
		To support voluntary sterilization projects in Nigeria, and to channel \$600,000 to AFRICARE, a U.S. based development and relief organization, to survey seven states and assess and meet the needs for medical and contraceptive supplies.	\$ 775,000
		To support voluntary sterilization programs in Mexico.	\$ 500,000
Amendment 10	July 22, 1985	To support a family planning professional education initiative in Arabic countries.	\$ 97,565

Amendment 11	August 5, 1985	To support a technical consultant for the voluntary sterilization program in Indonesia.	\$ 164,770
Amendment 12	December 31, 1985	To process and ship medical equipment in order to upgrade and enable 240 hospitals and 290 health centers to provide voluntary sterilization services.	\$ 1,390,887
			<u>Total: \$13,978,222</u>

*Bilateral USAID/Bangladesh funds: AVSC has a separate cooperative agreement (No. 388-0050-A-1012-07) with the USAID Mission in Bangladesh, the major purpose of which is to provide technical and financial assistance to the Bangladesh Association for Voluntary Sterilization (BAVS), the largest nongovernmental provider of voluntary sterilization services in the country.

No additional funds were added by USAID to this cooperative agreement during 1985 as there were sufficient funds remaining from previous obligations to support AVSC activities in Bangladesh. See Appendix A for a detailed report on the Bangladesh agreement.

*Expenses: Table 6.1 presents the 1985 AID-funds expenses (central and bilateral) by expense category. A total of \$13.5 million in AID funds was expended in 1985.

Organizational structure

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

Currently AVSC maintains three regional offices under the direction of the International Programs Division: the Asia regional office in Dhaka, Bangladesh; the North Africa/Middle East regional office in Tunis, Tunisia; and the South America regional office in Bogota, Colombia. In 1986, responsibility for programs in Central America and the Caribbean, now handled by staff in New York, will be transferred to the regional office in Bogota in an effort to enhance regional strategy development and coordination. In addition, plans are underway for a new Africa regional office in Nairobi, Kenya, and for country offices in Lagos, Nigeria, and Mexico City, Mexico. A director and program manager have been appointed for the Africa regional and Nigeria country offices, respectively and these offices will be opened in early 1986. The Mexico country office should be opened in mid-1986.

See Appendix C for a list of AVSC staff members and positions as of December 31, 1985.

Program management

AVSC's international program of grant and technical assistance is directed by the regional offices and field staff, with program and administrative support and policy direction from management and the technical divisions in New York. Technical support is also provided by consultants (see Chapter 4) and by contract services from other, specialized organizations such as INDEPS.

1985 was a year of review and assessment of AVSC's international program in preparation for developing a long-range plan for the future. In June 1985, AID conducted a midterm evaluation of AVSC's performance under the cooperative agreement. Major areas of review included AVSC's accomplishments toward meeting existing demand for voluntary sterilization, the quality of medical services and voluntarism in AVSC supported programs, the impact of the World Federation's activities, and AVSC's management capability.

The evaluation concluded that "AVS has used AID support effectively over the period evaluated. AVS has won worldwide recognition as a leader in assisting both private and public institutions in developing countries to provide safe and affordable voluntary sterilization contraceptive services. AID should continue funding AVS for the next five years." It also recognized the contribution of the World Federation in advancing professional education and medical quality assurance in the field of surgical contraception. Recommendations for improvements included strengthening AVSC's evaluation capacity and continuing to decentralize medical oversight of programs through the appointment of medical advisers in field offices. (Reference: "The Performance of the Association for Voluntary Sterilization in Developing Countries, 1982-1985," by Scott Edmonds et. al., produced for AID by the Population Technical Assistance Project of International Science and Technology Institute, Inc., Report No. 85-49-019, January 5, 1986)

Following this evaluation, in October 1985 AVSC conducted its annual program planning and development workshop for regional and New York staff. The focus this year was on beginning to develop a draft long-range plan for the association's activities for the next five years. This plan, which will be prepared and reviewed by AVSC's Board of Directors in 1986, will set forth what AVSC wants to accomplish by the end of 1991 in terms of program results and in terms of organizational capacity. It will also form the basis for discussions with AID for a new five-year cooperative agreement.

TABLE 6.1: AID Funds Expended by Budget Category, 1985
(000 Omitted) -- Unaudited

Category	Fiscal Year 1985			Percent of Total
	Cooperative Agreement DPE 0968	Bilateral Grant USAID Dhaka 3880050	Total	
Salaries	\$ 1,800	\$ 77	\$ 1,877	13.9%
Fringe	544	19	563	4.2%
Consultants	613	6	619	4.6%
Rent and Utilities	294	8	302	2.2%
Equipment and Furniture	97	2	99	0.7%
Supplies and Services	111	9	120	0.9%
Communications	172	4	176	1.3%
Travel	366	18	384	2.8%
Information and Education	21		21	0.2%
Regional Offices	674		674	5.0%
Technical Assistance and Leadership Activities	582		582	4.3%
Subagreements	6,918	1,196	8,114	60.0%
TOTAL	\$ 12,192	\$ 1,339	\$ 13,531	100.0%

Amount for subagreements differs from amount given in Table 2.1.
Table 6.1 is based on fiscal year 1985; Table 2.1, on calendar year 1985.



APPENDIX A

Annual Report 1985

USAID/Bangladesh Cooperative Agreement with AVSC

#388-0050-A-00-1014-07

I. INTRODUCTION AND SUMMARY

There follows a report on USAID/Bangladesh Cooperative Agreement #388-0050-A-00-1014-07 with the Association for Voluntary Surgical Contraception (AVSC). The report covers the period 01 January 1985 through 31 December 1985. Appended to the narrative are a variety of tables and graphs which offer a summary of inputs and outputs for the twelve month period.

AVSC wishes to take this opportunity to express our sincere appreciation to the USAID/Bangladesh Mission staff for the considerable assistance and cooperation extended to us throughout 1985.

The main focus of the cooperative agreement in 1985 remained the provision of technical and financial assistance to the Bangladesh Association for Voluntary Sterilization (BAVS). However, the year also saw significant attention to national-level VSC training needs and the "voluntarism" issue.

A summary of the foremost program accomplishments of 1985 follows:

- BAVS Institutionalization: BAVS launched a "self-reliance" project in January 1985 which at year's end saw significant progress in land requisition, cost-reduction, and income generation.
- Expansion of BAVS Training: BAVS trained more people than ever before in 1985 mainly due to an expansion of field agent and counselor training programs.
- BAVS Program Diversification: At year end twenty clinics had added an IUD service component and monthly insertions rose from the 5 to the 150 level.
- BAVS Program Evaluation: During the first half of 1985, BAVS undertook their first-ever comprehensive clinic evaluation, as a result of which focussed technical assistance was provided to clinics most in need.
- BAVS Management: A detailed management review resulted in changes in BAVS' organizational design, delegation of authority, staffing pattern, and salary structure.
- Voluntarism: The AVSC Asia Regional Office (AVSC/ARO) provided technical assistance regarding voluntarism to the USAID Mission, the Government of Bangladesh (GOB) and visiting consultants and drafted the first comprehensive report on voluntarism with respect to sterilization services in Bangladesh.

- National-level VSC Training: Two proposals were developed with the Ministry of Health and Population Control(MOHPC) designed to improve VSC clients safety and satisfaction by expanding and improving basic and refresher VSC training for government doctors.
- Grants Management: Significant administrative efficiencies were achieved in 1985 due to the consolidation of AVSC support to BAVS via a single, bilaterally-funded grant, and the institution of a comprehensive set of grants management and implementation guidelines.

II. THE BANGLADESH ASSOCIATION FOR VOLUNTARY STERILIZATION(BAVS) PROGRAM

The primary quantifiable BAVS program outputs during 1985 are summarized in Table 1. These outputs were achieved with an expenditure of approximately Tk.26,438,378 or US \$881,279.

A. Family Planning Service Provisions:

1. Performance: VSC services provided by BAVS in 1985 declined by 63% compared to 1984, from 102,311 in 1984 to 37,836 in 1985. The magnitude of the decline in 1985 was roughly equal to the increase in 1984. Tubectomy performance fell an eight-year low while total vasectomies performed in 1985 were on a par with 1982. The five-year trend of increased acceptance of vasectomy relative to tubectomy continued in 1985. A total of 23,022 vasectomies were performed in 1985 and 14,814 tubectomies for a vasectomy to tubectomy ratio of 1.5 : 1 (See Tables 5-8).
2. Cost per case: The BAVS 1985 budget was based on a projected 110,000 procedure caseload. Actual performance in 1985 turned out to be only 37,836 procedures. While AVSC and BAVS effectively controlled variable costs in response to the decline in VSC demand in 1985 ---- approximately \$600,000 of the \$1,485,284 obligated to BAVS under BGD-03-CO-9-B was not disbursed --- cost per case nevertheless rose 103% between 1984 and 1985; from Tk.345 to Tk.699 (See Table 4). Therefore, when government of Bangladesh(GOB) costs are added to AVSC/BAVS costs (an estimated Tk.104 for the medical surgical requisite, including cost of surgical apparel, and Tk.255 for compensation to VSC client, helper, and provider) cost per case in 1985 was approximately \$35 (Tk.1,058).
3. Medical Quality: Two tubectomy-associated deaths were reported to BAVS and investigated in 1985. Both deaths were found to have been attributable to the sterilization procedure making the overall 1985 BAVS VSC mortality rate 5.3 per 100,000 procedures and 13.5 per

100,000 tubectomy procedures. A total of 259 complications were reported by the 34 BAVS clinics operational in 1985. These rates represent increases over the previous two years (see Table below and Tables 9 and 10 attached).

BAVS VSC Attributable Mortality and
 Morbidity Rates per 100,000 Procedures, CY 1983, 1984 & 1985.

	1983	1984	1985
<u>Mortality:</u>			
● Tubectomy	5.3	2.4	13.5
● Vasectomy	3.3	0	0
Overall	4.4	1.0	5.3
<u>Morbidity</u>			
	86	154	685

4. Follow-Up: The trend of declining follow-up rates which began at the end of 1984 continued throughout 1985 to the point where less than half of all BAVS clients received follow-up services at the clinic at which they received their operation. In previous years, almost 90% of all BAVS clients received clinic-based follow-up (see table below and Tables 11 and 12 attached).

Per Centage of BAVS VSC Clients Followed-Up
 at BAVS Clinics, CY 1983-1985

	1983	1984	1985
Tubectomy	91	91	63
Vasectomy	84	84	34
Overall	88	87	45

The decline in follow-up seems clearly related to the termination of the BAVS policy of reimbursing clients and their "helpers" for the costs incurred in traveling to and from the clinic for follow-up services and appears to illustrate the facilitative effect of compensation payments in ensuring VSC clients access to post-operative services. AVSC worked with BAVS to develop alternative strategies to ensure those BAVS clients not returning for follow-up are receiving adequate post-operative care. The success of alternative approaches however, remains to be evaluated. The best long-term option however, may be to re-appeal to the government for permission to reinstitute the former follow-up system, or a slightly modified version of it.

5. Rejections: The per cent of VSC requestors rejected by BAVS increased 55% for vasectomy and 27% for tubectomy between 1984 and 1985 (see table below):

Per Cent of BAVS VSC Requestors Rejected, 1982-85

	1982	1983	1984	1985
Vasectomy	9	10	11	17
Tubectomy	9	9	11	14

The main reasons for rejection in 1985 (based on information from the first half of 1985 only) remained unchanged from previous years: for men, the primary medical reason for rejection was "hydrocele/hernia" and the primary non-medical reason was that they or their wives had already been sterilized; for women, the main medical reasons for rejection were pregnancy and anaemia and the main non-medical reason was not meeting the "parity-two" eligibility criterion.

B. IUD Services and Other Methods:

While an array of temporary methods have always been available at BAVS clinics for those rejected for VSC, BAVS added IUD service capability for the first time in 1985, thereby broadening the mix of clinical methods offered. At year's end over half of the 31 clinics in which BAVS plans to add IUD capacity, had begun providing them on a limited scale; monthly insertions totalled approximately 150. The institution of routine IUD services has been a slow process, involving the training of female medical and paramedical staff as well as field agents.

In addition, BAVS clinics provided over 9,000 cycles of pills, mainly to women who were rejected for VSC or who declined upon counseling against it, and over 250,000 condoms, almost exclusively to vasectomy acceptors for use post-operatively.

C. Training:

BAVS expanded VSC-related training activities in 1985. In total, 977 physicians, paramedics, counselors, administrative staff and field agents received training during the year. Areas of increased attention in 1985 included VSC refresher training for government doctors, counseling training for NGO staff, and improved training for BAVS field agents (see Table 1).

D. "Self-Reliance" Program:

In an effort to ensure access to quality VSC services and training over the long-term, BAVS launched a "self-reliance" campaign at the beginning of 1985. The need to begin planning for some manner of institutionalization was acknowledged for the first time throughout the BAVS system by devoting the 1985 annual conference to this theme and by forming self-reliance sub-committees at the HQ and clinic level. To date, a "self-reliance" strategy has been developed and a start made on its implementation. A summary of progress follows:

1. Tax-Exempt Status: BAVS began with the basics. They applied for and received tax-exempt status from the National Board of Revenue(NBR).
2. Cost Reduction: Approximately \$600,000 in funds budgeted for 1985 were not spent due to the implementation of cost-control measures throughout the year. In addition, a comprehensive management review led to the reorganization of HQ and clinic staffing and a reduction of budgetted posts from 1,789 in 1985 to 1,332 in 1986.
3. Income Generation: Fees were charged for the first time by BAVS for training provided to staff from BKKBN/Indonesia, the Family Planning Association of Bangladesh, and Pathfinder, Bangladesh.
4. Diversification of Funding Base: A proposal for adding MCH services to BAVS clinics was developed by BAVS with technical assistance from an AVSC-supported consultant. The proposal was to be supported with non-AVSC funds.
5. Local Fund Raising: Contributions totalling almost Tk.50,000 have been made to BAVS' self-reliance fund by local donors.
6. Land Acquisition: Eight clinics have applied for and received free plots of land from the Government and several more clinics are expected to acquire plots in the near future. Mechanism are being explored to assist clinics purchase and renovate or construct permanent clinic facilities. BAVS HQ has also procured a plot of land in Dhaka and has begun plans to construct a model clinic and training facility.

E. Health Care Component:

AVSC arranged for a local consultant to work with BAVS on evaluating the "Integrated Health Care Component(IHCP)" which has been in place for several years at seven BAVS clinics. As a result of the evaluation, a proposal was developed for a revised "MCH" component to be added to select BAVS clinics. At present, the proposal is still under review.

F. Program Planning and Strategy:

A number of factors converged in 1985 to focus attention on the issue of reorienting the BAVS program:

- * In 1985 BAVS marked its 10-year anniversary and the end of a decade of AVSC support. This historical juncture prompted a certain amount of organizational introspection centering on where BAVS has been and where they are going during their second decade.
- * The broadening of AVSC's program interests to include, for example, NORPLANT, raised possibilities and expectations for BAVS.
- * Two major USAID evaluations of BAVS and AVSC in 1985 caused a certain amount of stock-taking and a questioning of basic programmatic assumptions.
- * Both the overall design of the BAVS program as well as certain specific components such as the field agent network were increasingly scrutinized from the "voluntarism" perspective.
- * BAVS initiated a "self-reliance" campaign and began to think about the optimal size and shape of its program from the perspective of someday becoming institutionalized.
- * The number of sterilizations performed by BAVS declined dramatically in 1985. The precise reasons for this decline are unclear at this time and are being studied.

A variety of ideas and options for the reorientation of the BAVS program were discussed in 1985, though to date, no clear conception or consensus as to the optimal strategy has emerged. Among the main programmatic variables to be considered are (1) whether and to what extent contraceptive services routinely offered by BAVS ought to be broadened beyond VSC or, conversely, (2) how much of a VSC specialization to retain and how much relative importance to give VSC services, training, IEC and operations research (3) whether to add an MCH/"child survival" program component and if so which services to provide and to whom, and (4) to what extent can programmatic diversity be fostered among BAVS clinics so that programs reflect local needs, volunteer and staff interests and capabilities, etc.

Though the heightened focus on voluntarism and the decline in demand for VSC now appears as two of the most important variables to consider in reorienting the BAVS program, they should not be given undue attention as their importance may not necessarily last over time.

G. Program Evaluation:

1. Exceptional Clinic Project: For the first time in 1985 BAVS undertook a comprehensive evaluation of clinic performance. Based on quantitative and qualitative criteria, eight clinics most in need of focussed technical assistance were selected and visited by BAVS/AVSC teams. Action programs designed to improve performance were developed and are being implemented. One of the eight clinics, BAVS Cox's Bazar, was permanently closed at year's end when no progress was made.
2. Development of In-house Survey Capability: AVSC engaged a local consultant to assist BAVS develop the capacity of periodically survey clients to obtain statistically representative information on clients' socio-demographic characteristics, their opinion of services, and other issues of programmatic interest. The survey system will be presented in early 1986.
3. National Quarterly Evaluation: At AVSC's request, BAVS and other NGO VSC service providers were included in the quarterly, nationally - representative sample survey of sterilization services funded by USAID and implemented by a local contractor. A separate set of tables are prepared each quarter for BAVS which are useful in suggesting trends in clients' socio-demographic, such as age and parity, and referral patterns.
4. Follow-Up Survey: The centrally-funded BAVS follow-up survey of 920 female BAVS clients was nearing completion at the end of 1985. The women interviewed, who underwent tubectomy operations in the first quarter of 1985, showed a very high degree of satisfaction with the operation. Survey results also pointed to the need for improvements in pre-operative counseling and post-operative instructions. The survey report will be finalized in the first quarter of 1986, at which point BAVS and AVSC will begin the process of operationalizing the programmatic key findings.

H. Program Management:

1. Grants Management: 1985 was the first year during which AVSC supported the BAVS program with a single, multi-year, bilaterally-funded grant. This new funding mechanism and the use of a comprehensive set of grant's management and implementation guidelines developed by the ARO, led to a marked decline in the ARO's administrative burden related to BAVS. Administrative efficiencies gained allowed staff to devote more time to technical assistance and programmatic concerns.
2. Technical Assistance: The ARO arranged for a local consultant to assist BAVS develop a consolidated accounting manual. In addition, AVSC/New York staff provided financial and management assistance to BAVS and the ARO on several occasions throughout the year.

3. Management Review: In an effort to improve the efficiency of BAVS service delivery, a management evaluation was undertaken in 1985, the main results of which were:
 - * The BAVS salary and benefits package has been upgraded to allow BAVS to maintain its competitive position and attract and retain high-calibre staff.
 - * BAVS headquarters has been organized to reflect new program priorities, clarify lines of supervision, and in response to new job classifications and staff reductions.
 - * BAVS clinics have been reorganized to improve on-site program direction and accountability.
 - * A rationalized staffing formula was developed which reduced total budgetted BAVS staff from 1789 to 1332.
4. Executive Director: BAVS's first executive director resigned at the end of 1985 after almost two years of service. Finding a suitable successor should be a priority for BAVS in early 1986.

I. Implementation Problems:

The foremost implementation problem in 1985 was to plan and implement timely and appropriate programmatic responses to the substantial and sustained decline in demand for VSC. VSC performance between October 1983 and October 1984 rose to unprecedented levels. Based on the then prevailing levels, in October 1984 BAVS and AVSC developed the 1985 program and budget projecting a 110,000 VSC caseload. However, VSC performance began to fall in November 1984 and has remained at very low levels. In terms of financial management, BAVS was able to adjust to the decline quite successfully --- at year's end approximately \$600,000 of budgetted funds were not spent. Programmatic adaptations, by contrast, were not so effective and there may have been several reasons for this:

- * Recognition that the VSC decline constituted a problem in need of attention was slow, perhaps due to the assumption it would be a temporary phenomenon based on the history of wide fluctuations in the level of VSC acceptance in Bangladesh.
- * Once the decline was recognized as a problem, BAVS' limited research capacity made an accurate analysis of its causes difficult.
- * The increasingly politicized programmatic environment, with a focus on voluntarism and VSC, made the problem of increasing BAVS sterilization performance a particularly delicate one.

- * Individual BAVS clinics did not generally take the initiative to formulate and test innovative approaches to the decline in VSC demand; this may have been related to a number of factors including (1) the high degree of centralization in the BAVS management structure (2) the manner in which AVSC funds BAVS -- via a single, consolidated grant to BAVS HQ in Dhaka --- may foster a tendency to standardize programs across clinics rather than diversify programming (3) the BAVS management and staffing structure is such that many clinics lack an individual with the requisite authority and expertise to initiate and manage clinic-level programmatic changes.

At this point, it is still a matter of conjecture as to why VSC performance has fallen. Whatever the reason(s), it appears to have affected all three of the principal VSC service providers (the GOB, BAVS, and BFPA) as service statistics indicate parallel trends in performance among them. However, there was a difference in the magnitude of the decline for BAVS. VSC performance declined 52% for the national program and 63% for BAVS between 1984 and 1985. This difference may have been caused in part by the termination of BAVS's policy of reimbursing travel costs related to clients' follow-up visits to its clinics. In addition, the increase in government VSC service facilities and the improved availability and use of spacing methods, particularly IUDs, might have been contributing factors.

III. SUPPORT TO THE GOVERNMENT OF BANGLADESH

The ARO developed two proposals in 1985 designed to address the VSC training needs to government physicians and in do so, further elevate the medical quality of VSC services in Bangladesh. The two proposals reflect a two-pronged approach to VSC training --- one, to improve training Bangladeshi doctors initially receive while interns in medical school, and the other, to bring practicing physicians in to select BAVS clinics for VSC refresher training. Both proposals at years's end have reviewed and approved by AVSC and USAID and await government of Bangladesh approval.

IV. VOLUNTARISM

Support for the cooperative agreement enabled AVSC/ARO staff to attend the May 1985 "Leaders Symposium on Voluntarism in Surgical Contraception" in Sri Lanka, and the August 1985 AVSC/WF "Voluntarism Workshop" in New York.

With input from AVSC, USAID, and several others, the ARO drafted in October a report on the voluntarism of sterilization services in Bangladesh. The report was an initial attempt to present a comprehensive picture of voluntarism to Bangladesh, including a compilation of various indicators of

the program's voluntarism as well as a chronicling of voluntarism-related problems.

The ARO solicited and received a proposal for a vasectomy follow-up survey similar to the female follow-up survey which was, at long last, nearing completion at year's end. In addition, the ARO developed a proposal for studying the factors which influenced VSC incidence in Bangladesh. Both proposals remain under review.

Summary of BAVS Outputs, January-December '85

I. <u>SERVICES:</u>		
A. <u>Sterilization requested:</u>		
1. Male	27792	
2. Female	<u>17227</u>	
3. Total	45019	
B. <u>Sterilization Requestors rejected and percent rejected:</u>		
1. Male	4770	17.2%
2. Female	<u>2413</u>	<u>-14.0%</u>
3. Total	7183	16.0%
C. <u>Sterilization Performed:</u>		
1. Male	23,022	
2. Female	<u>14,814</u>	
3. Total	37,836	
D. <u>Follow-up Rate:</u>		
1. Male	34.8	
2. Female	<u>63.1</u>	
3. Total	45.9	
E. <u>Temporary Methods Provided:</u>		
1. IUDs	954	
2. OC(cycles)	9,101	
3. Condom (Pieces)	266,574	
4. Foam (vials)	111	
5. Foam (tablets)	142	
F. <u>Number of Clinics:</u>		
1. Opened during the period	Nil	
2. Total operational at the end of the period	34	
II. <u>TRAINING:</u>		
A. <u>Physicians:</u>		
1. BAVS VSC comprehensive	16	
2. BAVS VSC Refresher	31	
3. GOB Refresher	168	
4. VSC clinic Management (Foreign Physician)	16	
B. Paramedics	35	
C. Counselors	67	
D. Accountants	1	
E. Administrative Officer	4	
F. Field Agents	599	
III. <u>CONFERENCE/WORKSHOPS:</u>		
Annual Medical Workshop	1	

Table # 2 Summary of Activities Funded under the
"Consultant and Training" Budget line
between 01 January and 31 December 1985

Month	Amount	Purpose
January'85	\$10,425 (Tk.270,455)	Four BAVS Doctors and one Senior Program Officer, AVSC/ARO's study tour in Indonesia and Thailand.
May'85	\$1,427 (Tk.38,622)	Mr Gary Wm Newton, Assistant Director, AVSC/ARO's participation at Kalutara Workshop on Voluntarism in Sri Lanka.
June'85	\$5,657 (Tk.156,449)	Participation of Dr A Bari and Mr O.Z. Majumder of BAVS in the Intensive course on Development and Management of Fertility Related Income Generation in Community Based Programs of ACPCD, Bangkok from 10-29 June'85.
July'85	\$ 3,339 (Tk.93,775)	Four BAVS counselor's attendance in Volunteer Utilization Workshop at Colombo, Sri Lanka.
September'85	\$1,808 (Tk.53,128)	Attendance of Dr Azizur Rahman, President, BAVS at the SAC conference in Bordeaux and 11th World Congress of Ob/Gyn. in West Berlin.
November'85	\$208 (Tk.6,250)	Mr A Syed's consultancy for BAVS Accounting Manual.
November'85	\$2,030 (Tk.61,183)	Dr Suan Rowland's consultancy for BAVS MCH program development & evaluation of IHCP.

Table #73: Financial Status of USAID Cooperative Agreement #388-0050-A-1014-07 to AVS as of 31 December 1985.

Budget Line ⁸	Total amount obligated by USAID to AVS as of 01 November 1984	Expenditures and sub-obligations as of 31 December 1985	Balance as of 31 December 1985 (9)
1. Subgrants	6,003,800	a) 4,174,774 ¹ b) 4,622,203 ²	1,381,597 ⁶
2. Consultants & Training	150,000	120,263	29,737
3. Administrative Costs ⁷	210,450	218,209	(7,759)
4. Accounting and Audit	63,300	12,534	50,766
5. Vehicles	40,000	39,154	846
Total:	\$6,467,550	a) 4,564,934 ³ b) 5,012,363 ⁴	1,455,187⁵

1. This figure represents cumulative ARO disbursements for all bilateral subgrants through 31 December 1985.
2. This figure represents cumulative ARO sub-obligations for all bilateral subgrants through 31 December 1985.
3. This figure represents total cumulative disbursements (line #1) and expenditures under budget lines #2-5.
4. This figure represents total cumulative expenditures under budget lines #2-5 and total cumulative sub-obligations under budget line #1.
5. This figure represents the total amount available to expend and sub-obligate as of 31 December 1985.
6. This figure represents the total amount available to be sub-obligated for bilateral subgrants as of 31 December 1985.
7. "Local travel" and "bank charges" budget lines have been subsumed under "Administrative Costs" as of Amendment Six (29 August 1984).
8. AVSC may reallocate funds among budget lines upto to 15% of each line item without amending the agreement.
9. Balances in lines #2 and #3 are not yet final as of 31 December 1985.

Table # .4 : BAVS Expenditures, Performance, and cost per-case, 1983-1985

Y e a r	Expenditures (Taka)	% Change	Total VSC Performance	% Change	Cost Per Case (Taka)	% Change
1983	26,943,727	-	68,378	-	394	-
1984	35,270,808	40%	102,316	50%	345	(12%)
1985	26,438,378	(25%)	37,803	(63%)	699	103%

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Table - 5: BANGLADESH
 NATIONAL VSC PERFORMANCE CY 1980-85
 (Includes BAVS and Other NGOs)

Table - 5

MONTH	PROCEDURES	Y E A R S						
		1980	1981	1982	1983	1984	1985	1986
JANUARY	Vasectomy	1744	1313	3789	5300	22650	15271	
	Tubectomy	17973	20996	18477	24402	37094	17365	
	TOTAL	19717	22309	22266	29702	59744	32636	
FEBRUARY	Vasectomy	2340	2455	5821	5689	22314	13350	
	Tubectomy	24370	24779	27823	29585	43528	16086	
	TOTAL	26710	27234	33644	35274	65842	29436	
MARCH	Vasectomy	2440	1332	6860	7067	22799	14430	
	Tubectomy	22156	19576	31251	29794	37436	14319	
	TOTAL	24596	20908	38111	36861	60235	28749	
APRIL	Vasectomy	1015	2074	8591	4426	20316	13288	
	Tubectomy	13146	21284	28335	19938	27805	12396	
	TOTAL	14161	23358	36926	24364	48121	25684	
MAY	Vasectomy	231	3133	7015	4502	21201	12560	
	Tubectomy	2480	19491	28540	17970	23136	8181	
	TOTAL	2711	22624	35555	22472	44337	20741	
JUNE	Vasectomy	675	3395	8723	3484	19950	12176	
	Tubectomy	7600	16175	25296	12438	10061	6203	
	TOTAL	8275	19570	34019	15922	30011	18379	
JULY	Vasectomy	1132	2647	8470	4006	28732	14336	
	Tubectomy	13777	7736	12531	12217	25434	12147	
	TOTAL	14909	10383	21001	16223	54166	26483	
AUGUST	Vasectomy	1260	3509	5892	5641	29786	10935	
	Tubectomy	10333	13235	22082	18381	23140	6985	
	TOTAL	11593	16744	27974	24022	52926	17920	
SEPTEMBER	Vasectomy	3655	6552	11397	10147	33699	16117	
	Tubectomy	24134	11175	25631	20951	28528	15097	
	TOTAL	27789	17727	37028	31098	62227	31214	
OCTOBER	Vasectomy	3011	9138	17106	21205	46411	21514	
	Tubectomy	20643	19815	37578	41194	42196	17726	
	TOTAL	23654	28953	54684	62399	88607	39240	
NOVEMBER	Vasectomy	1503	4754	10718	29136	24398	14257	
	Tubectomy	14599	13194	24766	41476	22322	10729	
	TOTAL	16102	17948	35484	70612	46720	24986	
DECEMBER	Vasectomy	1098	3744	4333	14928	13951	10353	
	Tubectomy	14210	15752	17923	22171	15428	7012	
	TOTAL	15308	19496	22256	37099	29379	17365	
YEAR TOTAL	Vasectomy	20,104	44,046	98,715	115,531	306,207	158,234	
	Tubectomy	185,421	203,208	300,233	290,517	336,108	137,244	
	GRAND TOTAL	205,525	247,254	398,948	406,048	642,315	295,468	

Table - 6: BAVS VSC PERFORMANCE CY 1979-1985

M O N T H	PROCEDURES	Y E A R S							
		1979	1980	1981	1982	1983	1984	1985	1986
JANUARY	Vasectomy	106	158	218	1616	1334	6242	2085	1958
	Tubectomy	1054	2155	2638	3831	3152	5308	1554	932
	TOTAL	1160	2313	2856	5447	4486	11550	3639	2890
FEBRUARY	Vasectomy	33	191	270	2061	1250	5473	1701	1531
	Tubectomy	865	3590	3134	5032	3665	5996	1731	1014
	TOTAL	898	3781	3404	7093	4915	11469	3432	2545
MARCH	Vasectomy	120	187	253	3047	1225	4855	1440	
	Tubectomy	2063	2594	3395	5394	3586	4827	1327	
	TOTAL	2183	2781	3648	8441	4811	9682	2767	
APRIL	Vasectomy	100	140	344	2746	1158	4232	1502	
	Tubectomy	1223	2319	2602	4042	2417	3250	1105	
	TOTAL	1323	2459	2946	6788	3575	7482	2607	
MAY	Vasectomy	253	108	519	1684	1222	4243	1247	
	Tubectomy	1641	1622	2826	3482	2424	2660	719	
	TOTAL	1894	1730	3345	5166	3646	6903	1966	
JUNE	Vasectomy	278	155	641	1608	1032	4938	1558	
	Tubectomy	1923	2295	3042	2941	1968	1367	641	
	TOTAL	2201	2450	3683	4549	3000	6305	2199	
JULY	Vasectomy	647	220	1055	1665	1483	6749	2332	
	Tubectomy	3017	2726	1819	1866	1806	3556	1320	
	TOTAL	3664	2946	2865	3531	3289	10305	3652	
AUGUST	Vasectomy	213	151	957	1343	1733	5772	1786	
	Tubectomy	1310	1439	2743	2950	2318	3027	783	
	TOTAL	1523	1590	3700	4293	4051	8799	2569	
SEPTEMBER	Vasectomy	340	406	2911	2217	2951	5695	2337	
	Tubectomy	2248	3706	4337	3032	2772	3138	1642	
	TOTAL	2588	4112	7248	5249	5723	8833	3979	
OCTOBER	Vasectomy	547	543	3687	3215	6042	7618	3080	
	Tubectomy	2735	3656	4266	5131	5623	4827	2011	
	TOTAL	3282	4199	7953	8346	11665	12445	5091	
NOVEMBER	Vasectomy	251	374	2252	1861	7104	3185	2115	
	Tubectomy	2719	3064	3262	3406	5219	2201	1208	
	TOTAL	2970	3438	5514	5267	12323	5386	3323	
DECEMBER	Vasectomy	160	188	1402	914	3720	1758	1839	
	Tubectomy	2169	2274	2836	1922	3174	1394	773	
	TOTAL	2327	2462	4238	2836	6894	3152	2612	
YEAR TOTAL	Vasectomy	3048	2821	14509	23977	30254	60760	23022	
	Tubectomy	22965	31440	36891	43029	38124	41551	14814	
	GRAND TOTAL	26013	34261	51400	67006	68378	102311	37836	

Table # 7 Yearly Moving Average of BAVS VSC Performance
January 1983 through December 1985

Month	1983			1984			1985		
	Vasec- tomy	Tubec- tomy	Total	Vasec- tomy	Tubec- tomy	Total	Vasec- tomy	Tubec- tomy	Total
January	1975	3529	5504	2930	3357	6287	4717	3150	7867
February	1907	3415	5322	3282	3551	6833	4403	2794	7197
March	1755	3265	5020	3585	3654	7239	4118	2503	6621
April	1623	3129	4752	3841	3724	7565	3891	2324	6215
May	1584	3041	4625	4093	3743	7836	3641	2162	5803
June	1536	2960	4496	4419	3693	8112	3359	2102	5461
July	1521	2955	4476	4857	3839	8696	2991	1915	4906
August	1554	2902	4456	5194	3898	9092	2659	1728	4387
September	1615	2880	4495	5422	3929	9351	2379	1604	3983
October	1850	2922	4772	5554	3862	9416	2001	1280	3281
November	2287	3073	5360	5227	3611	8838	1912	1236	3198
December	2521	3177	5698	5063	3463	8526	1918	1235	3153

Table # 8: BAVS VSC PERFORMANCE AND VASECTOMY
TO TUBECTOMY RATIO 1975-1985

Y e a r	Vasectomy	Tubectomy	Total	Vasectomy to Tubectomy Ratio
1975	2,781	1,948	4,729	143:100
1976	2,063	5,148	7,211	40:100
1977	3,739	7,117	10,856	53:100
1978	2,634	15,602	18,236	17:100
1979	3,048	22,965	26,013	13:100
1980	2,821	31,440	34,261	9:100
1981	14,509	36,891	51,400	39:100
1982	23,977	43,029	67,006	56:100
1983	30,254	38,124	68,378	79:100
1984	60,760	41,551	102,311	146:100
1985	23,022	14,814	37,836	155:100
TOTAL	169,608	258,629	428,237	66:100

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Table # 9

BAVS Mortality Investigation and Summary
of Findings January to December, 1985

Name of Client/Sex	Name of BAVS Clinic	Date of Operation	Date of Death	Probable Cause(s) of Death	Findings
Rekha Rani Mukharjee (Female)	Khulna	12-6-85	18-6-85	1. Bladder/Bowel injury. 2. Bacteraemia/Septicaemia 3. Renal failure 4. Cardio-respiratory failure due to acute renal failure with haemorrhagic/septic shock.	Attributable
Rabia (Female)	Comilla	26-10-85	27-11-85	1. Septicaemic shock due to severe secondary infection. 2. Post Partum hypoproteaenemic oedema with anaemic heart failure. 3. Tetanus.	Attributable

TABLE - 10

CLINIC WISE MONTHLY COMPLICATIONS STATISTICS

JANUARY TO DECEMBER 1983

Clinica	January			February			March			April			May			June			July			August			September			October			November			December			Total				
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T		
1. Barisal	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	0	1	1	1	2	-	-	-	-	-	-	-	-	-	-	-	-	2	1	3				
2. Bhola	1	0	1	3	0	3	-	-	-	1	1	2	1	0	1	1	0	1	1	1	2	1	0	1	2	2	4	1	0	1	2	0	2	-	-	-	14	4	18		
3. Branmanbaria	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
4. Bogra	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	1	1	-	-	-	-	-	-	-	-	-	-	0	1	1		
5. Chandpur	-	-	-	-	-	-	-	-	-	1	0	1	1	0	1	0	1	1	1	0	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	1	4		
6. Chittagong	1	0	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1	0	1	-	-	-	-	-	-	-	0	1	1	-	-	-	-	-	-	-	2	1	3		
7. Comilla	1	0	1	-	-	-	0	1	1	-	-	-	-	-	-	0	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	2	3		
8. C.B.V.P.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
9. Cox's Bazar	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
10. Dhaka	0	2	2	0	10	10	0	12	12	-	10	10	-	-	-	1	2	3	1	9	10	1	9	10	1	4	5	0	9	9	0	8	8	0	4	4	4	79	83		
11. Dinajpur	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	1	1		
12. Faridpur	0	3	3	0	1	1	0	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	1	1	-	-	-	-	-	-	0	1	1	0	7	7			
13. Gaibandha	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
14. Joypurhat	-	-	-	1	2	3	-	-	-	3	1	4	1	0	1	-	-	-	1	1	2	2	0	2	5	1	6	3	2	5	8	2	10	1	0	1	25	9	34		
15. Jessore	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
16. Khulna	0	1	1	0	1	1	1	2	3	0	2	2	0	2	2	0	1	1	2	0	2	4	0	4	-	-	-	-	-	-	1	0	1	-	-	-	8	9	17		
17. Kishoregonj	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
18. Kushtia	0	1	1	1	1	2	1	0	1	1	0	1	2	2	4	3	5	6	2	1	3	0	3	3	-	-	-	0	2	2	-	-	-	-	-	-	10	15	25		
19. Mymensingh	-	-	-	0	1	1	-	-	-	1	0	1	-	-	-	-	-	-	-	-	-	-	-	0	2	2	0	1	1	0	1	1	-	-	-	-	-	1	5	6	
20. Naogaon	-	-	-	0	1	1	0	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	1	4	2	3	5	1	1	2	-	-	-	-	6	7	13		
21. Narail	-	-	-	-	-	-	-	-	0	1	1	-	-	-	-	-	-	-	-	-	-	-	1	0	1	-	-	-	1	0	1	-	-	-	-	-	-	2	1	3	
22. Natore	0	1	1	0	1	1	-	-	-	-	-	-	-	-	-	0	2	2	0	2	2	-	-	-	1	0	1	0	1	1	-	-	-	-	-	-	-	1	7	8	
23. Nilphamari	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	1	1	
24. Noakhali	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
25. Narsingdi	1	0	1	-	-	-	1	0	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	1	1	-	-	-	-	-	-	-	-	2	1	3	
26. Pabna	-	-	-	1	0	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	0	1	
27. Perojpur	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	0	1	1	0	1	-	-	-	-	-	-	-	-	-	-	-	-	-	2	0	2	
28. Rajshahi	0	1	1	0	2	2	-	-	-	0	1	1	-	-	-	-	-	-	0	2	2	-	-	-	0	1	1	-	-	-	-	-	-	-	-	-	-	0	7	7	
29. Rangpur	-	-	-	-	-	-	-	-	-	0	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	1	1	-	-	-	-	-	-	-	-	-	0	2	2
30. Serajganj	-	-	-	0	1	1	-	-	-	-	-	1	0	1	-	-	-	-	0	3	3	-	-	-	0	2	2	0	2	2	0	2	2	-	-	-	-	1	10	11	
31. Sylhet	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	0	1	-	-	-	-	-	-	-	-	1	0	1	
32. Tangail	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
33. Tongi	-	-	-	0	1	1	-	-	-	0	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	2	2	
34. Ulipur	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Total	4	9	13	6	22	28	3	17	20	7	17	24	6	5	11	6	14	20	10	19	29	11	15	26	12	14	26	8	23	31	12	13	25	1	5	6	86	173	259		

M - Male
F - Female
T - Total

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Table - 11

Table#11: BAVS Performance and Follow-up Report
From January to December '85

Name of Clinics	Vasectomy			Tubectomy			Total		
	Perfor- mance	Follow- up	Rate in %	Perfor- mance	Follow- up	Rate in %	Perfor- mance	Follow- up	Rate in %
Barisal	427	171	40.0	656	403	61.4	1083	574	53.0
Bhola	696	499	71.6	161	142	88.1	857	641	74.7
Brahmanbaria	1050	35	3.3	332	168	50.6	1382	203	14.6
Bogra	1818	774	2.5	637	440	69.0	2455	1214	49.4
Chandpur	408	246	61.0	246	215	87.3	654	461	70.4
Chittagong	1476	737	49.9	472	219	46.3	1943	956	49.0
Comilla	977	401	41.0	347	275	79.2	1324	676	51.0
C. B. V. P.	1140	241	21.1	-	-	-	1140	241	21.1
Cox's Bazar	25	16	64.0	141	74	52.4	166	90	54.2
Dhaka	1138	511	44.9	1954	1111	56.8	3092	1622	52.4
Dinajpur	353	198	56.0	444	337	79.9	797	535	67.1
Faridpur	162	109	67.2	338	255	75.4	500	364	72.8
Jaibandha	176	123	69.9	398	293	73.6	574	416	72.2
Jaipurhat	942	494	52.4	306	264	86.2	1248	753	60.7
Jessore	1268	353	28.2	340	233	68.5	1608	591	36.7
Khulna	221	171	77.3	502	343	68.3	723	514	71.0
Kishoregonj	256	180	70.3	267	202	75.6	523	382	73.0
Kushtia	474	381	80.3	1031	561	54.4	1505	942	73.0
Mymensingh	433	220	50.8	1018	702	68.9	1451	922	63.5
Naogaon	453	287	63.3	593	455	76.7	1046	742	70.9
Narail	420	138	32.8	36	31	86.1	456	169	37.0
Natore	204	112	54.9	364	242	66.4	568	354	62.3
Nilphamari	702	37	5.2	62	23	37.0	764	60	7.8
Noakhali	1033	172	16.6	207	132	68.7	1240	304	24.5
Narsingdi	2129	146	6.8	342	211	61.6	2471	357	14.4
Pabna	986	215	21.8	538	284	52.7	1524	499	32.7
Perojpur	253	125	49.4	139	113	81.2	392	238	60.7
Rajshahi	118	46	38.9	436	330	75.6	554	376	67.8
Rangpur	211	76	36.0	373	193	51.7	584	269	46.0
Serajgonj	320	132	41.2	488	149	30.3	808	281	34.7
Sylhet	1031	260	25.2	347	170	48.9	1378	430	31.2
Tangail	798	206	25.8	350	254	72.5	1148	460	40.0
Tongi	518	106	20.4	949	531	55.9	1467	637	43.4
Ulipur	406	95	23.3	-	-	-	406	95	23.3
Total	23,022	8,018	34.8	14,814	9,355	63.1	37,836	17,373	45.9

Table 12: VSC FOLLOW-UP RATES OF BAVS CLINICS

Name of the Clinics	Pre termination of F/U travel reimbursement (August 1984 - January 1985)						Post termination of F/U travel reimbursement (February 1985 - July 1985)					
	Vasectomy			Tubectomy			Vasectomy			Tubectomy		
	Performance	Follow-up	Rate of (%) follow-up	Performance	Follow-up	Rate of (%) follow-up	Performance	Follow-up	Rate of (%) F/U (%)	Performance	Follow-up	Rate of (%) follow-up
1. Dhaka	763	557	73	1315	1208	91.8	534	240	44.9	840	607	72.3
2. Tongi	575	327	56.8	708	628	88.8	58	37	14.3	401	245	61.1
3. CBVP	930	426	45.8	-	-	-	580	96	16.6	-	-	-
4. Narsingdhi	996	620	62.2	159	135	85.0	1143	43	3.8	141	91	64.5
5. Mymensingh	1123	989	88	1340	1213	90.5	208	89	42.8	594	387	65.2
6. Kishoregonj	458	449	98	401	400	99.7	58	53	91.4	93	89	95.7
7. Feni	1250	886	71.4	462	354	76.6	388	109	28.1	136	104	76.5
8. Faridpur	912	893	97.9	563	558	99.1	72	42	58.3	161	69	42.9
9. Chittagong	497	328	66	191	141	73.8	706	369	52.3	207	113	54.6
10. Cox's Bazar	15	14	93.3	115	101	89.5	10	8	80.0	61	41	67.2
11. Comilla	1056	685	64.8	271	250	92.2	457	146	31.9	185	147	79.5
12. Chandpur	298	277	93	247	232	94	152	70	46.1	106	88	83.0
13. Brahmanbaria	589	238	40.4	394	353	98.5	407	20	4.9	162	99	61.1
14. Noakhali	243	85	35	157	129	82.0	404	71	17.6	98	70	71.4
15. Sylhet	670	493	73.5	311	226	72.6	442	119	26.9	173	83	48.0
16. Khulna	936	793	84.7	1390	1229	88.4	106	74	69.8	293	219	74.4
17. Jessore	923	662	71.7	370	327	88.3	619	197	31.8	170	97	57.1
18. Narail	677	610	90.1	64	64	100	265	49	18.5	19	15	78.9

Name of the Clinics	Pre termination of F/U travel reimbursement (August 1984 - January 1985)						Post termination of F/U travel reimbursement (February 1985 - July 1985)					
	Vasectomy			Tubectomy			Vasectomy			Tubectomy		
	Performance	Follow-up	Rate of (%) follow-up	Performance	Follow-up	Rate of (%) follow-up	Performance	Follow-up	Rate of F/U (%)	Performance	Follow-up	Rate of (%) follow-up
19. Kushtia	1218	1129	92.6	834	691	82.8	219	174	79.5	512	289	56.4
20. Barisal	918	731	79.6	1171	999	85.3	229	106	46.3	375	281	74.9
21. Bholā	807	764	94.6	336	333	99.1	308	210	68.2	77	62	80.5
22. Perojpur	689	500	72.6	260	221	85	111	52	46.8	75	62	82.7
23. Rajshahi	325	282	86.8	525	483	92	56	11	19.6	191	148	77.5
24. Noagaon	1058	985	93.1	496	469	94.6	154	91	59.1	284	231	81.3
25. Natore	1534	1372	89.4	598	544	91	55	31	56.4	186	113	60.8
26. Rangpur	711	678	95.4	395	378	95.7	42	23	54.8	122	64	52.5
27. Gaibandha	204	191	93.6	254	238	93.7	19	13	68.4	128	85	66.4
28. Nilphamari	410	374	91.2	47	36	76.6	50	9	18.0	14	10	71.4
29. Ulipur, Kurigram	252	217	86.1	-	-	-	108	15	13.9	-	-	-
30. Bogra	923	796	86.2	626	567	90.6	647	205	31.7	283	187	66.1
31. Jaipurhat	1620	1465	90.1	261	247	94.6	351	170	48.4	156	148	94.9
32. Pabna	1094	845	77.2	687	580	84.4	390	85	21.8	254	161	62.6
33. Serajganj	469	412	87.8	516	393	76.2	143	57	39.9	218	60	27.5
34. Dinajpur	438	384	87.8	362	350	96.7	103	52	50.5	181	139	76.8
TOTAL:	25,577	20,457	79.98	15,826	14,079	88.96	9,794	3,136	32.02	6,899	4,604	66.73

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APPENDIX B

MAJOR EQUIPMENT ITEMS SHIPPED IN 1985

<u>Item</u>	<u>Average Unit Price</u>	<u>Quantity Shipped</u>	<u>Total Cost</u>
Air conditioner	\$ 462	12	\$ 5,544
Anesthesia cylinders	468/set	25 sets	11,700
Anesthesia machine	3,684	25	92,100
Aspirator, electric	592	6	3,552
Aspirator, manual	149	41	6,109
Autoclave, large (8080)	1,177	33	38,841
Autoclave, small (8020)	799	7	5,593
Falope rings	0.53	84,600	44,838
Lamp, OR, ceiling	299	17	5,083
Lamp, OR, emergency	1,414	9	12,726
Lamp, OR, floor	244	69	16,836
Laparoscope system	3,682	1	3,682
Laprocator system	3,221	14	45,094
Microscope	552	2	1,104
Medical kit #1	137	276	37,812
Medical kit #2	162	60	9,720
Medical kit #3	144	2	288
Medical kit #5	65	137	8,905
Medical kit #6	72	5	360
Model, training, female	134	5	670
Model, training, male	247	2	494
Projector, 16MM	622	28	17,416
Projector, Slide	297	10	2,970

Resuscitator, demand	258	33	8,514
Resuscitator, manual	72	100	7,200
Scale	155	29	4,495
Sterilizer	3,715	5	18,575
Sterilizer, drying	4,418	2	8,836
Sterilizer, portable 25 Qt.	75	5	375
Sterilizer, portable 41½ Qt.	124	22	2,728
Stretcher	383	22	8,426
Table, exam	536	15	8,040
Table, instrument (Mayo)	72	58	4,176
Table, operating, hydraulic	2,490	11	27,390
Table, operating, manual	1,200	48	57,600
Teaching attachment	2,069	4	8,276
Washing machine/dryer	1,065	1	1,065
<hr/>			
<u>Total</u>			<u>\$ 537,133</u>

APPENDIX C

AVSC STAFF FUNDED WITH AID DOLLARS

(As of December 31, 1985)

HEADQUARTERS (New York Office)

EXECUTIVE DIVISION

Executive Director Hugo Hoogenboom*
Executive Assistant Deborah Autorino
Secretary Meliha Pile

FINANCE AND ADMINISTRATION DIVISION

Director of Finance and Administration George Woodring*
Assistant to the Director Vacant

Finance Department

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

Administration Department

Assistant Director for Administration Sophia LaRusso*
Administrative Assistant Deborah Beauvoir*
Personnel Officer Marilyn Gainfort*
Personnel Assistant Helen Epps*
Secretary Laura Finver-Harman*
Travel Coordinator Lorraine Logan*
Administrative Secretary Sandra Patterson
Receptionist Margaret Sidor*
Mail Specialist Kenneth Browne*
Word Processor Ida LoGuidice*

Data Processing Department

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

Library Services Department

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

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APPENDIX C - (continued)

Publications Department

Publications Manager Pamela Harper*
Production Assistant Linda Levine
Secretary. Meliha Pile

MEDICAL DIVISION

Medical Director Douglas Huber, M.D.*
Deputy Director. Betty Gonzales Sansoucie*
Executive Secretary. Ruth Burns
Medical and Program Advisor. Zein El-Abidin Khairullah
Coordinator for Technology and Training. Keekee Minor
Assistant Director for Research and Evaluation Vacant
Research Associate Vacant
Senior Secretary Barbara Lockett

WORLD FEDERATION

Director Beth Atkins
Executive Secretary. Micheline Gaudreau-Reed
Assistant Director Georgeanne Neamatalla
Program Officer. Leslie Brandon
Program Officer. John Pile
Administrative Secretary Urmine Paul

INTERNATIONAL DIVISION

Director, International Division Terrence Jezowski*
Executive Secretary. Josephine Osmani

Program Department

Deputy Director. Lynn Bakamjian
Administrative Assistant Mildred Rondon
Program Manager (Anglophone Africa). Joseph Dwyer
Program Manager (North Africa/Middle East/Francophone Africa)
. Phyllis Butta
Senior Secretary Laurel Rapkin
Program Manager (Francophone Africa) Beverly Ben Salem
Senior Secretary Robert Flora
Grants Officer (Sub-Saharan Africa) Nancy Kish

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

Program Manager (Central America/Mexico) Roberto Chavez
Bilingual Secretary. Leda Massih
Program Manager (South America/Caribbean). Sylvia Marks
Senior Secretary (South America/Caribbean) Estelle Goldat
Grants Officer (Central America/Mexico). Cynthia Steele Verme
Grants Officer (Central America/Mexico). Beth Nivin

APPENDIX C - (continued)

Program Department (continued)

Equipment Services Manager Vacant
Senior Secretary Diahann Stokes
Equipment Officer. Syed Jafri
Equipment Assistant. Lorrie Fritz

AFRICA-MIDDLE EAST REGIONAL OFFICE

Director Fathi Dimassi
Assistant Director Vacant
Program Officer. Margaret Duggan
Program Officer. Vacant
Program Officer. Rafik Staali
Administration/Accountant. Mohamed Hafsa
Translator Abri Haddad
Executive Secretary. Odile Sassi
Typist Vacant
Typist Khediya Mediouni
Driver Nabil Chekir
Housekeeper. Mabrouka Arouri
Housekeeper. Cherif Saidi

ASIA REGIONAL OFFICE

Director Farruk Ahmed Chaudhuri
Assistant Director Gary William Newton
Assistant Director Konstantin K. Konturas
Program Officer. Dr. Rezaul Haque
Program Officer. Dr. Sadia Afroze Chowdhury
Program Officer. Ahmed Al-Kabri
Junior Program Officer Tulshi Das Saha
Chief, Administration & Personnel. Anthony Gomes
Executive Secretary. Subash Chandra Saha
Administrative Officer Abdul Wadud
Secretary. Ruhul Amin
Program Monitor. Dewan Mokbul Hossain
Program Monitor cum Librarian. Asaduzzaman
Typist Nazneen Haider
Typist Anowara Begum
Messenger. Abdul Kader
Messenger. Sirajul Islam
Guard. Abu Taher
Guard. Ali Ashraf
Guard. Akkas Ali
Guard. Moslem Howlader
Guard. Altaf Hossain
Driver Dulu Miah
Driver Abdul Jalil

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APPENDIX C - (continued)

SOUTH AMERICA OFFICE

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

*Employee funded through private and AID dollars